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THE ACTUALIZED CARING MOMENT:

A GROUNDED THEORY OF CARING IN NURSING PRACTICE

A thesis presented in fulfilment of
requirements for the degree of Doctor of Philosophy
in Nursing at Massey University
New Zealand

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Dedication

To the ones who have a beautiful compassionate heart
in thinking, writing, talking, and having care
for mankind, living beings and nature

To mother Somboon, and father Chankeaw
for giving life to three of us Payom, Chusit, Malee
and seeding metta* in our hearts and minds

To teachers in the form of persons, or books, and nature
for conveying knowledge and wisdom
to understand, to know, the way of life

To husband Peerapol who is alongside me
with love and understanding
To baby Anatta who brings the lesson of joy and sadness

To Euswas and Wiriya families for their kind support
To all beings who share common suffering and happiness
May all "beings" in this world be well and at peace

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* A Thai word derived from Pali language means loving kindness

ABSTRACT

The purpose of this study was to provide a partial theoretical description of the phenomenon of caring in nursing practice. Three practice settings involving cancer patients were selected: hospital, hospice, and community with thirty patients and thirty-two nurses participating in the study. A research design combining a phenomenological perspective and grounded theory strategies was implemented. Data were collected by indepth interview, participant observation, and records. The data were analysed by the method of constant comparative analysis.

A number of concepts were developed from the data and the theoretical framework of "The Actualized Caring Moment" was formulated to explain how the actual caring process occurs in nursing practice. This caring moment is the moment at which the nurse and the patient realise their intersubjective connectedness in transforming healing-growing as human beings in a specific-dynamic changing situation. The actualized caring moment is a gestalt configuration of three main caring components: The preconditions, The ongoing interaction, and The situated context.

The Preconditions, which consist of the nurse, personally and professionally prepared to care, and the patient, a person with compromised health and wellbeing, are prerequisites for the occurrence of the caring process. The nurse has the qualities of benevolence, commitment, and clinical competency to be ready to care. The patient is a unique person in a vulnerable state and requires assistance from the nurse to meet personal health needs. The Ongoing Interaction, the actual caring process, is the continuity of the nurse-patient interaction moment-by-moment which brings together six caring elements: Being there, Being mindfully present, A relationship of trust, Participation in meeting needs, Empathetic communication, and Balancing knowledge-energy-time. The Situated Context is the situation and environment where the actual caring process is taking place, and this is comprised of circumstances of the nurse-patient meeting and care-facilitating working conditions

The conceptual framework of "The Actualized Caring Moment" offers nurses an opportunity to understand their practice more fully in providing effective nursing service. Consequently, its implications are valuable for education, research, and the development of knowledge focused on the discipline of nursing.

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CHAPTER 1

INTRODUCTION AND OVERVIEW

This thesis is the report of a study into the phenomenon of caring in nursing. The report presents a framework which identifies elements of the caring process, and affirms that caring is an essential component of nursing practice. The first chapter provides an explanation of how the researcher's professional experience in nursing brought her to investigate the phenomenon of caring in nursing. This leads to a clarification of the purpose of the present study, the questions to which answers were sought and the significance of the study for nursing theory and practice. The chapter concludes with an outline of the structure of the thesis.

BACKGROUND OF THE STUDY

The researcher's professional experience in nursing

A spirit of enquiry concerning **"What nursing really is"** began for me, when I commenced nursing training in Thailand at the age of eighteen. It has remained with me ever since over a seventeen year journey in nursing. As a student and new graduate nurse-midwife, the experience of nursing consisted of procedures designed to assist the medical profession, for instance, administering oral medications, injections, giving and monitoring intravenous fluid, and attending to the admission and discharge of patients.

The satisfaction came, not from the tasks themselves, but from the opportunities which they provided to help patients with relief of discomfort and pain. I learned that, while not all pain and suffering could be prevented, for these are part of the human experience, a nurse can often bring relief just by her presence and by providing a few words. The following memory is a particular example which has influenced me as a nurse over the years:

> I was a fourth year student working in an Intensive Care Unit. I was excited as well as scared when learning how to use machines. One day a staff nurse demonstrated how to care for a patient with a tracheostomy[1] tube. She explained the sterile

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[1] See Glossary in Appendix 1

> technique and the technique used to suck secretions. While she was sucking secretion via the tracheostomy tube, I noticed tears coming out of the patient's eyes. Seeing her pain I could imagine how she was suffering as it was similar to the feelings which I experienced when aspirating water or food while coughing. When the nurse finished the procedure she left me with the patient because she had other things to do. I dried the patient's tears with a flannel. I looked at her eyes to convey understanding and said "It's over for this time and you can breathe comfortably. It's an awful feeling, but it's just for a short while. "She nodded her head. I continued to care for this woman for two days. Every time I cleared her airway by suction I was aware of, not only how I had been instructed to carry out this procedure, but also of her feelings. I tried to understand her communications and I explained things to her. I also reassured her that she was doing well. She was transferred to a surgical ward after two days, so I did not have the opportunity to nurse her again. Caring for this woman gave me more confidence in caring for other patients with a tracheostomy tube. Some months later while I was doing my shopping at an open market, a woman came to greet me but I could not remember her. She talked about her experience in the Intensive Care Unit and that I was one of the nurses who had cared for her. She conveyed her thanks for my help. She said "You are the one who tried to understand me and your explanations made me feel better. I was not so frightened about what was going on with me".

The desire for understanding nursing, led me to undertake a study of nursing practice in Thailand, using a quantitative approach (Kanjanangkul & Euswas (Wiriya), 1985). It aimed at finding out "what nurses and other personnel do". The data revealed a picture of nurses mainly performing tasks directed by medical instructions. Examples of major activities performed by staff nurses were: documenting, administering medications and intravenous fluid, taking blood samples, supervision of non-professional nurses and student nurses. Practical nurses (equivalent to enrolled or second level nurses in New Zealand) assisted patients to accomplish their personal daily activities and performed simple nursing procedures, such as recording vital signs. While the findings provided some useful information about nursing practice, they did little to further the understanding of its essential nature.

An opportunity arose for me to participate in an in-service education programme for staff nurses in a university hospital in Thailand where improvement of the quality of care is a major area of development. As Thailand is a Buddhist society, the Nursing Director of the hospital at that time believed that some aspect of Buddhist philosophy should be integrated into nursing practice to improve the quality of patient care. She set

a programme of self development for all levels of nursing personnel by using the Buddhist teaching framework in which compassion is one of the focus areas. This programme also encouraged nurses to reflect on their actions through the practice of meditation. Some nurses improved their practice by adopting a compassionate attitude toward patients, and by doing so nurses gained more satisfaction from their work. This in-service education programme implied that these nurses had a need for a philosophical and theoretical framework to improve their own practice, which is something that I was also seeking. I therefore decided to further my education at doctoral level. The works of Leininger, Watson, Benner, and Meleis motivated me to investigate the phenomenon of caring nursing practice.

Introduction to the study

Over the last two decades there has been increasing consensus among nurses that the major domains of nursing practice are person, environment, and health, and that the principle values underlying nursing practice are caring and wholism[1] (Rogers, 1970; Carper, 1978; Styles, 1982; Chinn & Jacob, 1983; Leininger, 1984; Watson, 1985; Munhall & Oiler, 1986). This study is concerned with the manifestations of caring. Recent literature, coupled with the definition of nursing endorsed by the New Zealand Nurses' Association, and a survey of the views of 90 New Zealand registered nurses undertaken by the present author all confirm the centrality of caring. The proposed study intends to look at the translation of this value into nursing actions.

> Nursing is a personal service, a service and art practised within a relationship, in itself, therapeutic. This ... presupposes a personal commitment which expresses itself in what may be the most intrinsically human of human acts - the act of caring. (Roach, 1982, p. 36)

Historically, nurses have affirmed that caring for people is their central focus (Nightingale, 1964; Henderson, 1966). However, because of the increasing use of technology in health care systems and the fact that nursing practice is dominated by a biomedical model, caring has been overshadowed in nursing practice and the investigation of the phenomenon of caring has been limited in the past. Colliere (1986)

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[1] In the literature both holism/holistic and wholism/wholistic are used. The present author's preference is for the latter, although where necessary to be faithful to an original source the alternative form is used.

warns that "the devaluing of care will prepare a very harsh society ... as care is an absolute necessity for life and it is our responsibility to make it recognised, valued and visible" (p.109).

Nurses perhaps more than other professionals retain a commitment to both scientific and humanistic values. Recently, caring has been recognised by a number of nurse leaders as a topic of scholarly and practical importance (Leininger, 1978, 1986; Watson, 1979, 1985; Benner, 1984). Leininger (1984) asserts that "caring is the essence and the central unifying, and dominant domain to characterise nursing" (p. 3). Watson (1985) states that the core of nursing is caring. She defines caring as the moral ideal of nursing with "concern for preservation of humanity, dignity, and fullness of self" (p.14). Brody (1988) identifies caring as a basic nursing virtue. The quality of care is determined by the virtue and the ethics of caring which reflect the compassionate attitudes and feelings of the nurses toward the patient as they perform tasks that are the essence of nursing.

From Benner's study (1984) of what makes expert nurses effective, it is clear that mere technique and scientific knowledge are not enough. A caring relationship is central to most effective nursing interventions. Benner and Wrubel (1989) view caring as a concept that is central not only to their theory of stress and coping but also to a theory of nursing practice. Many caring dimensions of nursing practice are hidden or invisible. The invisibility of caring reflects the caregiver's intent to preserve a person's integrity during dignity-stripping, painful, and sometimes embarrassing situations (Roberts, 1990). Benner (1984) gives the idea that caring is embedded in personal and cultural meaning and commitments. It can be understood only within the context in which it occurs.

Nurses' awareness of the concept of caring has been heightened in many countries, including the United States of America, the United Kingdom, Canada, and Sweden. In the United States of America, a Center of Human Caring has been established at the University of Colorado Health Science Center to investigate the phenomenon of caring, while in Sweden the major focus of research by nurses is on the "science of caring" (Gortner & Lorensen, 1989). The number of studies on caring has been increasing. However the concept is still not well defined, in particular, how caring is expressed in nursing practice. Further exploration of caring in various settings of nursing practice is

still needed (Leininger, 1984, 1988; Watson, 1985; Dier, 1988) and as recently as 1990 Robert's wrote:

> The characteristics of caring nursing practice are often, by their very nature, hidden. If caring is to become a core value of the health care system, these caring characteristics need to be uncovered so that they can be taught, rewarded, and recognised as contributing to successful patient outcomes. (p. 67)

PURPOSE OF THE STUDY

The **purpose** of this research is **to identify** and **authenticate those aspects of nursing practice which best typify caring.** In order to do this it is necessary to understand the meaning which caring has in nursing practice, for the nurses who perform it, and the patients to whom it is directed. The aim of the study extends to theory generation.

Since caring in nursing practice is too broad a notion to be addressed in a single study, the present research focussed on nursing practice involving a specific patient category. For this study the category was adults with a confirmed diagnosis of cancer or who were undergoing investigation of such a diagnosis. These patients were selected as respondents because the author believed that this group of patients had experience of being cared for, and because of their cancer diagnosis and treatment modalities they were often in frequent contact with professional nurses. Therefore they were expected to have experience to draw upon from which to formulate their perceptions of professional nurse caring.

THE RESEARCH QUESTIONS

In approaching the broad question of the relationship between caring as a value and caring as nursing actions, a subset of questions relevant to the context of the study were formulated. These were:

What does caring mean for nurses in their professional practice?

How do patients perceive themselves as being cared for by nurses?

Do, or can, patients and nurses identify caring actions?

SIGNIFICANCE OF THE STUDY

In the New Zealand context the link between nursing and caring has been made explicit. The New Zealand Nurses' Association has adopted the following definition of nursing:

> Nursing is a specialised expression of caring concerned primarily with enhancing the abilities of individuals and groups to achieve their health potential within the realities of their life situation. (New Zealand Nurses' Association, 1984, p. 3)

Despite that statement no previous study focussing specifically on caring in nursing has been undertaken in New Zealand. Although caring-focussed research has been conducted in the United States of America, the United Kingdom, Sweden, Finland, Norway, and Canada, the application of the findings to the New Zealand nursing context may be limited. An investigation of how New Zealand nurses perceive caring in nursing practice is needed.

Over the past two decades there has been much emphasis on developing theories and conceptual frameworks to guide nursing practice. However, many of these have not been adequately shaped by the practice of nurses since they were aimed at curricular construction rather than being drawn from practice (Stevens, 1979; Benner, 1984; Meleis, 1985).

As nursing is a practice discipline dealing with the complex human experience of health and illness, the knowledge within the perspective of the discipline should be relevant to all realms of practice (Donaldson & Crowley, 1978). One type of knowledge specific to nursing as a practice discipline is clinical knowledge (Schultz & Meleis, 1988). Benner points out that this knowledge is embedded in expert clinical practice. Therefore uncovering this knowledge is likely to facilitate the development of practice theory.

Both qualitative and quantitative methods have been used in studies conducted to uncover knowledge of caring in nursing. Most studies have been considered from one perspective only, either that of the nurse or that of the patient. The meaning and the characteristics of caring in nursing have begun to emerge from these studies. However, few of them attempt to generate a caring theory from actual practice.

The present study is directed towards further illumination of the phenomenon of caring in nursing practice from perspectives of both nurse and patient. The endeavour of theoretical development by using grounded theory strategies gives further significance to this research. It is expected that the theoretical framework developed from this study will assist nurses in using their skills for maximum therapeutic effect in their practice.

STRUCTURE OF THE THESIS

The account of this research study and its theoretical outcome is presented in ten chapters. The first three chapters provide a general introduction to the study. In **Chapter One** the background of the study and objectives of the research are introduced. **Chapter Two** contains a discussion and critique of relevant literature concerned with caring. **Chapter Three** is divided into two sections. In section one the discussion concentrates on methodological issues. The selected approach, which uses a phenomenological perspective and grounded theory strategies is described. Section two illustrates the manner in which the research was conducted. The study settings, the participants, ethical considerations, and the methods used to obtain and analyse the data are described. The research findings, which give rise to four categories are presented in Chapters 4-7. In **Chapter Four** the first two categories emerging from the study are discussed with supporting data. The first category is - The nurse: personally and professionally prepared to care. The second is - The patient with compromised health and wellbeing. **Chapters Five and Six** contain a discussion on the third category with its concepts and subconcepts indicated by the data - The ongoing interaction. **Chapter Seven** illustrates the fourth category with supporting data - The situated context. In **Chapter Eight** the integration and explanation of the theoretical framework is presented. The theoretical statements defining the characteristics of caring in nursing practice are also presented. **Chapter nine** is a discussion of the supplementary findings of the study which concern obstacles to the occurrence of the caring process. The research findings in relation to the literature on caring are discussed in **Chapter Ten.** Also limitations of the study and implications for practice, education, and research are presented. A concluding statement is also incorporated in this chapter. The thesis ends with an **epilogue** portraying poems on the episodes of caring in everyday nursing practice which the researcher has transformed from the data. Finally the researcher's reflection on caring in nursing is portrayed in an analog picture.

CHAPTER 2

REVIEW OF THE RELEVANT LITERATURE

In this chapter the reader is presented with relevant literature on caring. The word "caring" is used frequently in day to day conversation, and its importance has been addressed in a number of disciplines e.g. Theology, Humanities, Anthropology. To understand the meaning of caring in the nursing context, it is necessary to understand its meaning in other contexts. Therefore the discussion commences with the layman's meaning of caring. Then follows a review of caring from the perspectives of philosophy and behavioural science. Lastly, caring is discussed from a nursing perspective. Relevant overseas research on caring is discussed in detail, and the few existing New Zealand studies related to caring and nursing practice are also reviewed.

THE MEANING OF CARING FROM THE LAYMAN'S PERSPECTIVE

The words "care" and "caring" are widely used in everyday life. They are used in a positive sense, from caring for things to animals and people. "The term caring is used appropriately to describe a wide range of involvements, from romantic love to parental love to friendship, from caring for one's garden to caring about one's work, to caring for and about one's patients" (Benner & Wrubel, 1989, p. 1). An example of the word caring used in a speech is shown in the following quotation (cited Watson, 1985, p.31):

> The only true standard of greatness of any civilization is our sense of social and moral responsibility in translating material wealth to human values and achieving our full potential as a *caring* society.
>
> The Right Honorable Norman Kirk[1]

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[1] A former Prime Minister of New Zealand.

According to The Oxford English Dictionary (1970), the word "care" comes from the old English word "Caru" and the old German word "Kara" which mean 1) mental suffering, sorrow, grief, trouble; 2) burdened state of mind arising from fear; 3) serious mental attention; 4) charge; oversight with a view of protection; 5) an object or matter of concern, or solicitude.

In the *1975 Websters Dictionary,* the word "Care" as a noun means (1) suffering of mind; grief; (2) a burdensome sense of responsibility; anxiety; (3) painstaking or watchful attention; (4) regard coming from desire or esteem; (5) charge, supervision; and (6) a person or thing that is an object of attention, anxiety or solicitude. When care is used as a verb, it has the following meanings: (1) to feel trouble or anxiety or to feel interest and concern; (2) to provide for or look after; (3) to have a liking, fondness or taste for, or to have an inclination toward; and to be concerned about. When care is used in a negative sense as "not to care" it conveys the idea of indifference, inattention or disregard.

CARING FROM THE PERSPECTIVE OF PHILOSOPHY

Mayeroff (1971) gave a general meaning of caring as the process of helping another grow and actualize. This process is the common basic pattern of care in any context in which it occurs. Through the caring process the carer participates in the reality of the other. The carer sees the other as having potentialities which are expressed through the latter's need to grow. The caring process is at once an extension of, yet separate from, the carer. In this way the other is not dependent on the carer, for the other is a participant in that caring:

> In helping the other grow I do not impose my own direction; rather I allow the direction of the other's growth to guide what I do, to help determine how I am to respond and what is relevant to such response. I appreciate the other as independent in its own right with needs that are to be respected. (p. 7)

He identified eight essential ingredients of caring: knowledge, alternating rhythms, patience, honesty, trust, humility, hope, and courage. These ingredients were explained as follows:

1. **Knowledge:** In order to be caring toward another, one needs some knowledge of who is the other, what his/her needs are, and how to assist the other's growth.

2. **Alternating rhythms:** The one caring looks at the outcome of his/her actions by which he/she intends to care, and if the goal was not achieved, then the one caring modifies the actions to help the other.

3. **Patience:** As described by Mayeroff, patience is neither indifferent nor passive. Patience implies a giving of oneself to help the other's growth. The one caring must allow the cared-for to grow at his/her own pace.

4. **Honesty:** The one caring acts in a genuine manner with his/her own feelings. He/she tries to accurately assess what it takes to help the other. If mistakes are made, one learns from them.

5. **Trust:** The one caring believes and allows the cared-for to grow in his/her own way which is comfortable to him or her. A giving of trust on the part of the one caring encourages the cared-for toward self trust.

6. **Humility:** The one extending the caring recognises that he or she can learn something in any caring situation. Basic to humility is an openness and readiness to learn from the one who is cared for. Inherent in humility is a recognition and acceptance by the carer of his/her own strengths and weaknesses.

7. **Hope:** The one caring maintains the hope that his or her caring will help the cared-for to grow as a person. Hope is based in the present, alive with possibilities and potentialities, and projects the realisation of these possibilities into the future.

8. **Courage:** The willingness to go into the unknown future with the cared-for, courage is based on the projection of the present possibilities and potentialities into that future.

Buber (1958), an existential philosopher, had considered the fundamental fact of human existence as man with man. Care, as a sense of concern for the other, is fundamental to entering into a relationship. The forms for relationship are expressed as "I-Thou" and "I-It". The "I" is separate and distinct. The "It" refers to objects, whether things or individuals treated as objects. Buber used "Thou" when the individual as subject recognizes, knows, and cares for the other as subject. Each recognizes the other as a

unique and valued being with whom he shares existence. There is authentic human exchange within the "I-Thou" relationship. Each individual potentiates appreciation and nurturance of the other without imposing "I" on the other.

Heidegger (1962), a phenomenological philosopher, addressed care as the basic constitutive phenomenon of human existence. The essential relation of man to the world was one of care. "To be is to care", and the different ways of caring were the various ways of "Being-in-the-World". He conceptualized caring in two ways: 1) inauthentic caring existed when the person took on the responsibility for others and totally did for others and 2) authentic caring occurred when the person helped the other person to take care of himself. Heidegger considered care as primordial and the source of conscience. One's being was lost when one did not care, and the path back to being was by caring.

Heidegger used the following ancient fable to illustrate his view of care.

> Once when "Care" was crossing a river, she saw some clay; she thoughtfully took up a piece and began to shape it. While she was meditating on what she had made, Jupiter came by. "Care" asked him to give it spirit, and this he gladly granted. But when she wanted her name to be bestowed upon it, he forbade this, and demanded that it be given his name instead. While "Care" and Jupiter were disputing, Earth arose and desired that her own name be conferred on the creature, since she had furnished it with part of her body. They asked Saturn to be their arbiter, and he made the following decision, which seemed a just one:
>
> Since you Jupiter, have given it spirit, you shall receive that spirit at its death; and since you, Earth, have given its body, you shall receive its body. But since "Care" first shaped this creature, she shall possess it as long as it lives. And because there is now a dispute among you as to its name, let it be called 'homo', for it is made out of humus (earth). (1962, p. 242)

More recently Marcel (1981), a French existential philosopher, wrote about presence as an expression of a caring person. It is more than just being physically present. Marcel stated that the essential factor for "presence" is being with a person, actively listening and giving attention to the person. Existential presence is making oneself open and available to another in a manner of giving to the other so that a sense of value is communicated.

The following quotes from "The Philosophy of Existence" (1971) express Marcel's themes of presence and availability and provide a framework for a caring relationship.

> When I say that a being is granted to me as a presence ... this means that I am unable to treat him as if he were merely placed in front of me; between him and me there arises a relationship which surpasses my awareness of him; he is not only before me, he is also with me. (p. 24)

> It is an undeniable fact ... there are some people who reveal themselves as "present" -- that is to say, at our disposal -- when we are in pain or need to confide in someone, while there are other people who do not give this feeling, however great is their good will ... The most attentive listener may give the impression of not being present; he gives me nothing, he cannot make room for me in himself, whatever the material favors he is prepared to grant me. The truth is there is a way of listening which is a refusing ... Presence is something which reveals itself immediately and unmistakably in a look, a smile, an intonation, or a handshake. (pp. 25-26)

> The person who is at my disposal is the one who is capable of being with me with the whole of himself when I am in need; while the one who is not at my disposal seems merely to offer me a temporary loan raised on his resource. For the one I am a presence; for the other I am an object. (p. 26)

Marcel always identified existence with participation with others. The more one's existence took on the character of including others, the fuller the existence became. He termed this interdependence of man "intersubjectivity".

In her theory of caring, Noddings (1981) stated that caring relationships between human beings involve three parts. The first part involves a focus on the one cared-for, a first-person condition which she called engrossment. She described a second-person dimension as the one cared-for who receives and reacts to the caring. The third-person dimension is the outsider who can observe the caring actions. However, the observable actions alone could not determine whether or not one was truly caring for the other.

According to Noddings (1981), the essence of caring from the perspective of the one-caring is the awareness of the other's reality. The one-caring feels a need to take some action for the benefit of the one cared-for. "The commitment to act on behalf of the cared-for, the continued interest in his/her reality, and a continual renewal of commitment, are the essential elements of caring from the view of the one-caring" (p.141). Noddings (1981) believed that the one cared-for must provide indication of

having received the caring. The one cared-for should also be held in some regard, and the action not be performed from a sense of duty. If it was performed from a sense of obligation then care was absent, even though the one caring was physically present. On the other hand, one who is caring can be perceived as present even when physically absent, for instance, a nurse remaining aware of the need to check a patient often. Even when the nurse is not present physically, the patient may know that his or her well-being is being attended to. Whatever the one caring does for the cared-for is embedded in a relationship that expresses itself as engrossment of the one-caring, and in an attitude that warms and comforts the cared-for. Caring is shown in one's attitude, both verbally and nonverbally and when this is conveyed, Noddings believed that "the cared-for glows, grows stronger, and feels not so much that he has been given something as that something has been added to him" (p. 142).

CARING FROM THE PERSPECTIVE OF BEHAVIOURAL SCIENCE

Erikson (1968) views care as an essential component of psycho-social development occurring over a person's life span. He considered care to be concern for what has been generated through love of parents toward their children. Love is described by Erikson as a necessary catalyst that drives an individual into the adult state of development. The meaning of care given by Erikson is shown in the following quotation:

> From the stages of life such virtues as faith, will power, purposefulness, competence, fidelity, love, care, wisdom -- all criteria of vital individual strength -- also flow into the life of institutions. Without them, institutions wilt. (p. 141)
>
> Care originally meant an anxious kind of solitude, but I think it has taken on more positive connotations. I use "care" in a sense which includes "to care to do" something, "to care for" somebody or something, "to take care of" that which needs protection and attention and "to take care not to" do something destructive. (Evans, 1967, p. 53)

From Erikson's view, care is an adult virtue that is necessary for growth and development of the individual, and the coming generation and society as a whole. Care is a reaching outward by an individual in a giving, nurturing way toward another person.

Gaylin (1979) perceived caring as an essential ingredient in human development and survival. Caring was necessitated and called forth by the natural state of the human person. The human being's essential nature was caring. The caring process, caring and to be cared for were reciprocal. Therefore, essential for the capacity to be caring, was to be cared for.

Carl Rogers (1958, 1965) identified non-possessive care as the fundamental aspect of therapeutic relationships between the therapist and the participants which aimed at bringing about a desired personality change in the latter. The essential components of non-possessive care are those of empathy, unconditional positive regard and congruence. Empathy was explained by Rogers as the ability of the carer to sense the other's inner world of private personal meanings as if they were his own, but without losing the "as if" quality. In order to achieve this sense of the other, one must care in the sense of valuing the other enough to be involved (1957). Rogers described unconditional positive regard as "a feeling that is not paternalistic, nor sentimental, nor superficially social and agreeable" (1957, p. 97). According to Rogers (1958), congruence is an awareness and recognition of one's own feelings and reactions as well as an awareness of the feelings of the other.

Jourard's (1971) view of care is basic to interpersonal competence, in that the carer must have the ability to be genuine with those she/he is caring for. To be genuine is the ability to be open both to oneself and to others. Jourard identified the common fundamentals of nursing as "the dedication of oneself to helping the other fellow achieve worthwhile objectives - health, comfort, freedom from pain and suffering, the dissipation of ignorance, etc." (p. 201). In the following quotation he examines the concept of care by describing a "well nursed patient" as one who:

> Feels his nurses really care what happens to him, he knows that they know him as a unique person because they took the trouble to learn about him and he knows he told them much about himself. He feels free to call for help when he wants it, and does so. His nurse "tunes in" to him at regular intervals to sample his private, personal psychological world...."(p. 201).

CARING FROM THE NURSING PERSPECTIVE

When nurses are asked what they do as nurses, the most common answer is that "I provide nursing care", or "I care for my patients". In the same way when people are

asked what nurses do, the most common answer is that they take care of the patient. The common view of nursing to the public is the provision of care. In everyday practice, nurses always use the words "care" and "caring", and these always appear in nursing literature and textbooks. It is clear that the concept of care is deeply embedded in the professional values of nursing.

The evolution of the concept of care started in the Nightingale era. At that time nursing care was viewed as attending to the physical needs of the patient and his/her environment. However, even early this century recognition was given by a number of nursing leaders to the importance of the human qualities displayed by the nurse while providing physical care. Qualities such as kindness, gentleness, and a sympathetic manner were described as important in physical care (Scovil, 1909). By the 1950s, nurses began to focus more on the emotional and psychological wellbeing of the patients, although physical care remained an important aspect. With this recognition of the nurses' role in the emotional and psychological needs of the patient, the view of nursing as a therapeutic, interpersonal process was widely accepted within the profession by the 1970s (Peplau, 1952; Orlando, 1961; Weidenbach, 1964; Travelbee, 1966).

Peplau was one of the first nurses who proposed the notion of the relationship between the nurse and the patient as the central characteristic of nursing. She viewed nursing as "a significant, therapeutic interpersonal process", that is an "educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal and community living" (1952, p. 16). Peplau's work on nursing as a therapeutic interpersonal relationship stimulated increased attention on this aspect of nursing. The attention focused on a view of nursing care as promoting growth for both the patient and the nurse.

Henderson (1966), a prominent nurse theorist, developed inductively a definition of nursing which was adopted by the International Council of Nurses. She emphasized the importance of promoting independence of the patient as an aspect of, and expression of care. Henderson's definition of nursing is the most widely known and accepted definition of nursing care in the international nursing community.

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or

> knowledge. And to do this in such a way as to help gain independence as rapidly as possible. (p. 15)

Henderson described nursing care as assisting the patient to meet his/her needs either by doing for him/her, when necessary, or by providing conditions under which the person could do for him/herself. Care, for Henderson, was based on knowledge of the patient's needs, and of how to fulfil those needs in a way that promoted self-help and growth towards independence.

Kreuter (1957) defined nursing care as doing for others that which they would do for themselves but are unable to do. She placed most emphasis on emotional feelings between people when care is given.

> Care is expressed in tending to another, being with him, assisting or protecting him, giving heed to his responses, guarding him from danger that might befall him, providing for his needs and wants with compassion as opposed to sufferance or tolerance; with tenderness and consideration as opposed to a sense of duty; with respect and concern as opposed to indifference. (p. 302)

Kreuter also considered the growth of "trust and confidence" between nurses and their patients to be highly significant in good nursing care.

Leininger (1978, 1981, 1984, 1986) has long been a pioneer spokesperson in nursing for proclaiming the importance of care in the practice of nursing. She has emphasised the urgent need for a systematic investigation into the caring concept. Caring has been a major theme throughout her work in which she has stated that caring acts can be culturally shaped through beliefs, values, and practices of cultural groups. Leininger has defined caring in a general sense as "those assistive, supportive, or facilitative acts toward, or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (1981, p. 9).

Leininger (1981) identified caring as the essence of nursing and the unique and unifying focus of the profession. Helping people in time of need to achieve their daily living needs appears to be the essence of caring. She believed the study of caring could further the development of the body of nursing knowledge and advance nursing practice. Leininger defined professional caring as direct or indirect nurturing and skilful activities, processes and decisions related to assisting people in such a manner that

reflects behavioural attributes which are empathetic, supportive, compassionate, protective, succorant, educational, and otherwise dependent upon the needs, problems, values, and goals of the individual or group being assisted. Leininger defined "professional nursing care" as follows:

> Those cognitively learned humanistic and scientific modes of helping or enabling an individual, family, or community to receive personalized services through specific culturally defined or ascribed modes of caring processes, techniques, and patterns to improve or maintain a favorably healthy condition for life or death. (p. 9)

In her conceptual model formulated from studying transcultural nursing care theories and practices, Leininger proposed 27 major taxonomic caring constructs: "comfort, compassion, concern, coping behaviors, empathy, enabling, facilitating, interest, involvement, health consultative acts, health maintenance acts, helping behaviors, love, nurturance, presence, protective behaviors, restorative behaviors, stress alleviation, succorance, support, surveillance, tenderness, touching, and trust" (p. 13).

Watson (1979, 1985, 1987) is one of the contemporary nurse leaders and scholars who has been awakening nurses to investigate the phenomenon of caring in nursing. She has developed a perspective which combines an understanding of both science and humanities and therefore provides an excellent foundation for the study of caring in nursing practice. This perspective asserts that incorporation of caring into nursing practice is believed to bring about positive mental, physical, social, and spiritual health changes for the client. In her first publication Watson described ten carative factors guiding nurses in the delivery of health care. The ten carative factors provide a wholistic framework which addresses the needs of the person as a whole being rather than mere parts of the body. They outline a caring process which helps the patient maintain or attain health or die a peaceful death. The underlying assumption is that gratification of certain human needs is necessary for growth and development.

The ten carative factors cover a large area of nursing functions in achieving gratification of the whole person's needs. These carative factors are:

1. The formation of a humanistic-altruistic value system;
2. The instillation of faith-hope;
3. The cultivation of sensitivity to self and others;

4. The development of a helping trusting relationship;
5. The promotion and acceptance of the expression of positive and negative feelings;
6. The systematic use of the scientific problem-solving method for decision-making;
7. The promotion of interpersonal teaching-learning;
8. The provision of a supportive, protective, and/or corrective mental, physical, sociocultural and spiritual environment;
9. Assistance with the gratification of human needs; and
10. The allowance for existential-phenomenological forces.

Watson further developed her theory of nursing "Human caring" in her later book (1985). She identified transpersonal caring as the moral ideal of nursing. The caring occasion is composed of both the relationship between the nurse and the patient and the "what" and "how" of the nursing acts. In Watson's theory the knowledge of human behaviour and potential responses, the meaning of an experience to a person, enable the nurse's actions to solve the patients' problems in order to allow them to grow and overcome the problems.

The concept of care as a central focus in nursing was developed also by Bevis (1978). She looked at the changes that occurred in a human relationship over time as the caring process developed. She identified four stages in this process: (1) attachment; (2) assiduity; (3) intimacy; and (4) confirmation. The process begins with the recognition by those involved that there is the possibility of a relationship. An important task in this stage is that of self-revelation which is necessary for further growth of the relationship. Stage 2, assiduity, is one of working hard to develop the relationship. It represents the mutual decision to go farther than Stage 1. Important to this stage are respect, honesty, trust, and responsibility. Intimacy, Stage 3 of care, is characterized by deeper self-revelation. Here, both are free to reveal socially unacceptable things about self to the other. Stage 4, confirmation, is one in which those involved have supreme confidence in self and the other in the relationship. This stage is characterized by integrity and by expansiveness. Both are so confident and fulfilled in the relationship that they are free to open it to others. However, Bevis does point out that this last stage is not essential in all caring relationships and is not a necessary condition. According to Bevis, care is a process towards the goal of mutual self-actualization. Both parties in a relationship must be able to realise their abilities and their potential. She stated that if personal

growth does not occur for both within the relationship, the relationship cannot be considered as caring.

Within the philosophy of existentialism Paterson and Zderad (1976) conceptualized nursing as "humanistic nursing". They viewed care as being expressed both through, and within nurturing. The following quotation illustrates the caring act as conceptualized by Paterson and Zderad:

> In real life, nursing phenomena may be experienced from the reference points of nurturing, of being nurtured, or of the nurturing process in the "between". For instance, the nurse may describe comfort as an experience of comforting another person; the patient, as an experience of being comforted. However, while each has experienced something within himself, he also has experienced something of the "between", namely, the message or meaning of the "comforting-being-comforted" process. This essential interhuman dimension of caring is beyond and yet within the technical, procedural or interactional elements of the event. It is a quality of being that is expressed in the doing. (p.13)

Paterson and Zderad addressed the quality of being that made nursing an intersubjective transaction and transformed doing into caring. They suggested that the most important factor was "being with" another, by giving attention to them while being fully aware of and open to the shared situation as well as communication of the other one's availability. The awareness of "being with" led to the development of the human potential of the other.

Parse (1981) described caring from a human science perspective as "risking being with someone towards a moment of joy" (p.130). The essence of caring includes the risk of being exposed to possible injury in the struggle for growth; being with, in the sense of encountering and attending to the other; and a moment of joy, as the complementary rhythm of suffering-joying all at once.

From a philosophical approach, Roach (1984) considered caring as "the human mode of being" and indicated that this perception involves an ontology of caring. The ontological question asked is - what is the nature of caring? Central to Roach's approach, is the idea that the desire to care is human. The capacity to care, like other human capacities, must be affirmed and actualized.

According to Roach (1984), a caring behaviour in nursing is manifested through the attributes of compassion, competence, confidence, conscience and commitment. Compassion is operationalized as participation in the experience of another while being fully absorbed in the condition of being human. Competence is expressed as having the knowledge, skill, energy, motivation, judgment, and experience necessary for professional responsibilities. Conscience is recognized as directing one's behaviour toward the "moral fitness of things" (Roach, 1987, p. 64). Conscience arises from the experience of valuing all human beings. Commitment is a convergence between preference and choice that shows itself as devoted, conscious, willing, positive action (Roach, 1987).

Benner, in her 1984 book From Novice to Expert: Excellence and Power in Clinical Nursing Practice, pointed to the central role of caring shown in the exemplars of excellent nursing practice. The expert nurse is able to meld the instrumental and expressive roles of the nurse into a totality of action. The nurse masters technology while seeking to maintain the element of human caring in the midst of highly technical health care.

Further, in their book Primacy of caring - Stress and coping in health and illness, Benner and Wrubel (1989) view caring as a basic way of being in the world, and that it is central to human expertise to cure and to heal. Nursing is viewed as a caring practice whose science is guided by the moral art and ethics of care and responsibility. Benner and Wrubel show that the meaning of caring "as a word for being connected and having things matter works well because it fuses thought, feeling, and action - knowing and being" (p. 1).

Caring in nursing is viewed by the above authors as a concept that is central not only to their theory of stress and coping but also to their theory of nursing practice. They view caring as primary in three ways: establishing the condition matters and creating personal concern; enabling the condition of connection and concern; and providing for the possibility of giving help and receiving help. For instance, caring enables the nurse to notice subtle signs of improvement or deterioration in the patient. Caring relationships set up the conditions of trust that enable the patient to appropriate the help offered and to feel cared for.

STUDIES ON CARING IN NURSING

"Care/caring" has been embedded as a professional value of nursing since the Nightingale era. However, in the past it suffered from a lack of interest from nurse educators and scholars. Leininger (1978) was the pioneer motivator in the investigation of the phenomenon of care. Other nurse scholars, such as Watson (1979, 1985), Roach (1984), and Benner (1984, 1989) have continued extensively to emphasise the essence of caring in the practice of nursing. Since the last decade caring has attracted investigation by nurse researchers internationally and a vast number of studies on caring have been produced. It is beyond the scope of this research to review all of these studies. A number of studies selected for particular relevance to the present research are presented and discussed in the remainder of this chapter.

A qualitative study conducted by Henry (1975) aimed to identify the patients' perceptions of nurse behaviour as indicators of nurse care. Fifty patients participated in answering two questions: 1) Do you feel the nurse cares for, and about you? 2) What did she do or say that makes you feel this way? Henry classified the responses into three main categories: carrying out nursing procedures, giving information (what the nurse did); making herself available and accessible, being patient, friendly, kind, and considerate (how it was done); and "doing extra things" (how much was done).

Similarly to Henry, Brown (1981) conducted a study to identify nurse behaviour perceived by patients as indicators of care. The subjects were 80 hospitalized patients in surgical and medical units. They were interviewed and completed a Likert-type scale measuring the importance of nursing behaviour as indicators of care. Content analysis was undertaken to describe the nursing behaviour. A Canonical-Factor-Regression analysis was performed to examine dimensions of care as identified in the response to the Likert-type scale. The findings indicated two major aspects of care in response to the questions: "What the nurse does" and "What the nurse is like". There were eight categories of response to the first question: assessment and surveillance; availability and accessibility; nursing procedures; providing information; recognition and use of patient's knowledge; interpersonal communication; support of individuality and independence; and doing extra things. Two categories were drawn from the second question: personal qualities and professional qualities. The study also demonstrated two major aspects of care from descriptions of incidents in answer to two questions: "What the nurse does" and "How the nurse does". Four themes were found in

response to the first question: surveillance; demonstration of professional knowledge; providing information; and assisting with pain. Themes found in response to the second question were: amount of time spent; reassuring presence; recognition of individual qualities and needs; and promotion of autonomy.

Larson's (1981) study aimed to investigate the perception of oncology patients' and professional nurses' about important nurse caring behaviour. Fifty-seven oncology patients and fifty-seven professional nurses participated in the study. The researcher developed The Caring Assessment Instrument (CARE-Q) containing 50 identified nurse caring behaviours. The subjects were asked to sort CARE-Q into seven piles ranging from most important to least important. The findings suggested that nurses and oncology patients had significantly different perceptions of nurse-caring behaviours. For instance, the nurses perceived the following behaviours as the most important indicators of nurse caring: listens to the patient; touches the patient when he/she needs comforting; allows the patient to express feelings about his/her disease and treatment fully, and treats the information confidentially; gets to know the patient as an individual person; talks to the patient. On the other hand the patient perceived the following behaviours as the most important in nurse caring: knows how to give shots (injections), IV's (Intravenous drip) and how to manage equipment such as IV's, suction machines; knows when to call the doctor; gives a quick response to the patient's call; gives good physical care to the patient; gives the treatments and medication on time.

Ford (1981) conducted a survey to explore nurses' perceptions of caring, what behaviours were involved in caring, and how these nurses thought caring could be exhibited. One hundred and ninety two nurses participated in the study. The results indicated that the nurses' perceptions of caring involved (a) concern for another's wellbeing; (b) giving of oneself; (c) helping; and (d) empathy. The caring behaviours identified by Ford (1981) were (a) listening; (b) helping; (c) showing respect; and (d) supporting the actions of others. The exhibition of caring behaviours included (a) listening; (b) helping; (c) communication; (d) demonstrating; (e) assessing and meeting all needs; (f) providing support for staff; (g) promoting a professional organization; and (h) supporting the actions of others. The results of this study were ambiguous and difficult to interpret. Ford (1981) stated that nurses need to "promote and enhance the caring process" (p. 41), but this process itself was not clearly defined in the study.

Riemen's (1983) phenomenological study endeavoured to determine the essence of a caring interaction between a nurse and a patient. The sample consisted of five male and five female patients who had experienced interaction with a registered nurse. The data were collected by tape-recorded interview and the method developed by Colaizzi was chosen to analyse it. This method of analysis consists of seven procedural steps: 1) Subjects' description were read and re-read to get a sense of the whole; 2) Significant statements were extracted from the description; 3) Meanings were formulated from each significant statement; 4) Clusters of themes were organized from the formulated meaning; 5) An exhaustive description was produced from the above steps; 6) The exhaustive description was formulated into a statement; 7) The formulated statements were validated by the subjects (Colaizzi, 1978).

The findings indicated that in what was described as a caring interaction, nurses willingly and voluntarily gave of themselves. By their observation of the attitudes and behaviour displayed by the nurses, such as "sitting down and really listening and responding to the unique concerns of the individual as a person of value" (Riemen 1983, p. 65) the patients determined that the nurses were giving of themselves. As a result of such an interaction, patients experienced a feeling of physical and mental "relaxation, comfort, and security" (p. 65).

Riemen's study also demonstrated the aspects of a "noncaring" nurse-patient interaction. In this case, the nurses were perceived by patients as being physically present only because that was required as part of their job, instead of being present to offer assistance to patients. These nurses were viewed as being "bound by the rules" (p. 66). Included in the category of noncaring were nurses not present with patients because they were "too busy" to sit down and appreciate patients as human beings valuable in themselves. Patients perceived themselves as devalued and dehumanized by noncaring nurses. As a result of noncaring interactions, patients felt "frustrated, scared, depressed, angry, afraid, and upset" (p. 66).

Gaut (1984) used philosophical analysis to develop a theoretical description of the term caring. She posed the question "What must be true to say that S is caring for X?".

Five conditions were identified to answer this question. These were awareness, knowledge, intention, means for positive change, and the welfare-of-X criterion. These conditions were collapsed into three conditions:

> Condition 1: S must have knowledge about X to identify a need for care, and must know that certain things could be done to improve the situation.
>
> Condition II: S must choose and implement an action based on that knowledge, and intend the action to be a means of bringing about a positive change in X.
>
> Condition III: The positive change must be judged solely on the basis of a 'welfare-of-X' criterion (pp. 35-36).

The theoretical description proposed by Gaut provides greater understanding of the term care as an action or series of actions in the practice of nursing. However, further development of the description was addressed. Based on this description Gaut (1986) further proposed a model for evaluating caring competencies in nursing practice. Four competencies are necessary for caring:

> Competency 1, the nurse implements the tactic well or with skill; Competency 2, the nurse chooses a particular tactic for the right reasons; Competency 3, the nurse chooses goals within the context of overall goals; Competency 4, the nurse gives full consideration to the situational factors that may impinge on the appropriateness of the goals, tactics, and implementations. (pp. 80-81)

Within this model respect for a person's decisions, values, actions, and claims are required as a principle or norm for action.

An ethnographic study on institutional caring was undertaken by Ray (1984) to examine nursing in a hospital culture in order to develop a taxonomy of the nature of institutional caring. A total of 192 hospital personnel including nurses, physicians, housekeepers and secretaries participated in the study. A classification system consisting of four categories of caring was developed from the study. Ray explains these in the following manner:

> 1. Psychologic: a) Affective - relating to, arising from, or influencing feelings or emotions, expressing emotion, e.g., love; b) Cognitive - relating to knowledge used to define and interpret actions and events, e.g., decisions.

2. Practical: a) Social organization - relating to the practical considerations and activities of the sociocultural environment, e.g., political, legal, economic, and social structural characteristics; b) Technical - relating to techniques, principles, and/or method, or use of technology to achieve a therapeutic purpose, e.g., skill.

3. Interactional: a) Physical - relating to the body, nonverbal communication for the purpose of providing physical comfort, e.g., touch; b) Social - relating to interpersonal reciprocal action for the purpose of therapeutic outcomes, e.g., communication.

4. Philosophic: a) Spiritual - relating to matters of a sacred nature, e.g., prayer, virtuous or ritual acts, acts of faith, relation of man/woman with God; b) Ethical - relating to implications of morality, right or wrong, professional organizational principles of honour or virtue, e.g., trust; c) Culture - relating to perceptions, attitudes, and knowledge of the caring needs of persons of different cultural/ethnic groups within the hospital. (p. 98)

Ray stated that these categories point to the notion of an individual interconnected with the environment which includes the political, legal and economic system of bureaucracies and elements of ethico-spiritual-humanistic caring. She believed that caring within the institutional framework needs more knowledge about "social structure elements (political, legal, technological, social, and economic) in conjunction with the ethico-spiritual-humanistic elements" (p. 110).

Swanson-Kauffman's (1986, 1988) qualitative study investigated the human experience of miscarriage. The participants were twenty women who had experienced pregnancy loss prior to 16 weeks of gestation. Data were collected by interview and analysed using the method of comparative analysis. The findings revealed that five kinds of caring were needed by women who had suffered miscarriages. These caring modes can be described as those which involved "knowing" that the woman's loss is unique to her as a person, "being with" the woman in an engaged manner, "doing for" the woman by providing comforting and supportive measures, "enabling" the woman to grieve for the loss, and finally "maintaining the belief" that the woman could bear a child.

Wolf (1986) conducted a study to identify nurses' perceptions of caring behaviours. She developed "The Caring Behavior Inventory" from literature which contained words or phrases that represented caring. A convenience sample of ninety-seven registered professional nurses were asked to rank seventy-five caring words or phrases on a four-

point Likert-type scale. The result of the study suggested that the highest-ranked caring behaviours include both actions and attitudes. These are: attentive listening, comforting, honesty, patience, responsibility, providing information, touch, sensitivity, respect, and calling the patient or client by name.

Mayer (1986) replicated Larson's (1981) study on the perceptions of nurse caring behaviours with cancer patients and their families. Both the cancer patients and their families were asked to rank the most important nurse caring behaviours. The findings indicated that the patients appeared to value the instrumental, technical caring skills more than nurses do, whereas nurses valued expressive behaviour higher in their perceptions of caring. The most important nurse caring behaviour from the nurses' perspective, was listening to the patient, whereas patients listed knowing how to give shots, I.V,'s and how to manage the equipment like I.V.'s and suction machines, as the most important caring behaviours. Mayer summarized the following as the most helpful nurse caring behaviours from the patients' perceptions: give shots, I.V.'s, cheerful, encourages patient to call if problems, puts patient first, and anticipates that the first times are the hardest and pays special attention to the patient during the first clinic visit, first hospitalisation, first treatment. Caring behaviors from the nurses' perceptions included: listens, allows patient to express feelings, includes patient in planning and management of care, touches the patient, and perceives needs and plans of patient and acts accordingly. Caring behaviours from the families' perceptions were: honesty, clear explanations, information of relative's condition, making relative comfortable, interest in answering questions, provide necessary emergency measures, assure the relative, answer questions honestly, openly, and willingly; allow relative independence; teach family members how to keep relative comfortable.

Luegenbiehl (1986) identified the essence of nurse caring during labour and delivery, by using a phenomenological approach. The participants consisted of three groups: three recently delivered multiparous mothers; three birth attendants of recently delivered mothers; and three registered nurses working in a labour and delivery unit. The data were collected by tape-recorded interview and the Colaizzi method (see explanation on page 23) was selected to analyse the data. The findings indicated that nurse caring in labour and delivery was perceived when the nurse was believed to have acted 1) competently from a background of specific and general knowledge; 2) in a manner which was helpful, reassuring, and supportive to mothers.

Hernandez (1987) investigated the concept of caring as a lived experience of baccalaureate-prepared nurses. The study, in which twelve nurses were interviewed, sought to uncover whether caring exists as a direct and intentional professional process in nursing. A phenomenological approach was used and data were analysed by the Colaizzi method. The findings revealed fourteen themes of professional nurse caring: holism, being there, touching, listening, communication, social support, reciprocity, time, involvement, empathy, technical competency, professional experience, formal/informal learning, and helping. The findings also illustrated six themes of natural caring: being there, touching, social support, reciprocity, time/extra effort, and empathy. These natural caring aspects were found to be enfolded within the structure of professional nurse caring. In addition, the study's findings suggested that professional nurse caring can be a direct intentional process comprised of directly intentional caring actions. Professional nurse caring was found to be a discrete concept which differs from that of natural caring as the former's practice must be wholistic. Hernandez stated that "professional nurse caring requires that the nurse both identifies and respects all of the patient's human needs, including physical, psychosocial, emotional, and spiritual concern" (p. 166). This finding was supported by her previous qualitative study in which nurse caring was found to be wholistic, and it was also supported by Barr's description of caring among critical care nurses (Barr, 1985, cited in Hernandez 1987).

A phenomenological study on nurses' caring, as perceived by post-operative patients was conducted by Sherwood (1988). The study questions were 1) What do patients perceive as demonstrations of nurses' caring? 2) How do patients describe their feelings about demonstrations of nurses' caring? Five adult males and five adult females, recovering from general surgery were interviewed. The data were analysed by using the steps of phenomenology set forth by Spiegelberg which are explained as follows: 1) investigating the particular phenomenon; 2) investigating the general essences; 3) watching the modes of appearing; 4) exploring the constitution of the phenomena in consciousness; 5) suspending belief in existence of the phenomena; 6) interpreting the meaning of the phenomena (Omery, 1983).

The findings revealed that caring emerged in five categories: 1) Assessing needs - what was needed or expected; 2) Planning care - preparation and knowledge for managing care; 3) Intervening - responding to needs; 4) Validating - evaluating nursing actions and participant's condition; 5) Interactional attitude - positive growth producing

interactions. The study also indicated noncaring elements which centered around impersonal interaction, lack of information, no action or help, incompetence, hurrying and non-availability.

An hermeneutical study was conducted by Smerke (1988) with the aim of discovering and creating the meaning of human caring from nine disciplines which include: Psycho-neuro-immunology, Socio-Behavioral Science, Anthropology, Fine Arts, Humanities (including Philosophy and Ethics), Theology, and Nursing. Smerke interviewed experts from each discipline for their discipline's knowledge base on human caring. Selected literature from each discipline was also assessed for content validity by nursing experts. The modified hermeneutical strategies were implemented for analysis which resulted in the study forming three major outcomes: theoretical contribution, original and creative contribution, and enduring scientific contribution. The major theoretical meanings to emerge were: the experiential process, understanding of humanness, the healing modality, illumination of paradoxes, technical competence, and transcendence of time. There were seven major themes of the original and creative contributions. These were the essence of person/being, relationship/encounters, decisions/choices, and judgments, genuine dialogue, experiential process, healing modalities and human/economic resource exchanges. The enduring scientific contribution consisted of the interdisciplinary guide to the caring literature. The guide had five levels in which the first level was the all-encompassing term of human caring. Level two was caring and noncaring. Level three contained the seven major themes of caring, while the fourth level represented the process which facilitated the experience of the seven major themes. Level five represented the characteristics of caring from Level four.

Weiss (1984) conducted an experimental study to determine which verbal and nonverbal caring and uncaring behaviours, and which technical competency and incompetency in the nurse-patient relationship, were perceived as caring by female and male subjects. The selected subjects were 15 female and 15 male undergraduate university students. Weiss used eight videotaped scripts in which a female nurse's verbal, nonverbal, and technical behaviours were manipulated in a randomised experimental design. The data gathered by the seven-point Likert-type instrument revealed important differences between verbal and nonverbal nurse behaviour and the level of technical competency variables. The four way analysis of variance revealed that congruence between the behaviour variables was a significant factor in relation to

perceived nurse behaviours. When the nurse in the script portrayed verbal caring, nonverbal caring, and technically competent behavior, both female and male subjects exhibited a definite preference for her behaviours. When the nurse in the script displayed verbal uncaring, nonverbal uncaring, and technically incompetent behaviour, both female and male subject groups rejected her behaviours. By using the findings from this study and another randomized experimental study (unpublished) Weiss (1988) developed a "Model of nurse caring behavior". The focus of this model is the wholistic process of nurse care or caring with specific dimensions of behaviour or components that characterise care. Weiss stated that:

> Holistic care occurs when these components are brought together by the nurse to form the special process known as nurse care or caring. This term describes a process that exists when the nurse harmoniously demonstrates the three components of care: verbal caring, nonverbal caring, and technically competent behavior. (p.140)

In this model the patient is the focus of the process of the nurse care or caring, and the recipient of the property of nursing care. Using Kim's (1983) theoretical domains in nursing where nursing action consists of a client-nurse subsystem and a nurse subsystem, Weiss gave the idea of the term nursing care as performing and carrying out nursing activities in direct contact with the client, which is a client-nurse subsystem and the term nurse care or caring as the nursing action focused on the independent, intellectual and mental activities that occur solely in the nurse, which is the nurse subsystem. In Weiss's model, nurse care is a process and nursing care is a property.

Weiss (1988) proposed using her model to discover and validate the use of the term care in nursing. She carried out a study to test her model in identifying the difference between the process of nurse care or caring and the property of nursing care. Five model situations were used to determine the patient's needs and whether the process of nurse care or caring, or the property of nursing care existed. The findings revealed that all three components of the nurse caring process - verbal caring, nonverbal caring, and technical competency, must be present for nurse behaviour to be therapeutic and beneficial to the patient. When the nurse behaviour exhibits only one or two of the components, then only the property of nursing care is present.

Weiss's studies contributed to the clarification of the difference between nurse care/caring and nursing care, and also confirmed Hernandez's assertion of professional

nurse caring as a wholistic concept. Although Weiss's model showed that nurse care/caring is a wholistic process, it provided little explanation of how nurses translated caring into their actions. A further limitation was that the model was not derived from actual nursing practice.

Forrest (1989) used the phenomenological approach to identify the experience of caring from the nurses' perspectives in a study that was conducted in Canada. Seventeen nurses participated in the study. The central research question posed was - What is the essential structure of caring? - The data were collected by interview, and Colaizzi's procedure (see explanation on page 23) was used for analysis. Two categories emerged: involvement and interaction. The involvement category was comprised of four theme clusters: being there, feeling with and for, respect, and closeness. The interaction category included touching and holding, picking up cues, being firm, teaching, and knowing them well. The study also indicated factors affecting caring. Six themes emerged: oneself, the patient, frustration, coping, comfort, and support.

Morrison (1991) conducted a qualitative study to explore British nurses' perception about the meaning of caring in nursing practice. Kelly's personal construct theory and the repertory grid interview technique were used. A sample of twenty-five nurses were chosen to participate in the study. Seven categories emerged from the study providing a detailed description of caring: personal qualities; clinical work style; interpersonal approach; level of motivation; concern for others; use of time; and attitudes.

STUDIES RELATED TO CARING AND NURSING PRACTICE IN NEW ZEALAND

In the New Zealand context, caring has been made explicit in the definition of nursing - "Nursing is a specialised expression of caring ..." (New Zealand Nurses' Association, 1984, p. 3). However, caring in this context has not yet been defined. The first national survey investigating nursing practice in New Zealand hospitals was conducted by Walton (1989). Registered nurses and enrolled nurses throughout New Zealand were surveyed and interviewed. One aspect of the study findings suggested that nurses view "care" as the most important part of their work. Some examples of their response to the question - "What is the most important part of your work as a nurse?" were: "To give the best care to my patient"; "Caring for my clients and their families" (p. 24). However the study did not aim to identify what nurses meant by "care" or

"caring". From the above definition of nursing and the nurses' perceptions of their work, care/caring appears to be an important aspect of nursing practice. Therefore, there is an urgent need to clarify the meaning of caring.

The present researcher, Euswas (1989), conducted two preliminary studies on caring in nursing, in which New Zealand registered nurses were surveyed for their perceptions of caring in nursing practice. One hundred and forty questionnaires were issued to nurses, and ninety were returned. The first part of the questionnaire was a Likert-type scale asking nurses to rate how important they perceived caring to be as an aspect of their practice, and how they agreed with the definition of nursing endorsed by The New Zealand Nurses' Association. The second part of the questionnaire asked nurses to describe what caring means for them, and to give an example of a critical incident which illustrated caring from their experience. In addition, they were asked to list words which were closely related to caring.

The data were analysed by content analysis and the findings indicated that nurses viewed caring as a central concept in their practice. The studies further explored the meaning of caring in nursing practice which was identified as being multidimensional and consisting of six components: value dimension, expressive, action, relationship, knowledge, and purpose. The value dimension included areas such as humanistic values, cultural values, and professional values. The expressive component consisted of empathy, compassion, trust, concern, sharing, and willingness. Action components were helping, comforting, being there, empowering, advocacy, nurturing, advising, touching, and performing procedures. The major relationship component was co-participation. An important part of knowledge for caring practice was clinical expertise. Finally, the purposive component of caring consisted of meeting a health need and promoting healing and welfare. Although the meaning of caring in nursing practice began to emerge from these preliminary studies, they did not provide full understanding of how caring translates into nursing action in actual nursing practice.

These studies did however, guide the present researcher towards a further indepth investigation of the actual caring nursing practice, as there were no New Zealand studies which examined this concept. However, there are some studies which have been conducted to investigate the phenomenon of nursing practice and midwifery practice, which showed some related aspects of caring nursing practice. Therefore these studies are also reviewed in this section.

Christensen (1988) undertook qualitative research which focused on nursing dimensions relevant to a person's experience of being a hospital patient undergoing elective surgery. The research question -"What is happening here?" was in relation to the patients' experience of their illness and ensuing hospitalization. Twenty-one patients and nurses involved in their care participated in the study. Data were collected from participant observation, interview, and documents, with the method of constant comparative analysis being used for analysis. A theoretical framework of the Nursed Passage was derived from the data. The Nursed Passage is a patterned partnership with three elements: the temporal element is characterised by ongoing movement and constant change and is conveyed in a sequence of phases or stages; the participative element is portrayed as a patterned relationship in which both nurse and patient are actively involved in progressing the patient through the passage; the contextual element recognises complex factors within the environment which have an impact on the shape of the relationship between the nurse and the patient.

The grounded theory of the Nursed Passage is composed of five components: the Beginning, Settling In, Negotiating the Nursed Passage, Going Home, and the Contextual Determinant. The Beginning was described as the patient's experience with a health-related problem from initial awareness to admission to hospital for surgery. Settling In is the transition experience in which the patient enters hospital and begins the Nursed Passage. Both patient and nurse have their own pattern of work to perform during this phase. Negotiating the Nursed Passage which commences at the time of admission to hospital and continues until the patient goes home is the major concern of both. Nurse-patient collaboration is required to help the patient make his way through the Nursed Passage as effectively as possible. Patient and nurse each undertake their own complex range of activities during this phase. Going Home is defined as nurse-patient collaboration which undertakes new work associated with preparing the patient for the transition out of the Nursed Passage.

This study offers a fresh image of nursing as it occurs in the real world of practice. The theoretical framework which emerged serves to give a specific pattern to the transaction between a nurse and a patient who is undergoing surgical intervention. In the Nursed Passage nursing is perceived to occur within a synergistic relationship between the nurse as the agent of nursing and the patient as a recipient of nursing. This study has established the distinctive work of both parties. In this way it gives a distinctive shape

to nursing as a separate human service profession. While the theoretical framework offers a tool for nurses to enhance their practice. Christensen acknowledges that this theoretical discovery is at an early stage of development and that much work is needed still. "Congruence in this mutual activity is essential if the patient's path through the passage is to be maximally beneficial. Nevertheless, the manifestation of this agreement in the reality of nursing practice requires clarification" (Christensen, 1988, p. 334).

Bassett-Smith (1988) conceptualised the process of care offered by midwives on women's experiences of childbirth in the hospital as an authenticating process, and she proposed it as a theoretical framework for midwifery practice. This framework was developed from a study using grounded theory strategies in which ten couples and their attendant midwives participated. Data collection used were participant observation during each couple's experience of labour and birthing, and an antenatal and postnatal interviews. Constant comparative analysis was the method used for data analysis. The researcher defines Authenticating as a process that is engaged in by both midwives and birthing women, in order to establish the practice and experience of giving birth as being individually genuine and valid. Authenticating is multifaceted and is seen to include the intertwined and simultaneously occurring four phases of making sense, reframing, balancing and mutually engaging. Making sense involves a contemplative and deliberate course of action undertaken in order to render childbirth understandable. Reframing refers to the process of developing a mental structure that gives shape and support to one's picture of childbirth. Balancing refers to the act of weighing factors against each other in terms of their significance and relative priorities, and making choices to continue observing or acting in particular ways. Mutually engaging is defined as an intense reciprocal involvement shared by two people that forms the basis for a special expression of caring. Bassett-Smith's study demonstrates that the essential ingredient of midwifery practice is caring.

Paterson (1989) explored the lived world of nursing practice in an acute care setting. The work of Benner (1984) guided this piece of qualitative research in which a phenomenological approach was used. Twenty-two registered nurses working in medical and surgical wards of an acute care general hospital in New Zealand participated in the study. The findings revealed that the context of nursing practice is complex and multidimensional. Each day's work load for the nurses was a mixture of the predictable and unpredictable, which, in different configurations, passed through

three broad phases identified as Settling In, Working Through, and Handing Over. The Settling In phase for nurses involves familiarisation with a considerable number of patients, other staff member's activities and plans; absorbing a large amount of information within a short period of time; an orientation to individual responsibilities and priorities for the day; a cognitive-emotional orientation to the other staff members working that shift. Working Through is explained as nurses work through the day characterised as a typical day and an unusual day. A typical day is characterised by being familiar, busy and yet manageable. Participants' descriptions of a typical day were varied, some focused on tasks, some on patients, and some included task-focused and patient-focused descriptions. An unusual day was characterised by extremes of quiet or busyness. Handing Over includes writing the report, interaction between oncoming and outgoing nurses and providing the shift report. The nurse completing her shift can then go home.

The principal domains of practice which emerged within this study were identified as Monitoring and Ensuring the Quality of Health Care Practice; The Teaching/ Coaching Function; The Diagnostic and Monitoring Function; and Organisational and Work-Role Competencies. These findings corresponded with Benner's study, but two new competencies were identified. Coaching Through a Situation Bit by Bit was identified within the Teaching/Coaching Function, and Advising and Supporting Other Nurses was a newly identified competency within the domain of Organisational and Work-Role Competencies.

The study findings also revealed two major aspects where nurses make a difference: the notion of good, and developing clinical expertise. Paterson (1989) stated that making a difference is strongly related to the less visible part of nursing practice which is expressed through the art of nursing and the successful integration of art and science. "The 'notion of good', which is an expression of benevolent intent central to the work of the nurse is identified in situations where the nurse makes a difference" (p. 64). Nevertheless this study did not provide full understanding of how nurses integrate the "notion of good" into nursing action.

The studies of Christensen (1988) and Paterson (1989) provided more understanding of the phenomenon of nursing practice. However, clarification of the essential nature of effective nursing practice is still needed.

It is apparent from the above literature review on the meaning of caring that caring is an important feature in all societies as it has been addressed in many disciplines, such as, Humanities including Philosophy and Ethics, Anthropology, Socio-behavioural Science, Psycho-neuro-immunology and Theology (Smerke, 1988). At the present time the term care/caring seems to be used quite frequently in everyday life. For example, in New Zealand a current television broadcast uses the term "Earth Care" to motivate people to be aware of conserving the environment. A prominent educationalist referred to empathy and caring as a component of moral education in school in his paper - "The environment and moral education" - presented to a conference on "Our Common Future: The way Forward - Environmental Education in New Zealand" (Snook, 1991).

Although the meanings of caring suggest diversity, it has a universal theme (Smerke, 1988). Therefore caring in nursing also shares a common meaning with the language of the layman and usage in other disciplines. The meaning of caring from the disciplines of philosophy, anthropology, and behavioral science provides a foundation for the development of the concept of caring in nursing (Paterson & Zderad, 1976; Leininger, 1978, 1984; Watson, 1979, 1985). Caring has been addressed and studied more explicitly in nursing than in other disciplines during the last decade. A number of studies on caring have been conducted in the discipline of nursing in order to clarify the meaning of the term in the practice of the human health service and to provide a unique meaning for the discipline. Recently caring in nursing has been regarded as a wholistic concept (Watson, 1979; Hernandez, 1987; Weiss,1988).

Despite the large number of studies undertaken to uncover the phenomenon of caring in nursing, this is still not well articulated. Although understanding has increased, an analysis of nursing literature on caring from 35 authors by Morse, Solberg, Bottorff, and Johnson (1990) showed diversity in the conceptualisation of caring. The five conceptual categories which emerged from the analysis are: "caring as a human trait; caring as a moral imperative or ideal; caring as an affect; caring as an interpersonal relationship; and caring as a therapeutic intervention" (p. 3). The authors identified two additional categories of the outcome of caring: caring as a subjective experience of the patient and caring as a physical response. They also made linkage relationships between all categories and suggested that further clarification was required among these relationships.

Morse et al (1990) argued that at the present stage some conceptualizations of caring have limited application for clinical reality. For example, the perspective of caring as an affect in which feelings are perceived to be motivating nursing actions can be potentially damaging to the nurse because of over-emotional involvement. In addition, an affect can be devalued when there is a technological demand. The perspective of caring as a moral imperative or ideal can cause a dilemma for nurses as the society does not value caring. The same authors also addressed the urgent need to develop a clearer conceptualization of caring by moving to include patient-centered theories, not only nurse-focused theories.

> At this time, instead of enlightening the reader, examination of the literature only increases confusion. There is no consensus regarding the definitions of caring, the components of care, or the process of caring. (Ibid, p. 2)

The absence of significant studies in New Zealand on the meaning of caring in nursing has led the researcher to undertake the present study. The study intends to clarify how caring is expressed in everyday nursing practice. By incorporating a phenomenological interview, participant observation, and grounded theory strategies, the researcher endeavours to provide a theoretical description of caring nursing practice.

SUMMARY

Throughout this chapter the discussion has centered on the literature on caring. How the concept was defined from the perspectives of layman's language, philosophy, behavioural science and nursing were presented. The research studies on the phenomenon of caring in nursing conducted in other countries and the New Zealand context were discussed in detail. The identification of a knowledge gap in the literature provided the direction for the present study.

Chapter 3 will continue with a discussion of the methodological approach and the manner in which the present research was conducted.

CHAPTER 3

THE METHODOLOGY

This chapter is divided into two sections. The first section is a discussion of the methods used in the research. The second section describes how the research was conducted.

SECTION 1:

THE RESEARCH METHOD

The section commences with a discussion of research paradigms and nursing knowledge. This is followed by an exploration of the most appropriate research method for investigating the caring phenomenon. Lastly, the chosen research methods used in the present study - phenomenological perspective and grounded theory strategies - are discussed in detail.

RESEARCH PARADIGMS AND NURSING KNOWLEDGE

Research is a central means to discover or verify knowledge, and to generate or test theories. In any discipline research tradition or paradigm refers to the methods which are generally accepted and used to conduct research in that subject area. A definition of research tradition is provided in the following quotation from Laudan (1977):

> A research tradition is a set of general assumptions about the entities and processes in a domain of study, and about the appropriate methods to be used for investigating the problems and constructing the theories in that domain. (p.81)

This definition is related to Kuhn's (1970) idea of a paradigm - "a paradigm is a discipline's specific method of solving a puzzle, of viewing human experience, and of structuring reality" (Munhall & Oiler, 1986, p.8). These authors go on to say that a research paradigm or tradition plays an important role in shaping and weaving the way of knowing into a body of knowledge.

Nursing is a young profession and over the last 40 years nurse scholars have constantly reiterated the need to develop a distinct body of nursing knowledge. Four fundamental patterns of knowing have been identified from an analysis of the conceptual and syntactical structure of nursing knowledge. These are (1) empirics, the science of nursing; (2) esthetics, the art of nursing; (3) the component of personal knowledge in nursing; and (4) ethics, the component of moral knowledge in nursing (Carper, 1978). Chinn and Jacob (1987), drawing on Carper's four patterns of knowing, conceptualise nursing knowledge development as the whole of knowing which is an integration of the four patterns of knowing. "Each of the patterns of knowing are distinct aspects of the whole. Each pattern makes a unique contribution to the whole of knowing, and each is equally vital and must be integrated with other patterns as knowledge is developed and applied" (Ibid, p. 4).

Belenky, Clinchy, Goldberger and Tarule (1986) identified five patterns of women's ways of knowing: silence, received knowledge, subjective knowledge, procedural knowledge and constructed knowledge. **Silence:** the knowledge is at gut level, not cultivated by one's own thought. The persons experience themselves as voiceless and they accept the voice of authority for direction in their life and their work. **Received knowledge:** the knowledge is received from an external authority. The persons experience themselves as capable of reproducing knowledge from an external authority but not of creating it by their own ability. **Subjective knowledge:** the persons experience their own personal subjective knowing and intuition, but find this difficult to articulate. **Procedural knowledge:** the knowledge comes from structured procedures and systematic analyses. The knower uses objectivity as a measure of what can be known. **Constructed knowledge:** the knowledge comes from both subjective and objective strategies of knowing. The person who uses constructed knowledge integrates all the different ways of knowing. "All knowledge is constructed, and the knower is an intimate part of the known" (Ibid, 1986, p. 37).

Reflecting on the four patterns of knowing in nursing and on women's ways of knowing, Schultz and Meleis (1988) identify three types of knowledge specific to nursing as a discipline: clinical knowledge, conceptual knowledge, and empirical knowledge. **Clinical knowledge** results from engaging in the patient care situation, and from bringing multiple ways of knowing to solve the patient care problems. Clinical knowledge is the product of a combination of personal knowing and empirics involving intuition and subjective knowing. **Conceptual knowledge** is the product

of reflection on the nursing phenomenon. It explicates the pattern revealed in multiple patients in multiple situations and articulates them as models or theories. Nurse theorists are involved in articulating this type of knowledge. **Empirical knowledge** results from systematic study by research approaches: empirical-analytic, historical, phenomenological, interpretive and critical theory. Thus, research is a means of contributing to the accumulation of the body of knowledge for the discipline.

Kidd and Morrison (1988) consider that nursing is currently in the fourth stage of theory development which corresponds to procedural knowledge within the pattern of knowing discussed by Belenky et al (1986). This stage is characterised by an increase in varying approaches to theory development and an emphasis is placed on the procedure used to acquire knowledge. There is evidence of research conducted following two distinct research traditions leading to a quantitative/qualitative dichotomy.

Nursing research studies have followed the empirical-analytic paradigm or quantitative approach for a long time. Recently, nurse scholars have argued that the empirical-analytic tradition is not congruent with the holistic nature of nursing as a practice discipline concerned with human health-illness experience and human care (Paterson & Zderad, 1976; Donaldson & Crowley, 1978; Leininger, 1978, 1984; Benner, 1984; Watson, 1985; Munhall & Oiler, 1986; Chenitz & Swanson, 1986). Nurse researchers have become more interested in alternative paradigms and as a result there have been an increasing number of studies using qualitative approaches. For instance, Swanson-Kauffman (1986) studied the human experience of miscarriage and Benner's (1984) study illustrates use of the phenomenological approach to uncover domains of nursing practice and nursing knowledge embedded in expert clinical practice. Other studies, as cited in the previous chapter, have also used a qualitative approach.

Although the nursing profession has been searching for its own body of knowledge since the Nightingale era, it is still in a preparadigmatic stage (Meleis, 1985). As nursing is a practice discipline with a complex social phenomenon and holistic nature, "the generation of knowledge on which to base practice is the primary raison d'etre of nursing inquiry" (Schultz, 1987, p. 17). Therefore, nurse scholars urge the need for innovative alternative methods in moving towards wholistic inquiry (Watson, 1985; Meleis, 1985; Schultz, 1987). In addition, different types of research approaches are advocated for developing nursing knowledge (Schultz & Meleis, 1988; Gortner, 1984;

Sandelowski, 1986). "Advocates of different types of research approaches and methods have carved out criteria to validate their findings that are congruent with the particular designs and epistemological orientations that they follow" (Schultz & Meleis, 1988, p. 220).

APPROPRIATE METHOD FOR INVESTIGATING THE CARING PHENOMENON

The selection of a research method is not merely a technical choice but a reflection of the researcher's world view of nursing practice (Moccia, 1988). The present study aimed to uncover nursing knowledge about caring in everyday nursing practice from the perspective of nurses and patients. The researcher believes that nursing practice is a social world where the nurses and the patients engage in activities, and also that all human beings have an embodied way of knowing. Therefore, the subjective experience contributes to the development of scientific knowledge. This present research followed the perspective of phenomenology.

Benner and Wrubel (1989) characterise the phenomenon of caring as context-bound-inextricably linked to life situations. To study caring, the usual methods of traditional science are inappropriate as Benner states that:

> To examine care, we cannot rely on purely quantitative, experimental measurements based on the natural science model. Nursing is a human science, conducted by self-interpreting subjects (researchers) who are studying self-interpreting subjects (participants) who both may change as a result of an interpretation. Caring cannot be controlled or coerced, it can only be understood and facilitated. (Benner, 1984, p.171)

The present research intended to investigate the phenomenon of caring in nursing practice. **The focus research questions were: What does caring mean for nurses in their professional practice?, How do patients perceive themselves as being cared for by nurses?** and **Do, or can, patients and nurses identify caring actions?** The study concerned human experience: the nurses' experience of caring, and patients' experience of being cared for. Therefore a phenomenological perspective was initially chosen as the most suitable approach to uncover the meaning of the experience of caring, since the central concept of the

phenomenological perspective is lifeworld, the true reality of perception and experience (Donaldson, 1987). Omery (1983) states that "as long as experience has meaning, the potential is there for the phenomenological method to be utilised". (p. 59)

This study also intended to generate a grounded theory of caring in nursing practice. Glaser and Strauss's (1967) grounded theory method provides strategies for the discovery of theory from data. Hutchinson was critical that nursing has "few middle-range substantive theories that explain the everyday world of patients, families, nurses, and health care agencies" (1983, p. 129). Meleis and Schultz (1988) suggested grounded theory and phenomenology as innovative methods for uncovering practical knowledge.

Therefore, the method chosen for this particular study, which aimed to uncover knowledge about caring in nursing practice, is a combination of the phenomenological approach and the grounded theory method. A phenomenological perspective provides the means to gain data from a person's experience, and grounded theory provides the strategies for recording and analysing the data.

PHENOMENOLOGICAL PERSPECTIVE

Phenomenology is a philosophy and a research method which attempts to study the human experience as it is lived. "The goal of the phenomenological method is to describe the total systematic structure of lived experience, including the meanings that these experiences had for the individuals who participated in them" (Omery, 1983, p. 50).

Munhall and Oiler (1986) state that the perspective of phenomenological philosophy "focuses on phenomena as they appear in recognition that reality is subjective and a matter of appearances for us in our social world. Subjectivity means that the world becomes real through our contact with it" (p. 62).

The entire phenomenological attitude is one of understanding the meaning of the subject's experience from their perspective. In order to penetrate the world of the subject, the researcher must suspend or bracket the preconceptions or assumptions about the phenomena under study. "This process of recovering original awareness is called reduction" (Oiler, 1986, p. 72).

The phenomenological method is concerned with the transformation of human experience as it is lived into validated knowledge. Reinharz (1983, pp. 78-79) lists five steps in the phenomenological transformation.

1. A person's experience is transformed into actions and language that are available to him/her by virtue of a special interaction s/he has with (an)other person(s). In this case the other is a phenomenological researcher who creates a situation or context in which the person's inchoate lived experience becomes available to him/her in language. That's the first transformation.

2. The researcher transforms what s/he sees or hears into an understanding of the original experience. Because we can never experience another person's experience, we rely on data the subject produces about that experience, and we produce from that our own understanding. That's the second transformation.

3. The researcher transforms this understanding into clarifying conceptual categories which he or she believes are the essence of the original experience. Without doing that, one is simply recording, and recording is not enough to produce understanding.

4. The researcher transforms those conceptual categories into written documents (or other products such as a picture or poem) which captures what s/he has thought about the experience that the person has talked about or expressed in some way. That's another transformation. In all these transformations, something can be lost and something can be gained.

5. The audience of the researcher transform this written document into understanding which can function to clarify all the preceding steps and which can also clarify new experiences that the audience has. This is where the inductive principle leads.

The present study did not follow the entire process of phenomenological transformation since the study aimed to generate grounded theory. The phenomenological perspective provided the means to gain descriptions of the experience, that is, the first step of Reinharz's phenomenological transformation. Then the description or data were analysed by the method of constant comparative analysis associated with the grounded theory method directed at generating substantive theory.

GROUNDED THEORY METHOD

Grounded theory methodology was first developed by sociologists Glaser and Strauss in 1967 for the discovery of theory from the systematic collection and analysis of data in their research on dying patients. Many of the underlying assumptions come from symbolic interaction. Its developmental origins are comparative analysis and the generation of core variables. However, Glaser and Strauss offer modification and extension of the method:

> In this book we address ourselves to the equally important enterprise of how the discovery of theory from data - systematically obtained and analyzed in social research - can be furthered. We believe that the discovery of theory from data - which we call grounded theory is a major task... A major strategy that we shall emphasize for furthering the discovery of grounded theory is a general method of comparative analysis. (p. 1)

Grounded theory method has now been applied by many nurse researchers (e.g. Wilson, 1982; Hutchinson, 1983; Stern, 1987). Stern describes the method in a fresh style, translating from Glaser and Strauss's sociological language. She explains five aspects of grounded theory which are different from other methodologies.

1. The conceptual framework is generated from the data rather than from previous studies, although previous studies always influence the final outcome of the work.

2. The researcher attempts to discover the dominant processes in the social scene rather than describing the unit under study.

3. Every piece of data is compared with every other piece rather than comparing totals of indices. This method has been called qualitative comparative analysis.

4. The collection of data may be modified according to the advancing theory; that is, false leads are dropped or more penetrating questions are asked as seems necessary.

5. Rather than following a series of linear steps, the investigator works within a matrix in which several research processes are in operation at once. In other words, the investigator examines the data as it arrives and begins to code, categorize, conceptualize, and to

> write the first few thoughts concerning the research report almost from the beginning of the study. (Stern, 1987, pp. 81-82)

The central aspect of grounded theory method is the simultaneous process of collection, coding, and analysis of data. This complex process is termed theoretical sampling:

> Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. (Glaser and Strauss, 1967, p. 45)

Stern (1987) describes five steps in conducting grounded theory method: collection of empirical data; concept formation; concept development; concept modification; production of the research report.

Collection of empirical data: During the period preceding entry into the field the researcher makes the initial decision on the type of data to be collected. Data may be collected from observation, interview, documents, or any combination of these.

Concept formation: As data are received, they are analysed line by line for substantive content. This is the process of breaking the data into meaningful conceptual units to explain what is happening in the data. One unit is labelled as a substantive code, and often the label comes from the actual words of the informant. The codes are then categorized for differences and similarities, and may be used to conceptualise a relationship. This process is termed theoretical coding. All the received data are carefully compared. The theoretical framework begins to be generated from the data in this step.

Concept development: There are three main steps in expanding and densifying the emerging theory. These are reduction, selective sampling of the literature and theoretical sampling.

By reduction categories are compared with one another to find connections as a basis for collapsing into more general categories from which "core variables" can be identified. Selective sampling of the literature is then woven into the matrix of data, category and conceptualisation. As the main concepts become apparent, they are

compared so as to determine under what conditions they are likely to occur. Additional data will be collected in a selective manner by theoretical sampling to expand categories. The needs of the theory, rather than statistical considerations determine the data sources. If there is no new information added, the categories are saturated. This stage is termed theoretical saturation.

Concept modification and integration: The main activity is memo writing. Memoing is a method of preserving hunches, hypotheses, and abstractions. At certain points, the data will spark an idea and a memo will be made. Memoing commences with coding and is incorporated during the previous steps. The linkage of the memos will enrich the conceptual schemes of the analysis:

> Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding. Memos lead, naturally, to abstraction or ideation. Memoing is a constant process that begins when first coding data, and continues through reading memos or literature, sorting and writing papers or monograph to the very end. Memo-writing continually captures the frontier of the analyst's thinking as he goes through either his data, codes, sorts and writes. ....The four basic goals in memoing are to theoretically develop ideas (codes), with complete freedom into a memo fund, that is highly sortable. (Glaser,1978, p. 83)

Memos are self directed reminders. They serve as a free vehicle for the analyst in which to capture ideas. The major point is to record the ideas immediately when they strike. Memos may be only one sentence or a paragraph or several pages, and it involves continuous recording throughout the entire process of data collection and analysis.

Production of the research report : The research report presents the substantive theory which is supported by data from the investigation. The literature is used to expand the theory.

Literature use in grounded theory

The literature review in the grounded theory method varies from that of verification research. In verification research, the literature review is used to form a theoretical framework prior to beginning data collection. In grounded theory the literature is used

as a source of data to verify and elaborate categories in the discovery process of theory generation (Chenitz & Swanson, 1986; Hutchinson, 1986).

Glaser and Strauss argue that a literature review before data collection and analysis can distort and bias concept development from the data:

> An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study,in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas. (Glaser and Strauss, 1967, p. 37)

In a grounded theory study, when the core variables begin to emerge, "the existing literature, used as data, is woven into the matrix consisting of data, category, and conceptualisation" (Stern, 1987, p. 84).

Chenitz and Swanson (1986) consider that in a grounded theory, the literature review is an ongoing process. Initially, literature assists to identify what is known in the area of study and it is also used to establish the study's purpose and significance. During the process of data collection and analysis, literature is conceived of as data to verify the emerging theory, and at the end of the study the researcher will be able to place the developing theory in the context of existing theories.

STANDARDS IN QUALITATIVE RESEARCH

In conducting this study, the researcher followed criteria of standards or rigor in qualitative research rigor offered by Sandelowski (1986), Catanzaro (1988), and Burns (1989). Four criteria were outlined by Sandelowski (1986): credibility, fittingness, auditability, and confirmability. Credibility is achieved when the description and interpretations are recognised by the participants. Fittingness is met when the findings are clearly derived from the data, and it is applicable and meaningful to the community audience which is outside the study situation. The criteria of auditability is achieved when the reader or another researcher can follow the events in the study and understand their logic. Confirmability is met when auditability, fittingness, and applicability are established.

While Sandelowski (1986) provides the above criteria, Burns proposes five standards for critique. These are descriptive vividness; methodological congruence; analytical

preciseness; theoretical connectedness; and heuristic relevance. **Descriptive vividness** requires clear presentation of the site, the subjects, the experience of data collection, and the researcher's thinking during this process. The rigor of **methodological congruence** has four dimensions: documentation, procedural, ethical and auditability. Rigor in documentation requires the presentation of all elements of the study. The researcher should make clear the steps by which data were obtained. Also consent must be obtained from subjects. Auditability is explained in a similar manner to Sandelowski (1986). **Analytical preciseness** requires the researcher to record the decision making processes through which transformations were made at all levels from concrete data. **Theoretical connectedness** requires clearly logical and consistent expression which reflect the data, and congruence with the knowledge base for nursing. **Heuristic relevance** asks for the study to be valued by its readers for its theoretical significance when applied to nursing practice and for furthering the development of theory in the discipline.

In addition, as the grounded theory approach was chosen for the development of theory from data in conducting this research, the researcher also followed the five criteria of evaluation of grounded theory provided by Glaser and Strauss (1967). Firstly, a grounded theory has codes fitting the data and a practice area from which it is derived. Secondly, the theory explains the major behavior and interactional variations of the substantive area. In other words the theory works in that practice area. Thirdly, the theory possesses relevance related to the core variable. The actors in the setting recognise the categories. Fourthly, the theory can be modified to fit other settings. Finally, the theory is dense and integrated into a tight theoretical framework.

In developing a grounded theory, certain pitfalls may confront the analyst (Wilson, 1985; Hutchinson, 1986) since it is not a simple process. The first pitfall is premature closure which refers to ending theoretical sampling and coding before the full range for codes and categories have been discovered. Premature closure often occurs when the research is under time constraints. The second pitfall concerns what to do if in the available time" a core variable, or, basic social process, does not surface" (Wilson, 1985, p. 423). However, Wilson argues that it is worthwhile still to write a descriptive research report to offer directions for further development. The underlying assumption of grounded theory is that if the data are sufficiently rich and the analysis thorough then a meaningful explanation will evolve eventually.

SECTION 2:

CONDUCT OF THE RESEARCH

This section moves on to illustrate how the selected research method was implemented. The presentation begins with the focus of the research problem. The research settings and participants are then described. The account then moves on to show how data were collected and analysed within this method. An example of data analysis is included for purposes of illustration.

THE RESEARCH PROBLEM

The central research problem for investigation was - **What is the process of caring which is experienced by patients with cancer and the nurses who care for these patients?** Patients diagnosed as having cancer were asked to describe their experience of being cared for by nurses, and nurses who were involved in caring for these patients were asked to describe their experience of caring. From these two perspectives it was hoped a fresh interpretation of how nurses translate caring into nursing action might be gained.

THE RESEARCH SETTINGS

This study was intended to investigate the phenomenon of caring in nursing practice. Since caring in nursing practice is too broad a notion to be addressed in a single study, the present research focused on nursing practice involving a specific patient category, namely, adults with a confirmed diagnosis of cancer or who were undergoing investigation in relation to such a diagnosis.

The settings for this study were two public hospitals, a hospice unit, and patients' home settings in two New Zealand cities. From City A, three wards in a public hospital, namely an oncological ward, a surgical ward, and a gynaecological ward were selected, and also several patients under the community health service were visited at home. From City B, an oncology ward in a public hospital, a hospice unit and patients' homes under the hospice service were selected. The summary of research settings is illustrated in Table 1.

Table 1

The Research Settings

Research settings	
City A	**City B**
Public Hospital	Hospice Unit * @
Oncological Ward * @	Patients' Homes * @
Surgical Ward * @	
Gynaecological Ward * @	Public Hospital
Patients' Homes under Community	Oncology-Medical Ward*
Community Health Service Office*	

* Interview
@ Participant observation

In City A the public hospital is a general hospital and also a regional centre for cancer care. The oncology ward is a unit providing care for cancer treatment, crisis control, long term care, pain control and relief for relatives. It is situated within a multistoreyed block. There are two types of accommodation: four bed rooms and single bed rooms. The four-bedded rooms are located on one side of the building and the single-bedded rooms are on the opposite side with a corridor between.

The surgical ward chosen is a unit contributing care for patients undergoing surgical investigative procedures and surgical treatment of ear, nose, throat and urological conditions including cancer. This surgical ward has the same structural characteristics as the oncological ward.

The gynaecological ward is situated within a two-storey block. There are two types of rooms: six bed rooms and single bed rooms. This ward contributes care mainly for women with disorders of the reproductive system including cancer. Due to budget cuts in the health care system, some wards in this hospital have had to be closed. Therefore some other patients from medical and surgical wards have been moved to this ward.

Each of these three wards is staffed by a charge nurse with a team consisting mostly of staff nurses and enrolled nurses. The system of nursing care delivery in these three wards is that of primary nursing[1].

In City B there is one public hospital, a community health service, and a hospice service. The hospice service is a voluntary nursing trust with a budget subsidised by the Government. Both participant observation and interviews were conducted in the hospice service. In the public hospital the study involved only interviewing registered nurses working in an oncology-medical ward.

The hospice service provides care for the terminally ill of which the majority are cancer patients. The service includes providing care in a unit and in the community. The hospice unit is a home-like structure with three bed rooms - one room contains two beds, and another two rooms each contain three beds, and there is a room in a separate building providing for live-in families. The unit is staffed by registered nurses. The system of nursing care delivery is a combination of the cubicle nursing[2] and non-hierarchical team approach.

ACCESS INTO THE SETTING

Preparation period

The researcher acknowledged that she came from an Asian country and used English as a second language. Having decided to conduct field research in New Zealand, she endeavoured to gain a better understanding of the New Zealand way of life; to become familiar with the nursing care delivery system; and to increase her English language communication skills in the following ways: a) living with New Zealand English native speakers for over a year; b) acquiring New Zealand professional nurse registration to practice nursing and having a period of four months in caring for cancer patients at home; and c) gaining access into the hospital setting for practising data collection.

---

[1] & [2] See Glossary in Appendix 1

Initial entry

As this research involved studying human beings in a health care delivery system, it was submitted to the University Human Ethics Committee whose approval was received.

The researcher proposed conducting the study in a public hospital in City A by using observation and interviews to gain data. Therefore the proposal was also submitted to the Hospital Research Ethics Committee from which approval was also received. A meeting was then held with the Assistant Principal Nurse and the Charge Nurses. The researcher presented the study proposal and general acceptance was given. The Charge Nurses introduced the researcher to staff nurses and the study was explained. The study proposal (See Appendix 2) was left in the area and the Charge Nurses took on the responsibility of communicating with those staff who were not present on that day. Nurses were invited individually to participate in the study.

At the Community Health Service, the researcher held a meeting with the Principal Community Health Nurse and she introduced the researcher to District nurses, an Ostomy nurse and an Oncology nurse. The researcher explained the study proposal to each of these nurses individually and they were then invited to participate in the study.

For the settings in City B, as the hospice is a private nursing trust, the researcher made contact with a hospice nurse researcher and Nursing Director. The study proposal was presented to them and the researcher gained access into the setting. The hospice nurse researcher introduced the present researcher to the potential respondents. The study was explained and individual hospice nurses were invited to participate. The hospice nurse researcher also introduced potential patient respondents to the researcher.

Access to nurses in a public hospital in City B was given after the researcher made contact with one of the nurse supervisors. The latter introduced the researcher to the Charge Nurse of an oncology-medical ward. After explanation of the study, the Charge Nurse was invited to contribute to the study. She agreed to introduce the researcher to other potential nurse respondents. Individual nurses were then invited to be interviewed in their own time.

PARTICIPANT SELECTION

Nurse participants

The proposed study and the procedure for obtaining informed consent was explained to registered nurses in the selected settings and they were then invited to participate. They showed interest and willingness to share their experience of caring in everyday nursing practice and the consent form was signed (See The consent form in Appendix 6).

Thirty-two registered nurses participated in the study. Four identified themselves as charge nurses, twelve as staff nurses, four as staff chemotherapy nurses, one as an ostomy nurse, two as district nurses, one as an oncology nurse, and eight as hospice nurses. General characteristics of the nurse group are illustrated in Tables 2 and 3.

Table 2

Categories of Nurses

Self-identified categories of nurses	
Charge nurse*	4
Staff nurse	12
Staff nurse-Chemotherapy	4
Ostomy nurse	1
Oncology nurse	1
District nurse	2
Hospice nurse	8
Total	32

* Descriptions of all these categories are given in Appendix 1, Glossary

Table 3

Characteristics of Nurse Group

General characteristics of nurse group		
Total number		32
Gender	Female	32
Marital status	Single	10
	Married	22
Age	20-29	10
	30-49	21
	50-59	1
Nursing educational background		
Hospital training*		11
Polytechnic diploma*		13
Hospital training with a university first degree*		2
Hospital training with advanced diploma in nursing*		4
Hospital training with concurrent first degree university study		1
Polytechnic diploma with concurrent first degree university study		1
Number of years in nursing		
Less than one year		1
1-5		10
6-10		9
11-20		5
21-30		7
Working hours	Full time	23
	Part time	9

* See Glossary in Appendix 1

Patient participants

Adult patients in the selected settings were asked to participate in the study on the basis of the following criteria: that they were confirmed with a diagnosis of cancer or undergoing the investigative procedures; that they were over 16 years of age and able to communicate in English without difficulty; that they had no recent history of psychiatric illness; that they indicated willingness to be part of the study by giving written consent following the explanation of the study and their desired participation in it.

In accordance with the requirements stipulated by the Hospital Research Ethics Committee, patient participation in the study had to be approved by the Charge nurse and doctors who had the patients under their care. The Charge nurse suggested potential respondents. The researcher then introduced herself and invited them to participate in the study. The study proposal, including the procedure for gaining the consent form was explained to them, and they were invited to participate in the study. Those who showed a willingness to participate in the study then signed a consent form. The Charge nurse and the doctors then signed the consent form showing their approval of the patients participating in the research study (See The patient's consent form and The doctor's consent form in Appendices 7 and 8 respectively). Characteristics of the patient group participating in the study are shown in Tables 4 and 5.

Table 4

Characteristics of the Patient Group According to the Stage of the Disease and Medical Intervention.

Characteristics of the patient group	
Undergoing investigative procedures	4
Undergoing surgical treatment	6
Undergoing chemotherapy or radiotherapy	16
The terminally ill	4
Total	30

Table 5

General Characteristics of Patient Group

General characteristics of patient group		
Total number		30
Gender	Male	12
	Female	18
Marital status	Married	24
	Single	3
	Widowed	1
	Divorced	2
Age	20-39	3
	40-59	15
	60-79	12
Occupation	Clerk	2
	House wife	5
	Librarian	1
	Cleaner	2
	Nurse	1
	Laboratory worker	1
	Computer engineer	1
	Pharmacist	1
	Farmer	3
	School teacher	3
	Horse trainer	1
	Cook	1
	Accountant	1
	Mechanic	1
	Retired	6

Table 6

Types of Cancer of Patient Group

Types of cancer	
Ovarian cancer	5
Breast cancer	10
Cervical cancer	1
Lymphocytic leukemia*	1
Cancer of colon	1
Lymphoma*	7
Multiple myeloma*	1
Cancer of the bladder	3
Cancer of the liver	1
Total	30

* See Glossary in Appendix 1

ETHICAL CONSIDERATIONS

Potential risks associated with the study

The aim of this study was to develop the theoretical meaning of caring in nursing practice from the perspective of patients with cancer and nurses caring for them. The methods of data collection were interview and observation. In the sense that the study was not intended to interfere with or alter events in any way it did not carry any risks or hazards for the participants. However, it was recognised that cancer is perceived as a life threatening illness, which made these patients potentially more vulnerable to emotional stress than patients with other kinds of illness. Interviews and the presence of the researcher during the period of observation could also increase their stress.

The researcher was aware of these potential risks and planned to prevent or minimise them by getting to know the people and building a relationship of trust. To this end all the respondents were contacted by the researcher prior to beginning the data collection and the researcher had an orientation period with nurses and allowed time for supportive discussions with patients. The researcher also avoided the use of words or questions that would increase emotional stress and made it clear that she would willingly accept requests for postponement of interviews.

Explanation of the study and informed consent

The researcher personally approached each potential respondent, and provided an explanation of the study. Written informed consent was completed by the respondent. The following elements were covered in the explanatory statement:

> The researcher was interested in discovering how nurses experience caring for patients; and how these patients experience being cared for by nurses.
>
> It was hoped that the study would contribute to a better understanding of caring and hence to improve the quality of care for cancer patients.
>
> The study aimed to describe what happened in nursing care situations, not to change them in any way during the course of study.
>
> The success of the study depended on the willingness of the participants to describe their experiences, and their thoughts.

Participation in the study would require each respondent's agreement to take part in a series of interviews with taped or written records, and to allow the researcher to observe nursing care situations and record fieldnotes.

Participants were free to ask for any explanations about the study at any time and were free to withdraw from the study at any time, without prejudice to their care.

Participants were free to select the time and places for interviewing. Selected observation of nursing care events would be with the participants' agreement.

All information obtained would be kept in the strictest confidence and the identity of individual respondents would not appear in the final report, a copy of which would be made available to the hospital.

Confidentiality Safeguards

The following aspects were taken to safeguard confidentiality of information and preserve participants' anonymity in the final report: all data for the study was collected by the researcher; pseudonyms were used for all participants and their names and identifying details were not included in any publications or reports of the study; recorded interview and fieldnotes were secured in a safe location and only the researcher dealt with these records; an assurance was given that they would be destroyed as soon as the thesis and examination process was completed; respondents were also given written assurance of confidentiality as part of the consent form signed by them, and the researcher, prior to their participation in the study.

DATA COLLECTION METHODS

In line with the phenomenological perspective and the grounded theory strategies, data for the present study were obtained by three main methods: interview, observation, and audit of nursing and medical notes. The study aimed to uncover the human experience of caring and being cared for. In order to gain a naive perspective of the participants' experience, the researcher endeavoured to set aside or suspend all her preconceptions on caring.

As the researcher has been a nurse for over seventeen years, she has experience of caring for patients. Therefore she acknowledged her previous experience of caring before data collection was started. Although a literature review was undertaken in the initial period of developing the proposal, and was used to guide the formulation of the research problem, during the period of data collection the literature scanning on caring

was stopped. In this way the literature did not colour the researcher's picture of the area under study.

In order to enter into the participants' world, the researcher made every attempt to develop a relationship which was characterised by mutual respect and concern for the participants' wellbeing.

Interviews

Interviews were conducted after the participants signed the consent forms. For nurse participants the first interview was aimed at gathering demographic data and exploring knowledge, thoughts, beliefs, and attitudes about caring for patients in everyday practice. Additional interviews were conducted to clarify the first interview and explore further the experience of caring by asking the nurse participants to describe incidents from their practice.

For patient participants, the first interview also was intended to gather demographic data and explore the participants' knowledge, thoughts and beliefs about nurse caring. The interviews that followed continued to explore the experience of being cared for by nurses, by asking them to describe incidents.

For both the nurse and the patient, the main aim of interviews was to capture information in the participants' own words. The researcher allowed them to express their thoughts and feelings as much as they could. The semistructured interview guides as shown in Appendices 3 and 4 were used. The time and place of the interviews were dependent on the readiness of the participants.

Where appropriate informal interviews also took place with nurses and patients as soon as possible following the researcher's participant observation of nursing care events. The aim of these interviews was to ask the participants to describe what was happening in the situations, including descriptions of their thoughts and feelings.

The number of interviews for each participant varied from one to five, as it depended on the condition of the participants. For example, some patients were too ill after undergoing chemotherapy treatment. With the permission of the participants, nearly all of the interviews were tape recorded. Some of the informal interviews following

participant observation were recorded by means of written notes. The interview tapes were transcribed into written text as soon as possible for the purposes of analysis.

Observation

The researcher entered into the setting as an ***"observer as participant"***. That is to say, from the beginning she identified her role as a nurse researcher working in the field to gather information and participated in everyday activities and interacted with nurses and patients. However it was made clear that she was not responsible for providing nursing care to patients, although she participated, for example, in morning and afternoon nurses' reports; helped nursing staff prepare and serve morning and afternoon tea and made beds. Becker (1958) summarises the meaning of participant observation in the following terms:

> The participant observer gathers data by participating in the daily life of the group or organisation he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of events he has observed. (Becker, 1958, p.652)

With the agreement and willingness of nurses and patients, the researcher spent time observing nursing care situations while nurses provided nursing to the patients. The researcher made observations in three ways. Firstly, by spending time with nurses during the whole morning duty from 7 a.m. to 3 p.m. or afternoon duty from 2.30 p.m to 11 p.m. in order to observe the whole 8 hour nursing work. Secondly, by being with nurses to observe planned nursing care events, for example, admitting a patient, giving chemotherapy, teaching colostomy care, and being with the patient on return from theatre. Thirdly, by sitting with patients waiting for nursing care events to occur and observing while nurses provided nursing care.

In observation, time was spent with nurses and patients on a one to one basis. The researcher used the participant observation guide as shown in Appendix 5 for observation of the events. Field notes were recorded briefly after the end of each event and every single detail was recorded later in that day. Unstructured informal interviews followed each observation as soon as possible and where appropriate.

Phase of data collection and analysis

In this study data collection and analysis occurred concurrently. There were four main phases of data collection and analysis.

Phase one: Data collection commenced in City A in an oncological ward, a surgical ward, and a gynaecological ward respectively. All data from nurses and patients were analysed for codes and categories.

Phase two: Data collection then moved to a community setting in the same city. Data from nurses and patients were analysed for codes and categories. The codes and categories that emerged from this phase were compared with those from phase one.

Phase three: Further data collection then moved to the hospice setting and an oncological ward in City B. All data from nurses and patients were then analysed for codes and categories, and compared with those which emerged from phase one and phase two.

Phase four: All codes and categories were pooled and compared. Selective sampling of literature and selective sampling of data was then carried out. This led to the development of central concepts and the generation of an integrating framework.

The emergent theory was then validated by some of the participants in the settings and other nurses with experience in this field.

A summary of data collection is shown in Table 7.

Table 7

Summary of Data Collection

Data sources and time frame for data collection		
Total time period:		10 months
Number of participants:	Patients	30
	Nurses	32
Number of interviews:	Patients	70
	Nurses	80
Number of hours in the field		640
Documentation:		
	Nursing assessment forms	
	Nursing care plans	
	Nursing progress notes	
	Medication records	
	Observation records	
	Fluid balance charts	
	Nursing referrals to District nurse	

Memos

During the entire process of data collection and analysis, the researcher recorded questions, ideas and hunches. The first memo began on the first day of data collection and analysis. Memoing was continued throughout all phases of data collection and analysis. Four types of memos were recorded: methodological memos, observational memos, theoretical memos, and personal memos. The first three were suggested by Schatzman and Strauss (1973) and the fourth was introduced by Wilson (1985).

Methodological memos instructed the researcher about issues related to methodological approaches in the study. For example, a very early memo was noted about the appropriate time for patient interviews in the hospital.

> MM 1 Date.....
>
> The ward seems quiet after the morning nurses hand over work to the afternoon nurses, and after visiting time is over. It might be an appropriate time for interviewing the patients.

Observational memos were derived from field notes. They contained the who, what, why, and where of the situations. The researcher applied this type of memo for preserving important incidents selected to be used as supportive data.

> OM Hos Refer FN 6 ND and NR Date
>
> Mr K, a terminal patient was lying in bed in a room in a hospice unit. His wife was staying with him in that room. At about 8 p.m. two nurses came into the room to prepare Mr K for sleep. Nurse R cleaned his face and gave him a back rub and talked to him.
>
> Mr K had had a stroke before he developed cancer. His speech was very slow. Nurse R listened to him and paced the conversation. The other nurse (Nurse D) was talking with Mr K's wife. Both nurses tried to help Mr K to be in the most comfortable position. They asked him how he felt and asked his wife to participate in helping him. The nurses adjusted pillows three times because he was not comfortable. The first time he said "No... it's... not.. quite... right". The second time he said "No". After the third adjustment of the pillows he said "Yes... that's... right". And then they were laughing. One nurse said "Should we say goodnight to you, K. Mr K replied "No, could... you ...sing... a... song... for... me. I ... heard ...

you ...sing... this ...morning." Nurse R smiled and said "Oh no." Mr K said " You... sing...a ...song... please". Nurse R then stood close to him and smiled and started to sing while Nurse D came close to Mr K 's wife and put her arm around her, and Nurse D also sang that song. The researcher also joined in singing. Mr K smiled and closed his eyes. Then all said goodnight.
(OM= observational memo; Hos= hospice; ND, NR = Pseudonym of nurses; FN= Field note)

Theoretical memos were most prevalent in this study. They served as a means to interpret, infer, conjecture and hypothesise in order to build an analytic scheme. The following example is part of the record of the first theoretical memo.

TM 1 Refer NK FN1 Date.....

I ask myself what is happening between the nurse and the patient? The nurse purposely meets the patient. The nurse and the patient are interacting and responding: smile, eye contact, hold hands. What about their thoughts and feelings before and during the interaction? Follow up in the first interview.

(NK= Pseudonym of a nurse; FN= Field note)

Personal memos: These were notes about the researcher's own feelings, reactions, and reflections. The researcher used this type of memo to monitor her own energy level.

Date.....

I was really tired yesterday. The ward was very busy, and nobody was interested in me. I spent time helping the nursing staff to prepare and serve morning and afternoon tea. I said hello to nearly every patient and had a general chat but no one was ready to be interviewed. I approached one of the afternoon nurses to participate in my study because she was going to give chemotherapy to one of my patient participants and I would have liked to observe that nursing event. She replied to my invitation with "No, I won't, thank you. You could observe the patient but not me." I felt really down and I asked myself - how can I do this if nurses are not willing to participate in the study? I reviewed how I had approached that nurse and the situation on that day. I could understand that she was busy at that time because she was the only nurse available to give chemotherapy that day and she also had to supervise another two nurses who were under training for giving chemotherapy. I said to myself "Oh, it was not the right time." It was the only time that I felt really down. I told

myself that I needed a break. I spent the time during my break in meditation practice and I felt really good.

.....

Date.....

As soon as I walked into the ward, one nurse asked me how I was getting on and she was interested in what I was doing. She said "It is interesting and important. I understand what you are doing. People don't know what we do. They think that nurses do things such as looking after a child - bathing, feeding....." I felt really good that day. I made plans for an interview with that nurse.

.....

Date.....

I spent half the morning trying to approach patients for interview that day but nearly all of them were not ready because of the chemotherapy treatment the day before. One patient, a lady whom I had chatted with yesterday and to whose husband I'd already talked, spoke to me. I had not invited her to participate in the study because she looked ill. She said to me "You are looking lost today, Payom. I know what you are studying. I have had a chat with J (another female patient). She told me about you. I feel really good today and we can have a talk." She held my hand while we found a suitable place to conduct the interview. I finished my field work about the same time as the morning nurses. I walked out of the ward with one nurse, and while we waited for the lift the nurse said to me "I've got another dollar today. What have you got Payom? I know, you've got love". "What a wonderful day", I said to myself.

All these memos were recorded and sorted in a variety of ways throughout the process of data collection and analysis. In particular, theoretical memos were important records of conceptual ideas for theory generation.

DATA ANALYSIS

The method of constant comparative analysis was the key strategy for data analysis in this study. In the process of analysis, every unit of data is compared with every other unit, and all data gathered are compared with those already at hand until a picture of the whole emerges. Glaser and Strauss (1967) described the method of constant comparative analysis in the following way:

> We shall describe in four stages the constant comparative method: 1) comparing incidents applicable to each category, 2) integrating categories and their properties, 3) delimiting the theory, and 4) writing theory. Although this method of generating theory is a continuous growing process - each stage after a time is transformed into the next - earlier stages do remain in operation simultaneously throughout the analysis and each provides continuous development to its successive stage until the analysis is terminated. (p. 105)

Data analysis in this study commenced on the first day of data collection and continued on until the interpretation of the theoretical framework was gained. Data analysis is illustrated in the following ways:

Substantive coding: Data were analysed line by line in an attempt to capture the conceptual substance. In this way the data were broken into meaningful information segments. These information bits were then labelled as a conceptual unit. The following example is part of a nurse interview description. The information sections are underlined, and labelled codes would then be written on the right hand side.

... in caring for these persons I want to impart something from myself to them to give them strength, but that may be unique to me, but when I talk to them I feel they need some strength, I feel myself almost physically trying to transfer energy to them to help them. The way I communicate for this is very important. I had to set up a relationship with these people, so the first thing that has to be in the foundation of that relationship is trust....

imparting
giving strength
transfering energy
communicating
trusting relationship

Theoretical coding: Substantive codes were compared and examined for relationships. Then they were clustered and labelled at a more abstract level. The following example illustrates clustering of conceptual units and labelling them at a more abstract level. Being benevolent is one of the theoretical codes.

Benevolence

Data from nurse interview:

I'm a Christian, caring is my value.
I'm willing to help people.
I'd like to try to treat the person as myself.
You've got to feel like you genuinely want to do it.
It's from here--inside, you know, yourself. (A nurse participant puts her hand on her chest.)

Data from patient interview:

They care for you all the time, they are genuine.
They've got your welfare at heart.

I was squashing her hand really tight. She was willing to have me do that. She cared enough in her capacity as a nurse to overcome the pain I was giving her, to help me. That to me is really caring for someone, being willing to take on a little of their hurt.

They are very understanding, very friendly.

I feel their feeling towards me, they're being kind, you know. I feel something glows out of them toward me as kindness.

Categories: Theoretical codes then were compared and reduced into categories moving to a more abstract level. Theoretical codes become properties of categories. Glaser and Strauss (1967) indicate that categories and their properties are concepts indicated by data. The following example demonstrates the collapsing of theoretical codes from nurse and patient interviews into a more abstract level to make a category of a nurse personally and professionally prepared to care.

The nurse: personally and professionally prepared to care

Benevolence Commitment Clinical competency

In this study, a number of concepts have been developed from data. As the researcher is not a native English speaker, a dictionary search was used to confirm the meaning of the term chosen to define the concepts. The researcher acknowledges a debt to Christensen (1988, 1990) who first used this approach to concept development. The process of analysis resulted in four main categories: a category of The nurse: personally and professionally prepared to care; a category of The patient: person with compromised health and wellbeing; a category of The ongoing interaction; and a category of The situated context.

SUMMARY

In this chapter the discussion has centred on two main aspects - the research methods and how the present research was conducted. In the first section the discussion focused on research methods in relation to nursing knowledge development, and the most appropriate method for investigating the caring phenomenon in nursing. The patterns of knowing in nursing have been presented. The chosen method for the present study - phenomenological approach and grounded theory strategies - has been discussed in detail. The phenomenological perspective provided the means to gain data and the grounded theory strategies guided data analysis in developing theory. Discussion on standards in qualitative research, and the evaluation and credibility of grounded theory, has been included.

The second section detailed how the research method was implemented. First of all, an explanation of the settings, the participants, and ethical considerations was presented. Then the data collection and analysis were described and an example was given of how data were analysed. The categories which emerged from data analysis have also been stated. The details of each category and its properties as developed from the data are presented in Chapters 4-7, while the integration of the theoretical framework is presented in Chapter 8.

In Chapter 4, the first category of **The nurse: personally and professionally prepared to care**; and the second category of **The patient: person with compromised health and wellbeing**; will be discussed with supporting data.

CHAPTER 4

NURSE AND PATIENT: CONCEPTUAL CATEGORIES

The categories of The nurse: personally and professionally prepared to care, and The patient: person with compromised health and wellbeing will be presented in this chapter along with their concepts and subconcepts supported by data. The chapter is divided into two sections.

SECTION ONE

THE NURSE: PERSONALLY AND PROFESSIONALLY PREPARED TO CARE

In this section the category of The nurse: personally and professionally prepared to care, is discussed with supporting data from both nurse and patient perspectives. The discussion commences by defining the meaning of the category and continues with the meaning of its three dimensions: benevolence, commitment, and clinical competency.

The term "The nurse: personally and professionally prepared to care" conveys that the nurse is not only an individual human being, but also a professional person who has developed qualities or capacities for caring. With these qualities the nurse is ready to help the patient.

In a health care delivery system the nurse is a professional person providing nursing care to a patient. The nurse and the patient make contact in order for the nurse to assist the patient to meet situational health needs, and this requires the process of caring. From field data, it was apparent that both nurses and patients perceived that for the caring process to occur the nurses must have caring qualities embedded within themselves. That is to say, to be able to provide nursing care, the nurses must have developed within themselves the quality to be caring. The field data indicated three concepts to explain the qualities of caring: benevolence, commitment, and clinical competency.

Benevolence

The term "Benevolence" was developed from the data as a suitable word to describe the nurse's personal values or framework of life in performing good deeds. The meaning of the term is confirmed by a dictionary search. 'Benevolence' means 'intention of good will'; 'doing good or giving aid to others rather than making profit' (Collins, 1989). The use of this term by Christensen (1988, 1990) is acknowledged.

To be human beings living in this world nurses have their values to guide their actions and behaviours. They value other human beings as they value themselves, and they also value helping people who are in need of help as a notion of doing good. In particular, in their practice, they are willing to give of themselves to help patients who are facing health-related problems.

During interviews all nurses in the study expressed human values and altruistic values. The following three examples are nurses' descriptions of their meaning of caring which reflect these values.

> **I firmly believe in people's right to maintain their own integrity as a person ...** and I believe in promoting that at all times ... so that I'm not making decisions for them ... I'm helping them to make decisions that may enhance their quality of life ... their home situation which is all part of that ... so that's how I see it. I sometimes feel that in caring for this person **I want to impart something from myself to them to give them strength ...** but that may be unique to me ... but when I talk to them I feel they need some strength ... **I feel myself almost physically trying to transfer energy to them to help them.**
> (Nurse J, Interview No. 1)

Key to transcripts

( )	Researcher comments to provide clarity
...	Pause
..//..	Material edited out
Names	All names used in the text are pseudonyms
*	Terms explained in glossary (Appendix 1)
@	Extract used more than once to clarify different concept
Bold type	Indicates substantive content

> Starting from **I like people ... I want to help them ... give them strength.**
> (Nurse Je, Interview No. 1)

.....

> It's hard to say ... it's something **you do with your gut feeling. You've got to have some degree of it ... intrinsic within yourself.** For me it's more clear when I come to nursing.
> (Nurse A, Interview No. 1)

Some nurses revealed that their human values and altruistic values were derived from a religious belief, and they used these values in their personal life and incorporated them into their professional practice.

> I'm a Christian, **caring is my value ... I am willing to help people.**
> (Nurse R, Interview No. 1)

.....

> **I believe in God** ... God loves everybody ... **with the eyes of God you give tender loving care to your patient.**
> (Nurse An, Interview No. 1)

.....

> **Christ ... is the model of life** ... you can't go wrong.
> (Nurse T, Interview No.1)

Some nurses have their own personal framework of life. They possess human values, and value helping other people as a notion of good which is not derived from any particular belief system.

> I'd like to try **to treat the person as myself, my family.**
> (Nurse S, Interview No. 1)

.....

> It's not something you can be forced to do. **You've got to feel like you genuinely want to do it.**
> (Nurse Ly, Interview No. 1)

.....

> **It's from here - inside you know yourself.** (She put her hand on her chest.)
> (Nurse Ke, Interview No. 1)

.....

> **I think it's wanting to use your knowledge and skills to help that person who is ill ...** and it's something spiritual ... because it's not actually something you can say. @
> (Nurse J, Interview No. 1)

Nurses also explain that the qualities which help them to be caring come from their own experiences of life. In one example, a nurse gives a reflection on her own experience of illness which allowed her to empathize with her patients.

> For me, **I've personally been in the hospital, sick, really ill.** Personally I draw on that a lot, also I am a parent. I draw on that a lot ... a lot of empathy with other parents ... you could relate that feeling with your own feelings. I do think a lot about the way I felt. My need at that time kept me aware ... maybe help to understand people's feeling of possibly dying and the way how to cope with that. I think ... you draw life experience too .. **Life experience has taught me a lot about people's needs when they are ill ... because I have been in the position to be able to cope with the family. I've been in the hospital when I was a teenager.**
> (Nurse P, Interview No. 1)

.....

Some nurses explained that the quality of caring is a learned process developed since the early stage of life. The following excerpt is one example.

> **That basically it's with me ... and that care I'm sure I've had that through my life ... that care and concern.** I think it makes me better equipped to be able to commit myself... whereas if I had been neglected ... I'm not saying that if I hadn't been cared for I wouldn't be able to care myself but **because I have been looked after and cared for as a child it's taught me what caring is.**
> (Nurse S, Interview No. 1)

Patient participants also perceived that nurses have benevolent intentions to help them, as shown in the following excerpt:

> They care for you all the time, **they are genuine, they've got your welfare at heart.**
> (Patient Be, Interview No. 1)

.....

One female patient reflected on her experience which she labelled as "real caring" in the following excerpt.

> I was squashing her hand really tight ... **She was willing to have me do that** ... She cared enough in her capacity as a nurse to overcome the pain I was giving her to help me ... **That ... that ... to me is really caring for someone willing to take on a little of their hurt.***
> (Patient R, Interview No. 1)

.....

Patients in the study made some reference to "friendliness and kindness" as an important personal quality in a nurse who is caring, for example:

> They're very **understanding ... very friendly.**
> (Patient P , Interview No. 1)

.....

> I feel their feeling towards me ... they're being kind ... you know. **I feel something glows out of them toward me as kindness.**
> (Patient G, Interview No. 1)

Commitment

As nursing is a practice discipline providing services to human beings who are facing health related-problems, human care has a profound professional value with a moral foundation. The individual nurse promises to herself to put the professional value of altruism into practice. The term "Commitment" was developed from the data, and is used to describe the nurse's feeling of being obliged to put altruistic values into practice. The use of the term "Commitment" by Roach (1984) and Watson (1985) sensitised the researcher to using the term in this context. The following excerpts from

statements made by the nurse participants show that 'caring' is a professional moral obligation.

> **We have to care otherwise we shouldn't be nursing.**
> (Nurse A, Interview No. 1)
>
> .....
>
> **You've got to care to be a nurse.**
> (Nurse S, Interview No. 1)
>
> .....
>
> **It's required in a nurse and we all measure each other up by our ability to care.**
> (Nurse Ly, Interview No. 1)
>
> .....
>
> We chose nursing because **it gives us a profession through which we can exhibit caring.**
> (Nurse J, Interview No. 1)
>
> .....
>
> **It's a criterion of their performance that they are able to care for their patients/families, and for each other.** And it's very high on the list of things you expect from a nurse.
> (The Charge nurse L, Interview no 2)
>
> .....
>
> **... giving my utmost as much as I can.**
> (Nurse T, Interview No. 2)
>
> .....
>
> I can say that I'm a good nurse... **as soon as I get into the ward, the time is for my patients. I try to give all my attention to them.**
> (Nurse K, Interview No. 1)
>
> .....
>
> Usually when I go to work I park my car in front of the hospice. After I get out of my car... **I've put my feet firmly on the ground and walk into the hospice. I leave other thoughts behind ... and tell myself ... this time is for my patients ... I try to give myself as much as I can.**
> (Nurse D, Interview No. 2)
>
> .....

Patient participants in this study also perceive that 'caring' is a professional nurse commitment. The following descriptions provide some examples of how they see this commitment.

> They are nice to me ... actually most of them ... there is **one or two that shouldn't be in the profession,** but **most of them are really genuinely caring people** and you find that with a lot of people this is what drew them to become a health professional - that they cared.
> (Patient Ba, Interview No. 2)

.....

> They are **dedicated to their job.**
> (Patient Be, Interview No. 1)

.....

> She might have had a off night or not slept very well or been feeling not very well ... and **yet she's got to come on and be very caring and great to all of us ...** try to be patient and nice to somebody who is being naughty ... at the same time be caring to you.
> (Patient J, Interview No. 1)

.....

> I've always found that **if you ring the bell they will come immediately ... and will show concern** and even though they're rushed out of their feet they never complain. They never sigh or anything like that at all ... They just don't mind.
> (Patient S, Interview No. 1)

.....

> I've found they've been the same to all the patients ... **no matter how difficult they might be** ... or even the case of an old lady who was very hard of hearing and **all the nurses showed so much patience.**
> (Patient B, Interview No. 1)

Clinical competency

The use of the term 'competence' by Roach (1984) sensitised the researcher to develop the term "Clinical competency", to explain the nurse's sufficient skill and knowledge in helping the patient to achieve situational health needs. This term is indicated by the data. In order to be able to assist the patients to meet their situational health needs, nurses must have clinical knowledge and technical competency which they have gained

from professional education and experience. The main knowledge base is humanistic with scientifically supported knowledge.

In caring for the patient with particular health related problems, the nurse must have experience in clinical practice in that area for a certain period of time until she develops her clinical knowledge and technical skills.

> **You learn the knowledge, but you gain the wisdom** itself ... don't you. **Experience over the years and feeling for the patients itself.**
> (Nurse Ly, Interview No. 1)

.....

> Caring is meeting needs ... and it's also **giving something of yourself and doing that and it's using a whole variety of skills and knowledge that you have yourself ... because you give to different people in different ways.**
> (Nurse Je, Interview No. 1)

The following statement shows the belief that the nurse's professional knowledge and skills affect the outcome of the patients' wellbeing:

> Caring is the professional practice that **you have the knowledge and skills to help them**, and that you can relate to many different people. To use the word again, you actually care what happens to them and you have some impact in what's happening to them and that **you can affect the outcome for all of them. And by being a good caring nurse you can hopefully help the person to have a better experience in hospital, or have a better quality of life or be more comfortable.**
> (Nurse L, Interview No. 1)

To be a professional caring nurse, the individual nurse learns to gain experiential knowledge or practical knowledge through her practice, as is stated in the following excerpts.

> I see it as two things, as a physical thing that we are taught to do, that it is easy and that we do it off pat because we've always done it and then there's the mental thing that **I think as you spend longer here becomes more into the profession and you become better.**
> (Nurse Ke, Interview No. 2)

.....

> I think a lot of the **skills I have been acquiring came by time and experience.**
> (Nurse Ly, Interview No. 1)

.....

> **As the time goes by you become very much more comfortable with the technical skills.** So I would say that when I do a dressing or change a drip bottle, I don't pay as much attention to changing the drip as to talking to the person.
> (Nurse K, Interview No. 2)

.....

Patients also perceive that when a nurse cares she must have professional knowledge and technical skills. The patients say that:

> **Without technical skills they can't really put into effect their practice.**
> (Patient A, Interview No. 2)

.....

> Well **my dressing needed to be changed ... and it's quite a procedure and ... then the lines have to be changed every day ...** and take time perhaps they wouldn't have with another patient. And that takes up extra time ... so you know they're probably run off their feet doing all the things ... So what they have to do is monitor the most important things and do them first ... like changing the beds ... they would do that later... when they have time to do it. They are pretty quick and efficient.
> (Patient H, Interview No. 3)

.....

> ... **administering drugs which takes expertise ... and making sure that their patient is comfortable and seeing ... anticipating problems ...** but also being able to talk to them sometimes and find out what's upsetting the patient.
> (Patient Ba, Interview No. 2)

A female patient identified the different levels of competencies she had noticed in individual nurses. The nurse who has spent a longer time practicing in the particular area of nursing practice is more competent than one who has spent a shorter time.

> The qualified nurse as - one in this ward - she hasn't been in the ward as long as the others, you can sense that she is unsure with certain things. Each time I come up she's getting better, she's got used to more and more routine. Sometimes she can't remember what she has to do. Now I've found that she is much more secure. **She knows**

> **the little things that there is not a rush to do and what things that she has to do straightaway and you get that sense that once they're qualified longer, they know the important things to do - the others even though qualified they still learn.**
> (Patient A, Interview No. 3)

In everyday nursing practice, nurses work in association with other health professionals. With clinical competency, the nurse is confident of questioning medical personnel in order to protect patients' welfare if it appears that an error has been made, for instance in a prescribed drug dosage. The following excerpt demonstrates an example of the nurse's confidence in her competency.

> We do all the drug calculations because the chemotherapy is done on the body weight ... done on surface area. And you've got to make sure the blood counts are right ... and this date that it's signed and that drug that you are giving is the right dose ... You have to know all the side effects. I'm forever looking in my book and refreshing my memory ... knowing what it is. That's the major thing - knowing the counts and things are right. Some of the doctors can make mistakes ... and I mean we're supposed to pick them up ... because that's very important. **And there have been a lot of times when we had to go and say - "Oh look this is wrong" ... and they say "Well thanks for picking it up."** That's one of the major things when you're drawing up ... you know that someone else has checked it ... and you have to really have trust in that person for checking it because I mean ... if you make a mistake they should pick it up too. But they're all good here.
> (Nurse T, Interview No. 1)

A male patient related his experience with one doctor and the fact that he appreciated the nurse caring with her clinical competency to protect his welfare.

> A long time ago a young doctor put the needle in for my chemo* ... I could feel that it was not right and I told him... and he said " What are you doing for a living?" I said "I am a horse trainer" and he said "You are a horse trainer but I am a doctor." He put the needle in and went away. **After that a nurse came to me and I told her of my feeling and she checked it and she took it off straightaway.**
> (Patient B, Interview No. 1)

In another example, a male patient talked about his experience with differences of competency in individual nurses.

> Last month when I went out of the hospital ... the district nurse came to see me and did the dressing for my Hickman*. She didn't know

> that I've got infection at the Hickman ... and I didn't know either... Then I came to the hospital for the next chemo. **As soon as I've got into the ward the nurse checked everything ... and she knew straightaway that I've got infection at the Hickman...** so I couldn't have chemo that time. **The nurses in this ward are very thorough ... and very caring. They have their expertise ...** you know. I was scared of infection because the Hickman is in my heart ... They taught me everything ... I've been very careful about it since that time. I always look at the mirror when I do my Hickman ... to see it clearly. I guess the district nurse might not have as high experience as the nurses here ... or she might not see the Hickman very often.
> (Patient W, Interview No. 3)

.....

The individual nurse is a unique person, and therefore the quality to be caring varies according to life experience and professional experience. As an example one nurse and one patient say:

> I think it's wanting to use your knowledge and skills to help that person who is ill and it's something spiritual because it's not actually something you can say, well you do say, that **some people have it and some people have it to a lesser degree and some people have it a lot more.@**
> (Nurse J, Interview No. 3)

.....

> Some of them perhaps do their training and are really not that keen ... and it's just a job and you do come across that odd nurse ... and you do pick them out. I can tell they're there to do a job ... and the other one comes along and you can see that she's absolutely. .. she's meant to be a nurse ... and **she's so caring that just naturally comes to them. You pick it up straight away** as a patient you do.
> (Patient J, Interview No. 1)

.....

Professional nurse caring, the qualities embedded in an individual nurse, is a developmental process through personal life experience and professional experience. The nurse develops these qualities from an early stage of life and through professional experience, which includes educational processes and her own professional practice. In other words, the nurse has been sensitised to be caring in her personal and professional experience.

> It's hard to say ... it's something **you do with your gut feeling. You've got to have some degree of it ... intrinsic within yourself. For me it's more clear when I come to nursing.**
> (Nurse A, Interview No. 2)

.....

> **To me nursing has defined care a lot more...** but certainly hasn't changed what I think care is ... its just defined it. **And that's basically it with me ... and that care I'm sure I've had that through my life.**
> (Nurse S, Interview No. 1)

.....

> Caring is basically showing appreciation for that person as a person, and they have worth and they are important and they are directly involved in their own care. It's giving them their own responsibility and you don't take it off from them. **It's something I incorporate from my background, my beliefs and attitudes, what I've been taught at Tech* and what I've learnt since I've come out of Tech.**
> (Nurse Sh, Interview No. 1)

.....

With her qualities of caring a nurse achieves professional actualization and this motivates her to put caring values into practice.

> **I know that it's particularly rewarding and perhaps it also helps - the energising is when you reach these really ...** and it happens quite a lot in my work ... that you reach this absolutely wonderful level.
> (Nurse J, Interview No. 1)

A nurse builds up personal caring qualities and professional caring qualities through her life experience and professional practice. These qualities prepare her to be ready to provide nursing service to the patient. The next section continues with discussion of the patient, a person with compromised health and wellbeing.

SECTION TWO

THE PATIENT: PERSON WITH COMPROMISED HEALTH AND WELLBEING

In this section the category of The patient: person with compromised health and wellbeing, is discussed with supporting data. The discussion begins by defining the meaning of the category and continues with a discussion on the meaning of its dimensions.

The term "The patient: person with compromised health and wellbeing" was developed from the data to describe the patient with cancer as an individual human being whose normal life situation is interrupted by a disease. Therefore he/she tries to make every effort to restore potential wellbeing.

Patients with cancer perceive the disease as life threatening and they respond to this perception with their whole being. As a result the patient is in a state of decreasing self comprehension and self help, and requires assistance from health professionals to regain potential wellbeing. Three dimensions were generated from the data to describe the patient as a person with compromised health and wellbeing. These are: uniqueness, vulnerability, and needing assistance.

Uniqueness

The term " Uniqueness " arose from the data itself, for example in a nurse comment "I think that mainly their uniqueness...their different situations..." It is used to explain a particular patient who is an individual whole person differing from other individual persons. A dictionary search confirmed the meaning, "Uniqueness" as being the 'only one of a particular type'; 'single'; 'sole'; 'without equal or like' (Collins, 1989).

The whole individual person has three inseparable components: biophysical, personal life experiences, and personal beliefs and values. All nurse participants perceived that in the process of caring they saw each patient as an individual whole person within his/her particular situation.

As a professional nurse, caring is recognising the value of individuals. To me with the people on my ward ... **I think that it's mainly their uniqueness ... their different situations and being able to recognise that ...** in my professional capacity and work with them with whatever has brought them into hospital ... It's not caring, even loving, but more in the value of the individual in ... being able to recognise that and be able to work with many different people. And it's definitely helping them ... being able to help people with problems that they have lost the power to control ... and being able to help them get some control in their lives back again.
(Nurse L, Interview No. 1)

.....

Looking after the **whole being of the person ...** that is how I see caring.
(Nurse P, Interview No. 1)

.....

Caring for me is taking care of the whole patient ... friends and family, getting away from being task oriented, being sensitive to the patient's ... friends ... and family. **Caring from my point of view toward the patient is what we do to a particular patient.**
(Nurse K, Interview No. 1)

.....

For me caring as a nurse is that **you look at a person and you see a whole lot of things ... like who that person is and what their background is and ... what their support network is and what their knowledge is ... and what their expectations are and you incorporate that into how you look after that person ...** because caring for a person means using all that knowledge about the person and then sort of filling in the gaps.
(Nurse Je, Interview No. 1)

.....

Caring is the **wholistic approach to nursing. You have got to look after every aspect ... You have got to look after the physical ... mental ... spiritual** side of nursing and the different races ... You have got to appreciate they've got different cultures and you've got to respect their needs.
(Nurse Ly, Interview No. 1)

.....

I think that when we're caring **we look after a person for their whole being not just for certain areas** especially cancer patients. They come in and they are often very worried which is understandable so ... regarding B ... she came in ... I spent quite a

lot of time with her on the first day that she arrived ... talking to her... sitting with her and trying to go over what was going to happen to her in the operation ... that she had to prepare herself for what to expect later. She was quite worried when she first came in.
(Nurse Lu, Interview No. 1)

.....

Just recently I've been with **this man ... he's an accountant ... he's a ... you know... an intelligent man in his own right ... he was absolutely devastated when I met him because he'd been diagnosed with liver cancer of unknown origin ... and he presented with very severe pain problems ... and he needed a lot of support and I was seeing him on a daily basis ... I was monitoring his pain relief because he came out of hospital with pain still not totally adjusted ... and he has had very severe problems ...** Now in seeing him daily he was at first leaning on me terribly because he needed that backup **to him and why we were doing this ... and what would happen.**
(Nurse J, Interview No. 3)

The patients perceive themselves as unique persons with their own beliefs and values, and life experience. The patients in the study value human care. The following excerpt demonstrates one example of a patient displaying her value of caring.

From my point of view ... I think, **caring is not just the health profession ... we need a caring society.**
(Patient Bb, Interview No. 2)

.....

The patients perceive themselves as unique people. The following description shows one patient's perception about himself and his own situation.

I deal with my own situations ... and I look at the situation and I take it into account. I deal with it ... and then I calculated in my mind an action that I'm going to take on the evidence that I have. Now my attitude at present is that I have cancer ... which I've been told ... in medical opinion it's terminal and it's going to kill me ... now I haven't actually accepted that because I don't have any intention of dying at this stage ... so I intend to live and that's the way I approach my life ... but I'm also not stupid in as much as I know that the cancer is there and it can kill me ... but I'm not going to give in to it. I'm going to stay.. //.. **I possibly ... I'm not blowing my own trumpet here but I had the strength and the power before but I'm that type of person.** I didn't know what sort of person I was in that respect ...

> because I've never been tested before in the past but when I found the situation ... I found I had the strength.
> (Patient Jo, Interview No. 1)

When patients experienced being cared for by nurses they described how the nurses perceived them as individuals and treated them as human beings, not as objects. In the first excerpt, a female patient related her experience when she had been in the hospital in the past. At that time she experienced being treated by the nurses as an object. However, at the present time, nurses recognised her as an individual person.

> It's not as um ... it used to be when you went into hospital ... you more or less became a number... and you were treated as, not so much as an individual ... but as a digit ... you know... a number. Now that's all changing ... you notice it coming through now ... **you're now realising you've got to treat the whole person- and oh there was one other thing, they include the family.**
> (Patient R, Interview No. 1)

.....

> They **care for each one as an individual,** not just as numbers or anything.
> (Patient S, Interview No. 1)

.....

> They more or less **treat the person as well as the disease.** And they give you choices.
> (Patient Ba, Interview No. 2)

.....

> They look after **each patient individually**, they don't treat you like a number ... they sort of take you as you are.
> (Patient B, Interview No. 1)

.....

> They treat you like one of them as staff ... **as though you're not a patient ... but a person here ...** well they're so caring you know... **they make you feel like one of the staff.**
> (Patient P, Interview No. 1)

Vulnerability

The patient with cancer experiences the disease as life threatening and is in an uncertain life situation, which makes the person lose some degree of his/her self comprehension, self control, and self help.

The term "Vulnerability" was developed to describe the characteristics of a patient with cancer who is liable to be physically or emotionally wounded or hurt. Three patterns were generated from the data indicating vulnerability: experiencing a life crisis, facing uncertainty, and being in a state of dis-ease/distress.

Experiencing a life crisis

The term "Experiencing a sudden life crisis" was developed from the data to describe life situations of patients with cancer who at one stage undergo extreme deterioration of wellbeing. A dictionary search was undertaken to confirm the meaning.

When patients with cancer first recognise some abnormal symptoms or signs, they perceive that their wellbeing has been disrupted. This compels them to seek help from health professionals. The symptoms vary in severity - some are mild but some are acute. The awareness of having cancer surfaces when the decision to seek medical investigation is being made. When the diagnosis of cancer is confirmed the patients perceive that their life is threatened and they experience a sudden life crisis. The total being responds to the word 'cancer'. The nurse labels patients in this stage as 'the newly diagnosed'. These perceptions are demonstrated in the following excerpts:

> From my experience it's probably the worst time for the patient. **The newly diagnosed were the most shocked ... the most confused ... the least resilient ...** because everything that had gone before suddenly had a big question mark over it and their life that had been going along reasonably smoothly ... suddenly had a whole lot of doubts about it and I thought ... I used to feel that those people were the most vulnerable and needed the most human support.
> (Nurse Je, Interview No. 1)

.....

The following two excerpts demonstrate the patients' expression of sudden life crisis.

> I think one of the largest problems is ... with **newly diagnosed patients is that it all happens so fast that they don't take it in ...** and I think that's why they need the nurses. Most of the doctors and nurses are good ... but you're stunned. I mean you can't absorb all the information together.
> (Patient Ba, Interview No. 2)

.....

> **Shocking ...** because ... it was so short notice for me and I didn't have any pain or anything it was just a matter of an x-ray and then I was ... I have it ... told me I had it ... I've just got a little bit of a pain in the shoulders and bits and pieces and another x-ray in the chest ... **it all happened so quick to me ...** and I lost um ... in four days I lost five kilo's ... and worry thinking about it ... thinking about my family ... thinking about different things ... but I went to a different hospital out of town originally ... but once I came back to my home town ... which is here ... I settled down and got to know the people and the staff and settled down and just settled into the ... as a normal person ... and if I had time to think about it ... and time to settle into ... but **originally it was a real shock ... it was because the word cancer was spoken ...** because everybody ... when you've got it you're meant to die, aren't you ... that's it ... but it's not like that ... and it was the biggest shock for me.
> (Patient P, Interview No. 1)

In some periods while undergoing some forms of treatment, the patients also experience a life crisis. The following excerpt is one example of a crisis situation.

> **I got very depressed and thought I was going to die ...** I had that septicemia ... I had my spleen out ... and about four months after I'd had my spleen out ... it took me a long time to get over that operation and I don't think I was looked after very well. I told you about that last night. And then I had the ... and I just went really depressed and I saw a psychiatrist and I really thought that I was going to die and the psychiatrist was really good ... she was good value and we had counselling ... my husband and I ... because my husband doesn't cope very well either and everything just happened at once ... it was terrible.
> (Patient Ba, Interview No. 3)

.....

Both nurse and patient participants perceive that when the disease continues progressing and the medical treatment fails to control the disease, the patient/family faces the crisis of imminent life ending.

> I just thought what a bum, **I'm down and I'm dying ...** and I said to my husband "Well ... we're all going to die" and he said "Well ... we're all going to die ... you've just accelerated the process", and I felt "Damn" and then I felt "Hell ... I might not yet" and I talked to the specialist and they said "We may be able to control it for another couple of years"... I may go into ... after this next session of ... but the **lymphoma* is getting more and more aggressive... now I am depressed.**
> (Patient Ba, Interview No. 2)

.....

I've got a man now who has got a brain tumour ... and he is a man in his fifties with a wife with youngsters ... and he had surgery and radiotherapy. **He's been told several times by the doctor that he's terminally ill** but he still hasn't actually come to terms with it and ... we have to go fairly slowly with him.
(Nurse J, Interview No. 2)

.....

Though they're having chemo or whatever for their cancer **really they're dying.** That's how I see it - maybe they'll get a couple of years grace but it's like their death certificate is already signed in some way.
(Nurse S, Interview No. 2)

Facing uncertainty

The term "Facing uncertainty" was developed from the data to describe the life situation of the patient with cancer who is confronted with an inability to accurately predict future survival or death. This meaning is consistent with a dictionary definition (Collins,1989).

Due to the progressive nature of the disease and the different responses of the individual patient to medical treatment, a prediction is made difficult. Therefore the patient always fears the unknown future of surviving and dying. The following excerpts provide examples of how the patients perceive uncertainty.

It might happen in the next two years ... **you never know ... it might not happen for ages.**
(Patient A, Interview No. 2)

.....

Fear of being alone and left, what do I do next? 'Oh goodness ... **what's going to happen?'**
(Patient H, Interview No. 2)

.....

I've just lived day by day ... **you can't plan ahead.**
(Patient V, Interview No. 1)

.....

We talk quite openly about **if I do become terminal** and how we will go about handling it ... and I've actually quite accepted the fact that I will probably die in the next ... well ... see the thing is at the moment the things ... they didn't look too good ... two years ago and

I'm still here and they're talking about that they could probably control this disease for another year... or two.
(Patient Ba, Interview No. 3)

.....

The fear of the future ... it's always there. With J's condition we know it possibly will deteriorate ... but I feel as if I can cope now. Before we got into the hospice group ... I was getting to the stage where I didn't think I could cope.
(Patient J's wife, Interview No. 1)

Being in a state of dis-ease or distress

The term "Being in a state of dis-ease or distress" was indicated by data to describe patients with cancer facing the immediate moment of discomfort, worry, anxiety, difficulty, or burden.

During the moment to moment experiencing of illness or undergoing medical treatment, the patients face discomfort or distressing situations. These could be physical, psychosocial, or psychospiritual. The three following excerpts provide examples of patients in a state of physical discomfort.

When I was downstairs a little girl from polytech* she came and she had a talk with me. **I had a very very bad cough ...** and she came and talked to me ... that was rather sweet ... she wasn't a registered nurse I feel she looked after me ... at that time I was in isolation.
(Patient A, Interview No. 2)

.....

Well I had a situation in the hospital, they had these concrete block mattresses ... that's what they feel like. They are filled with concrete blocks! They're as hard as ... shocking. I know they have to have them but I used to, I didn't sleep very well on them and I used to writhe around all over the place, the heat and everything in the hospital **at that particular time was intense and I used to be saturated with sweat ... you know perspiration ...** I used to get saturated in the night.
(Patient Jo, Interview No. 1)

.....

When the patients are undergoing invasive technical procedures, they experience immediate moments of physical and psychological discomfort. The two following excerpts are examples.

> One time they were having trouble finding my vein and it takes about a half an hour to get the vein and **it hurts ... very scary ... very sore.**
> (Patient A1, Interview No. 2)

.....

> You know, just general things which keep your mind off ... staring at what she's doing there ... because **you're sore enough** as it is and you think well ... all the poking and the prodding it's only going to **make you sorer ... and you do get a bit anxious about yourself ...** You don't mean to but you do.
> (Patient M, Interview No. 1)

.....

A nurse explains about her patient being in a state of psychological discomfort because of the deterioration of her physical condition.

> **She's depressed** but she's not depressed about the fact that she's dying ... she knows she's dying and this is not her problem ... **she's very depressed about her mode of dying because she can't swallow very much ... she can't eat.**
> (Nurse J, Interview No. 3)

The following two excerpts demonstrate that patients experience moments of psychological discomfort because of their fear of having to confront previous unknown medical situations, such as an exploratory operation or a chemotherapy procedure.

> Even when you're down in the theatre ... they 're wonderful to you down there ... you know ... they know that **you're feeling uptight** about going in ... and they talk to you about all kinds of things hoping to get your mind off of it.
> (Patient M, Interview No. 1)

.....

> And some patients are **really frightened of chemotherapy ...** They are just so frightened of the unknown ... The nurse needs to take time to talk to them.
> (Patient H, Interview No. 2)

.....

Some patients experience psychosocial discomfort as shown in the following excerpt. A male patient worries about his family's future financial condition because of his uncertain life situation.

> **I was worried about D's future.** I've done a lot of things in financial and other practical ways to make it as easy as possible for her ... things such as insurance policies.
> (Patient Jo, Interview No. 1)

.....

A terminally ill patient explains her experience of psycho-spiritual discomfort in the excerpt below.

> You've got to make what you can of life and I don't know if there's anything after life. I don't know if there's a heaven or a hell ... I can't imagine there being a hell ... **it just scares hell out of you.**
> (Patient Ba, Interview No. 3)

.....

Needing assistance

The term "Needing assistanc " was derived from the data to describe the patient's situation which necessitates help during the period of illness and while undergoing medical intervention.

During the moment to moment experience of illness, and while undergoing medical treatment, the patients' ability to achieve personal needs in everyday living is decreased, therefore they are in situational need of assistance from professional nurses in order to live through their illness or prepare for a peaceful death.

The patients' assistance needs are constantly changing from moment to moment, hour to hour or day by day. The assistance required by patients depends on responses to the illness and medical treatment. The following excerpts demonstrate the nurses' perception that each individual patient's needs of assistance is different.

> Caring, for me, is taking care, finding out the patient's needs. Needs associated with physical, mental, spiritual, social needs ... **all needs that are required by that person.**
> (Nurse K, Interview No. 1)

.....

> Caring for a person means ... using all that knowledge about the person and then sort of filling in the gaps. You can't care for a person if they don't ... **I mean some people need a lot more**

> **knowledge than others ... some people need a lot more support than others because they haven't got it from somewhere else ... some people need a lot of physical help because of the physical things they can't do for themselves ... other people don't need any physical help ... but you can sense that they've got emotional deficits or gaps and you might look at another patient and see that they're a part of the family and that their emotional needs are being met by the support network ...** so caring, for me, ... is like a big umbrella that you use your knowledge to plan **what kind of care each individual needs.**
> (Nurse Je, Interview No. 1)

In order to maintain and promote wellbeing, the patient needs assistance from nurses to achieve the activities of daily living in all aspects - physical, psychosocial, and psychospiritual. The following excerpts demonstrate the patient's situational need of assistance.

> I'm fairly independent. **When I'm really ill and cannot do things for myself** ... like basic bodily functions ... washing and that **I expect to be cleaned.**
> (Patient Ba, Interview No. 2)

.....

> **They gave me a bed bath ... brought my meals to me ... generally looking after me. At that time I couldn't help myself ... I rang the bell to go toilet ... shower.** One girl took time to wash my hair ... cut my toes nails. Just stopping and talking makes you feel that you are somebody here.
> (Patient A, Interview No. 1)

.....

> A nurse cares - they answer the bell ... **help you to the toilet if you need it ... a shower... and is present to you.** All the nurses here are very caring. They make your bed ... **help you to get dressed if you need it** ... help you with the things that you can't do by yourself. Last time I was here I had to have a scan done **I missed my lunch ... they kept it and put it in the microwave for me** - that is caring ... laughing with you, remembering your name. Just being there ... answering the bell ... joking with you. **One time they were having trouble finding my vein ... one nurse came up ... sat and talked to me to take my mind off** that they couldn't find my vein ... that is a caring thing.
> (Patient A, Interview No. 1)

The following excerpt demonstrates a patient's assistance needs from a nurse so as to meet her personal needs when she is too ill to do them for herself.

> **They stop and come and talk to you, they explain things to you ...** if they thought the bandage wasn't done properly they do it and they do lots of things they don't have to do ... things you don't expect them to do and that's caring ... because they care enough for you to take that extra little bit of time when they're busy to do things when they don't have to, even blow drying hair if you've got any! **Little things ... tend to be big things when you're sick.**
> (Patient H, Interview No. 1)

.....

A nurse explains in the following excerpt how she assists a patient in her first postoperative day to achieve situational needs. These are monitoring bodily functions so that the patient is in a safe condition; promoting physical comfort; and providing information.

> But this morning really it's **the physical need.** She needed to be kept hydrated ... and she had been a bit low in the night so things like **getting her I.V. fluids up and going ... measuring in and out put.** Keeping an eye on her wounds, and drips ... and all those physical things. **Giving her a sponge ... helping her turn in bed ... keeping her pain under control** by giving her medication and all through I think ... educating her about what all the bits were for.
> (Nurse Ke, Interview No. 2)

.....

When the disease has progressed into the terminal stage and the medical treatment can no longer be controlled, the patient and the family experience an awareness of dying and the patient's need for a peaceful death surfaces.

> When you're talking things through ... talking about ... the District nurse came to see me ... he's a man and then J came on Thursday ... and just talking through what I can do and D's done hospice nursing and I said if I become terminal **"I want to die at home and I want it to be pain free and have all the care I can" ...** I think I've had a lot available to me and the nurses here if they've got a chance ... they'll talk to you.
> (Patient Ba, Interview No. 3)

.....

A nurse explains in the following excerpt that when a patient enters the terminal stage he/she expresses spiritual needs.

> ...**by the time they get into the terminal stage** of illness people who have never thought of death who have never thought of religion, a god or any spiritual being, turn right round and say - **"Surely I haven't lived for twenty years for nothing ... what is it all about ... there must be something else".** Then he started questioning what else there could be.
> (Nurse K, Interview No. 1)

Each individual patient has different situational needs for assistance, and these needs are constantly changing. The following excerpt demonstrates an example of a terminally ill patient's needs for assistance from a nurse.

07.30	Assistance of positioning and monitoring epidural pain control*
07.45	Assistance with morning medication
08.15	Assistance with having breakfast
08.55	Assistance with having a shower, positioning on a sofa, prepare magazine, turn on T.V.
09.50	Assistance with positioning into bed
12.36	Assistance with positioning with his wife helping to place sheep skin on his bed
12.55	Assistance with having lunch

The following example demonstrates the moment to moment assistance needs of a patient having chemotherapy with the problem of vomiting.

Assistance with positioning
Giving a bowl
Explanation and supporting
Cleaning mouth and face
Checking intravenous drip
Checking anti-emetic
Giving intravenous anti-emetic drug and explanation
Giving explanation to relative who has just arrived to see the patient
Continuing to check the patient's feelings

SUMMARY

The category of The nurse: personally and professionally prepared to care, developed from the study data demonstrates that the nurse must have capacities or qualities of caring. These are benevolence, commitment, and clinical competency. These qualities are developed from her personal and professional values and professional experience, and in providing nursing care The nurse must have these qualities for the caring process to occur.

The patient: person with compromised health and wellbeing, has been described with dimensions of uniqueness, vulnerability, and needing assistance. The data revealed that the patients are individual persons with life situations that are threatening and they experience constant change in dis-ease/distress situations. The patients, therefore, require assistance from a professional nurse to alleviate discomfort, meet personal needs in daily living and promote potential wellbeing or peaceful death.

In chapter 5 and chapter 6 the discussion moves to the category of Ongoing Interaction, which occurs when a nurse and a patient make contact.

CHAPTER 5

THE ONGOING INTERACTION

The third main category to be developed from the data was labelled - The Ongoing Interaction. The related concepts are Being there; A trusting relationship; Participation in meeting needs; Empathetic communication; Being mindfully present; Balancing knowledge-energy-time; and Actualized caring moment. In this chapter the presentation commences with the meaning of the category and follows with a discussion of the first five concepts with supporting data. The latter two concepts will be discussed in Chapter 6.

ONGOING INTERACTION

The term "Ongoing Interaction" was determined after the researcher reflected on the data provided by the nurse and the patient participants. It is used to explain the continual movement forward of a mutual or reciprocal action between the nurse and the patient in their helping relationship.

In any health care setting where a nurse provides nursing service, the nurse brings qualities of caring to meet patients who are unique vulnerable persons needing assistance to improve their wellbeing. To achieve this purpose requires the caring process which occurs within the continuity of the interaction between the nurse and the patient.

In the process of caring the nurse translates her caring values and knowledge into the action of helping the patient to achieve situational health needs. The nurse is always aware of having a moral commitment to help the patient and she respects the patient as a valued person with dignity. The nurse conveys caring through certain behaviours and activities. Within the continuity of interactive processes the nurse and the patient reach the stage of mutual engagement. The nurse recognises the feeling of caring that she transmits to the patient and receives a response from the patient, and the patient can feel the caring from the nurse and he/she responds to that caring. It is the two way response of giving and receiving which brings positive outcomes to both the nurse and the patient. As both the nurse and the patient are human beings, feelings are involved

in the process of caring. However, the nurse learns to balance her energy level not to be over emotionally involved with the patient.

The ongoing process indicates the actual process of caring explained by its six concepts as mentioned earlier. The detail of each concept as a caring element is further explained with supporting data.

Being there

The term "Being there" arose from the data. It was used by nurses and patients when referring to one person needing another person to be with him/her. It occurred frequently in the data.

For caring to occur, a nurse must be present with a patient and be ready to respond to the patient's needs. She can either be physically present or make herself available to the patient. From the interviews, nurses expressed their meaning of caring which demonstrated **being there** as an element of caring in the following excerpts:

> It is not an easy word to define ... but you know **caring is to be there** when a person needs another person. If I care for that person I would be there.
> (Nurse S, Interview No. 1)

.....

> **Make yourself available** for them ... always put the bell near them when I do something with another person.
> (Nurse P, Interview No. 1)

.....

> **I am there for them** ... giving them my time.
> (Nurse K, Interview No. 1)

.....

> **Being with them** ... touching care ... mobilising them ... actually getting them up and walking with them and also being with them emotionally if they're having bad news and a bad time. A lot of the caring here is actually **being with people and being for** people.
> (Nurse L, Interview No. 1)

.....

From the patient interviews, the experience of being cared for by nurses was of the nurse **being there** for them.

> **They're usually there** when I need them.
> (Patient W, Interview No. 1)
>
> .....
>
> **They're always around you** ... spending time explaining things to you, talking with you. They're not just doing a job and then going away.
> (Patient A, Interview No. 1)
>
> .....
>
> **They are there for a purpose** and they do it very well. They are nurses and also friends.
> (Patient J, Interview No. 1)

A relationship of trust

The term "Trusting relationship" arose from the data itself. It was used by nurses and patients to refer to the belief in each other; of their relationship of giving and receiving help.

When a nurse and a patient first make contact, they are strangers. In order to provide care, a nurse needs to establish a relationship with the patient. Although the patient is ready to trust the nurse as a professional person, developing a further trust interpersonally is required as an element of the caring process. The nurse opens herself and allows herself to come close to the patient, respecting the patient as a unique valued person with dignity.

The nurse shows her genuine willingness, attention, empathetic understanding, and her competence in knowledge and technical skill to help the patient. The following excerpts demonstrate that when nurses care for patients, they need to develop a relationship with the patients.

> When I care for the person I need to **establish a trust relationship**. I allow myself to be friends with them, close to them.
> (Nurse P, Interview No. 1)
>
> .....

> **I had to set up a relationship with these people, so the first thing that has to be the foundation of that relationship is trust.** They trust me and know that I will do what I say, that I am there when they need me, that I'll respond to their calls.
> (Nurse J, Interview No. 1)

.....

The patients expect help from the nurses as professional people and they are ready to trust the nurses.

> **You can't help yourself, you've got to trust them first to help you.** They know your needs, they know your problems.
> (Patient W, Interview No. 1)

.....

> Even after an operation and you're unconscious ... they're doing things, giving you drugs, giving injections and everything - **your life is in their hands, so you've got to trust them. They're thinking of you all the time and you trust them.**
> (Patient Be, Interview No.2)

.....

The nurse establishes a trust relationship by opening herself to become friends with the patient. She tries to reduce the distance between herself and the patient by downplaying the respective roles of nurse and patient.

> They are very friendly. **The first day I came they called me by my Christian name, I feel close to them, I feel warm.** They respected me, they asked me first was it alright to call me like that.
> (Patient S, Interview No. 1)

.....

> Introducing yourself at the beginning of the duty and letting them know you're their nurse for the next eight hours and reassuring them that if they want something they can call you. Just good communication and **making them feel they're really special to you.**
> (Nurse Sh, Interview No. 2)

.....

> If the nurse has time to spend and talk to you, not just about your health but you get another person and they talk about their home lives and **you learn to trust them more. I think trust is the basis of caring.**
> (Patient Ba, Interview No. 2)

.....

The following excerpts show that the patients trust the nurses when the nurses convey their willingness to help the patient with their competence in clinical knowledge.

> The patient can actually trust that you are a reliable person and that you are genuinely concerned for them.
> (Nurse L, Interview No. 2)

.....

> You need to be confident in your knowledge and show that you are there for them, willing to help them, so that they can be confident in you and trust you.
> (Nurse Ke, Interview No. 1)

.....

> **I feel if you know that they've got your best interest at heart, you're going to be quite confident to swallow that pill or put up with that thing in your arm or whatever.** But if you feel that they've not really got your best interest at heart, then it's difficult.
> (Patient D, Interview No. 1)

.....

> **She gave me a good bath. I trust her.**
> (Patient P, Interview No. 1)

.....

Participation in meeting needs

The term "Participation in meeting needs" was developed from the data to describe the nurse actively involved with the patients in meeting their situational health needs.

The patient has the direct experience of the illness and has self knowledge to help herself/himself to live with the illness. However this knowledge and physical ability is too limited to fully achieve their personal needs. Therefore the patients need the professional nurse's assistance to help them live through the illness. Both the patient

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and the nurse work together finding out the patient's needs and setting goals to achieve them by sharing their knowledge and experience. In any nurse-patient situation the nurse uses her specialised knowledge to identify all kinds of patient needs - physical, psychosocial or psychospiritual, and tries to meet those needs at that time with the patient's participation. The nurse gives the patient the control and choice and endeavours, with the patient's participation, to meet those needs. The participation also includes the patient's family and friends involved in the patient's care.

Five subconcepts were identified to explain the concept of participation: sharing information, helping, being an advocate, negotiating, and teaching and learning.

When the patient is in the hospital, his/her autonomy tends to be reduced. The following excerpt demonstrates one nurse's perception of a caring nurse; one who gives control back to the patient.

> **The caring one is the one who leaves the patient feeling strengthened, or leaving a patient in control,** some of it comes down to knowing that sometimes people need to be nurtured and to have things done for them, because it's dreadful and other times it's actually giving the person back the authority or permission to look after themselves, because institutions and illness and doctors and other things take away people's autonomy. **A big part of caring for me, is giving back autonomy.**
> (Nurse Je, Interview No. 1)

A staff nurse related her experience of caring for her patient while performing a nursing procedure.

> I talk to them, try to make them feel comfortable, try to give them privacy and **give them the element of control,** so they feel as though they've got a bit of control in the situation too, that they're not just in hospital and these things are happening and they can't do anything about it. That's important to let people have a say in what's happening. Like the lady having the stitches out, like **it was up to her to tell me to stop when she needed me to stop.**
> (Nurse Ka, Interview No. 1)

The excerpt below demonstrates a nurse allowing the family to be involved in the patient's care, thus giving them autonomy.

> Her husband responds to what is going on and wanted to be in there today while she was washing, and helped so that's good, things like that, so that's all part of the caring. Just sort of letting it go along

> and **just letting them voice what they want and trying to sort of work in with what you can do and they want** and sometimes just to cut out a bit of the rigidity that's around the place, and it was the husband or family were not to be in the room, that used to be how it was. And encourage the family to look after the people.
> (Nurse K, Interview No.2)

.....

In the following excerpt a female patient described her experience of being cared for by a nurse. She felt that the nurse respected her dignity as a human being.

> I had to have my bottom painted purple. I said to the nurse "Well I'm a sook, is it going to sting?" "Well, it could do a little bit," she said ... "I'm not sure" ... but I said " Well just put a little bit on first" and she did as I asked. She handled me gently and was very understanding.
> (Patient G, Interview No. 1)

Sharing information

The term "Sharing information" is used to describe the nurse and the patient exchanging with one another their knowledge acquired through their experiences. The use of the term 'sharing' by Leininger (1981) sensitised the researcher in developing the term.

In working together to find out problems, needs, and to solve the patients' problems, both nurse and patient share their knowledge and experience. Information sharing frequently appeared in the data as shown in the following examples:

> **They always explain things to you ... they ask you and they tell you** ... which is different from a long time ago ... I was in the hospital and they didn't tell you ... they just did what they wanted.
> (Patient R, Interview No. 1)

.....

> The district nurse comes out once a week and talks to me to make sure that I am eating properly, answering questions if I have any and talk, have a laugh, make sure that I am not on my own, not lonely. When I had to have my dressing done they came out and did the dressing and they showed me what to do and explained. **They**

> **answered questions explaining things as much as they can.** If they can't they get someone to answer.
> (Patient A, Interview No. 1)

.....

> **They explain side effects of the medications, what is going to happen, how long my treatment could take.** If they can't answer they just say they don't know, it depends on x-ray and things like that.
> (Patient H, Interview No.2)

.....

The following description demonstrates a nurse's perception of a patient sharing information.

> I believe what people tell me ... **now I know that some people might want to tell you their story ... but if they know that I believe them they will tell me the whole story ... so they tell me everything because they see that I'm ready to believe what they say** instead of me telling them what's wrong ... If they tell me they've got pain or that they have problems ... I listen to everything they say and put it all together because it's all part of that person.
> (Nurse J, Interview No. 3)

The following excerpts show that patients perceive themselves as sharing information.

> I told them ... I used to have a problem with my vein ... I need to have bandaging.
> (Patient A, Interview No. 1)

.....

> **I tell them about myself ... like I'm a small eater and I prefer to have vegies.**
> (Patient Ru, Interview No. 1)

.....

Helping

The term "helping" arose from the data itself. It occurs frequently in the data from both nurses and patients. It is used to explain participatory actions of the nurse in assisting the patient to meet needs or to alleviate discomfort. The use of this term by Leininger (1981) is acknowledged.

The nurse responds to the patients' needs by assisting or doing for them when they are unable to help themselves, and this must be on the basis of agreement between the nurse and the patient.

> It's definitely helping them. **Being able to help people with problems that they have lost the power to control and being able to help them get some control in their lives back again. Helping in a physical way, making someone more comfortable.** We deal with a lot of dying patients so that's the satisfaction really in caring for those people and helping them and also helping the family as well.
> (Nurse L, Interview No. 1)

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> Mr A needs a bit of push today ... he was not confident to get out of bed and walk by himself. **I reassured him ... I said ... "You can do it" ... and I stood by him. Finally he did ...** and he's pleased about it.
> (Nurse R, Interview No. 1)

.....

> A few years ago, **I came in and I had a backache.** It just wouldn't go away and one of the nurses came, it was at night. **She came in and she rubbed my back for ages and gave me a hot water bottle.**
> (Patient H, Interview No.1)

.....

> My aspect of patient caring was that **when I went into a hospital ... I was hurt ... I was sick ... I needed help. Now to me ... caring was giving me that help ... removing that pain where they could and if they could.**
> (Patient R, Interview No. 1)

.....

> **They gave me a bed bath ... brought my meals to me ... generally looking after me. At that time I couldn't help myself** ... I rang the bell to go toilet ... shower. One girl took time to wash my hair ... cut my toenails. Just stopping and talking makes you feel that you are somebody here.@
> (Patient A, Interview No. 1)

.....

> I felt I could take a shower by myself, they were very supportive and encouraged me, they never tried to push me into doing something I wasn't ready for. **I had noticed too that they listen to what**

you're saying instead of trying to tell you to do things you don't feel you're ready for.
(Patient S, Interview No. 1)

.....

Being an advocate

The term "Being an advocate" arose from the data itself. It was used by nurses as a part of their caring practice. It is used to explain the nurse acting to intercede on behalf of the patient.

In some situations the patient is unable to communicate to other health professionals or his/her family or friends to ask for his/her needs. The nurse takes action to support or speak for the patient to achieve something which is needed for his/her welfare.

A huge part of nursing caring is being an advocate, because an astonishing amount of people simply never ask what they want to ask or say what they want to do, they're very intimidated, enormously intimidated by hospitals and doctors and I think that nurses often care a lot more about what their patients think and want because they're around them frequently and because they're not seen as quite so threatening and I think they have a huge responsibility for passing information, not only nurse to doctor but nurse to nurse and nurse to department and in between the family as well. Because you can think of couples who, married couples who, you know the situation where you see couples who are protecting each other from the information and I think nurses can act as an advocate in that situation as well. That's probably for me working in that situation as an advocate but I think for any nurse the advocate role is a huge part of caring.
(Nurse Je, Interview No. 1)

.....

I think when the nurses don't stand up and say to the doctors that's not fair for the patient. **Really the nurse is the patient's advocate because the nurse is always in on the doctor's discussion.** And they should be standing up to the doctors for the patient's own care. Just so that there's another mind and it's not all just going down one street, other avenues are looked at.
(Nurse Sh, Interview No. 1)

.....

The following excerpts demonstrate the nurse acting as an intermediary between the patient and the doctor.

> Nurses are more morally and human based. Doctors ... they care, but they don't have the time to be involved with what is happening to this person. He was very tired ... he didn't want to go on the file (Appointment schedule). Half way through his treatment, his feeling was very lousy and he wanted to die. **I actually pushed that the patient's treatment be discontinued and I acted as his advocate.** The doctor said ... "Yes, o.k, clinically he is doing well but if he wants to discontinue, tell us." So I said to the patient "How about one more go, one more treatment and then we look at it". I got contact with him over the period of being at home every second day, I rang him about how he is coping. He actually got through the next treatment and he carried on and had another three treatments. Today he is living quite normally and he appreciates what is going on now. (Nurse K, Interview No. 1)

.....

The following excerpts demonstrate the nurse acting as an intermediary between the patient and his/her family.

> We talked to the doctor this morning ... my husband and I understood and interpreted in different ways. **My nurse came and talked to us clearly after she talked to the doctor.** (Patient Do, Interview No. 1)

.....

> I think sometimes you've got to include your husband ... things like that. Not keep things away from them. Tell them exactly how you are feeling. If your husband walks in the door to visit you one day ... if you are a nurse ... stop him and say, " She's off colour... she's a bit depressed today ... she needs a bit of a cuddle". (Patient D, Interview No. 1)

Negotiating

In some nursing situations when the patient and the nurse do not agree, the nurse sets up a discussion to achieve a settlement. The term "Negotiating" is developed from the data to describe the nurse actively participating to meet the patient's needs by discussing to reach an agreement with the patient. The use of this term by Christensen (1988) is acknowledged. The following excerpt is an example.

> We had one lady last night that I was looking after. She's my primary patient now and I met her yesterday. She's had a mastectomy and she's got a fungated* wound, so it's quite a deep hole and fungated. But she needs to have it dressed twice a day and we wanted to bandage it and we wanted to put a breast binder on because we thought that would be better, so we put one on and then in the afternoon she was quite upset she doesn't like the breast binder, but she didn't want it at all and so we ended up bandaging her but her wound was very smelly and that was upsetting her so we got some powder which is very good at taking the odour away and put that on. Put extra pads on and then bandaged it which is what she wanted us to do, she didn't want the breast binder on, so that was a more caring situation because we were respecting her wishes and we were caring about how she felt as a person. It would have been easier for us to keep using the breast binder but she didn't want it so I think we've made her happier in that way and it's been a two way thing. We've changed our minds and she's told us what she wants, so I think we came to a good solution in the end.
> (Nurse B, Interview No. 1)

.....

Teaching and learning

The term "Teaching and learning" is used to explain the mode in which nurses convey to patients specialised knowledge which they are lacking in order to help them to learn to meet special needs. Examples of technical knowledge that patients needed to learn in order to help them to maintain bodily function and prevent complications are dressing the wound; colostomy* care; and care of Hickman*.

> I'm teaching him, I'm teaching him about his medication, I'm teaching him how to cope, I'm teaching him why these things are happening to him, I'm also showing him that as a person who has knowledge about his disease and his problems that I can help him and that I'm there to help.
> (Nurse J, Interview No. 1)

.....

> When I had to have my dressing done they came out and did the dressing and they showed me what to do and explained. They answered questions explaining things as much as they can. If they can't they get someone to answer.
> (Patient A, Interview No. 1)

.....

In the following excerpt a female patient reflects on her experience of the nurse teaching her the procedure of how to care for the Hickman.

> I had a good teacher, the nurse that taught me and she was very good. She'd say "When you get the saline and put that on, and put that on the left, and I still do it, and put your Hep saline* on the right and you'll know which is which. Well put the bottles next to them". And she was very simple, well she was having me on a bit too but I remember, you know, it was silly little things. Now I always know, even if the bottles fall off the table, have an accident or you forget, I always know that the one on the left is the saline and the one on the right is the hep saline. She was good, she was one of these teachers that made you feel you had the ability to do it. Some people have that, they teach you, they don't make you feel that you're stupid and can't do it, they make you feel that you can do it. I think self-sufficiency with the patients is important.
> (Patient Ba, Interview No. 3)

Empathetic communication

The term "Empathetic communication" is used to describe the nurse imparting her thoughts, feelings, and understanding of the patient's feelings through congruency of verbal and nonverbal contact. Nurses transmit caring through the congruency of verbal and nonverbal behaviours when communicating with patients. It is human to human contact between the nurse and the patient via touching: physical touch through body contact; emotional touch through eye contact and facial expression; verbal touch; and other body language. Of particular relevance are facing, listening and engaging in dialogue. In facing the nurse comes close to the patient or physically touches the patient, or both, and maintains eye contact, and expresses understanding and feelings through facial expression congruent with the patient's emotional state. It is through listening to what the patient is saying that the nurse picks up cues. Listening is congruent with other body language, such as tilts of the head, asking with the eyes, and agreeing by nodding her head. Through engaging in dialogue the nurse conveys understanding and picks up cues through conversation with the patient. The nurse uses a moderate volume when speaking, and uses language conveying a clear meaning and warm regard. The interview excerpts which follow illustrate these processes:

> I had one lady who was very very deaf and of course that makes it very hard to show that you care. **But then just by putting your arm around her she really sensed that and she hugged me back. They really wanted that contact.**
> (Nurse Sh, Interview No. 1)

.....

> **I think that touch is one of the biggest things that we use.** If you look around, you can say in words, well you don't say "I care" but when you talk to them you've got that there, but I think probably body language, touch, we use touch a lot. I know that I've noticed that I use it a lot more than I used to because it's more accepted now as part of the sort of caring thing. You'll go in and say "Hi, how are you?" And you'll touch their hand or you'll, you know if they are upset, I mean last week we had this woman, one of our primary ladies which was last Friday, why I was upset because she actually died but she had a tracheotomy* and she was literally choking to death and that's the way she was going to die and she just needed, she didn't need words, just needed your hand, she just needed your presence there, and that was sort of a caring thing, and touch. Somebody was feeling really lousy you'll go up and you'll stroke their brow or you'll, you know, things like that, so your body language thing is a real big thing.
> (Nurse Ke, Interview No. 2)

.....

> I sat close to her, **I looked at her eyes to show that I understood how she felt.** In caring you need to be genuine.
> (Nurse A, Interview No.1)

.....

A female patient with breast cancer expresses her feeling of being cared for by a nurse when a nurse conveys her understanding through touch.

> What I wanted to do was cry. Well it was very lucky being in a small hospital, a lot of them were very caring. They would sit on the bed and give you a cuddle. It might sound stupid but it made you feel better and you felt that another woman knew how you felt.
> (Patient J, Interview No. 1)

.....

Another woman reflected on her experience of being cared for by a nurse when she was told of her cancer. The nurse expressed caring for her through touch.

> One nurse she was lovely, she just took me under her wing, so to speak, like a mother hen and she guided me round. Because the doctor spoke to me and told me about everything, but it just went in

one ear and out the other, I never heard a word he said, but she took my hand and said to me "Now, you don't worry about a thing, you just go home now and you come back and see me at half past seven tomorrow morning, and we'll take it from there." **And I was that confused, I didn't know what I was doing because it was a shock to my whole body, to my brain and I just couldn't comprehend it really and I came back in the next day and she just guided me round everywhere. And she put her arms round me and made me feel like I was her little chicken. She did! And sometimes all you need is a touch.** If you're feeling sad or upset all you need is someone to put their hand on your shoulder or just to put their hand on your hand and show that they care. And straight away you feel that the person is caring for you and you feel a little bit better towards the situation. When I arrived that morning she told me about someone she knew that had had a breast operation and she said "Try not to worry about anything, it's easy for me to say but try not to worry about anything, it's too early to tell yet, you must wait until the specialist has done what he has to do and looked into it and they can get back to you on that. The best thing you can do instead of trying to think of everything and getting yourself upset, just think of one thing at the moment." And I think that helped me too, by thinking about one thing at each time I had to have something done instead of getting all stewed up worrying about what was going to be done, I just blocked it out. She was like a mother hen. She saw my daughter and she said to my daughter, "Your mummy needs lots of love and care at this moment." And she said to me, "When all my patients come in, especially when they get bad news", even though she was a nurse she said "I always give them a cuddle" and I think that was nice that she really did care.
(Patient M, Interview No. 1)

.....

Nearly all of the nurse participants perceive that in the process of caring nurses must be able to get into the patient's feelings.

A lot of times when I look after patients ... **I put myself in their shoes ... in their place.**
(Nurse L, Interview No. 1)

.....

Being sensitive to their needs you need to be able to recognise them ... you have to be in charge of ... **you need to have empathy ... you have to be able to, put yourself in their shoes.**
(Nurse P, Interview No. 1)

The following excerpt shows nurses conveying their empathetic understanding in helping a postoperative female patient getting out of bed.

> Both of them helped me very very slowly down on to the stool just as if they could feel what I was feeling even though that's impossible and they just gently let me down.
> (Patient A, Interview No. 1)

Being mindfully present

The term "Being mindfully present" is used to describe the nurse's condition of being constantly present in the awareness of herself and while being involved in patient situations, and responding to them appropriately. The term "mindful" arose from the data itself. In developing the term "Being mindfully present" the researcher has been sensitised by the concept of "Right mindfullness" (Sammasati)[1] from her Buddhist background.

> Sati[2] (Mindfullness) means to bear in the mind or bring to mind. Sati is the state of recollecting, the state of remembering, the state of non-fading, the state of nonforgetting.... (Phra Thepvatee,1988, p. 2)

The nurse reflects on her qualities of caring embedded in herself, and then translates these qualities into action by being physically present and fully aware of herself being involved with the patient she is dealing with at that present time. Three subconcepts were generated from the data to explain the concept of being mindfully present: concern, awareness, and attentiveness.

The stage of being mindfully present is an activator for the nurse's readiness to act in her caring practice on a moment to moment basis of her lived experience. That is to say, the nurse is fully awake in every moment in which she is dealing with the patient as indicated by the statement below.

> **You have to be mindful every second, every minute,** dealing with the person, the drugs, and other things.
> (Nurse P, Informal interview)

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[1] & [2] Thai words derived from Pali language

In the process of caring a nurse is always conscious of herself helping the patients while she is with them.

> **I'm always thinking I'm helping the person.** I'm really alert to the things they tell me, just observing and carefully listening. (Nurse Sh , Interview No.1)

The following excerpts demonstrate that the nurse is fully present with her patient. She gives her total attention and reaches out to what the patient is feeling, and she feels and knows what is happening to herself and the patient.

> **What I'm indicating to them is, I want to know from them where they're at and how they feel about things and that I'm there to listen to them and while I'm talking to them I try not to be distracted by any other thing.** I have to put all my other jobs out of my mind so I don't imply to them that I'm in a hurry. You know, they've got to feel that I'm there totally for them and that I'm not just rushing in and going on to something else, and so that they've only got half my attention and so they have to have my total attention. I'll sit fairly close to them. I may also put my hand on theirs and I might make contact with them. That depends on, you know sometimes some people might resent that so I have to, you know, whether they would feel comfortable by touch or not, otherwise I'd sit reasonably close to them and imply a closeness. **In other words I'd get right in, into there in a circle sort of thing. And, but I don't push myself in, I have to feel, you know, I have to get the right aspect from them as to know how they feel and I don't want people to feel unsettled. What I really do is let them know that I'm here, who I am, what I do and that I want to know about them and how can I help them.**
> (Nurse J, Interview No. 2)

.....

> **You start off with what your intention is to achieve or to reassure or to overcome a problem or to listen to what's wrong and I think you set out with certain ideas of what you're going to, how you're going to behave, what you're going to exhibit as a caring manner.** But I think that what you are really conscious of is the feedback that you're getting from that person as to what interaction is taking place. That you're trying to, you're listening to them or whether they're talking back to you. Whether you feel that they're opening out to you or whether they're responding to what you're trying to inform them on. And perhaps if you seem to be lacking in understanding of something you

might be trying to explain and you can see by their expression that they're getting it and they're feeling the relief coming over and they are responding to that.
(Nurse J, Interview No. 3)

.....

Concern

The term "concern" arose from the data. It is used to describe the nurse's affect towards the patient. 'Concern' means 'to relate to'; 'be of importance to or interest to'; 'affect' (Collins, 1989). The use of the term "concern" as a care construct by Leininger (1981) is acknowledged.

By being able to respond to human suffering, a nurse puts herself in the patient's situation. She feels for the patient or is anxious about the patient's problems and welfare. All of the nurse and patient participants in this study used the word "concern" to describe how nurses demonstrate caring. Some examples in the following excerpts illustrate this:

I think it is the concern they show for my well-being, that's what comes through to me. As far as they are concerned, nothing else exists but me and D (Patient J's wife) in our particular situation and when they come here and they deal with us they exclude everything else other than us and they deal with us.
(Patient J, Interview No. 1)

.....

You're concerned about someone and see that they're in pain or that they're upset and you're caring about them and trying to change things, trying to help them. I suppose that's caring. It's looking at people and seeing they've got problems and not just ignoring it and wanting to do something about it, just being aware and wanting to help them with their problems.
(Nurse Bb, Interview No. 1)

Awareness

The term "awareness" arose from the data itself. It is used to describe the nurse's sensitiveness, alertness, perceptiveness of herself and the patient. At the time a nurse is in the patient's situation, she is conscious of her own feelings, thoughts, and actions in

helping the patient, as well as the patient's feelings, thoughts, and actions. She reflects on her knowledge and moral commitment towards the patient's welfare.

The three following statements are descriptions by nurses about their awareness of themselves in using knowledge to assist the patients in every moment that they are with them.

> **I go into the room and ask myself "what is happening now? and how can I help her? what she needs from me now is this, not that".** You draw your knowledge and experience into the situation at that time.
> (Nurse Ke, Interview No. 1)

.....

> ... **just being aware and wanting to help them** with their problems.
> (Nurse M, Informal interview)

.....

> **You have to be aware of that moment being with them.**
> You have to know yourself, what you are doing.
> (Nurse K, Interview No. 1)

.....

In every moment of lived experience with the patients, nurses are fully aware of integration of all kinds of knowledge: self knowledge, ethical knowledge, esthetic knowledge and empirical knowledge in assisting the patients. A nurse explains her experience in the following excerpt:

> **Knowledge of experience, knowledge of whether you've had the same experience yourself or whether you're experienced in doing it for other people before. Your experience of the way that person reacts.** You might have knowledge of their past history, they might have never had a catherisation but they might have had a lot of other horrible procedures and you could be aware of social problems that they have. **All sort of effects might not be directly related but it affects the way you think about things at the time.**
> (Nurse Ka, Interview No. 1)

.....

The following two excerpts demonstrate the nurses' empathetic awareness. The nurses are sensitive to their own self and the patient self.

> **My main thought is I like to treat them like I'd treat my family if they were sick, and how I would like to be treated.** There's a lot of people around who don't have the family background that I've had and so I want to give something to them. **I think that my main thing is I want to make sure that they're comfortable.**
> (Nurse Lu, Interview No. 1)

.....

> A lot of them feel anxiety to the chemotherapy. I can understand that ... I 'd be the same. I think that's a lot of it too. **You have got to think about the patient - how would I feel sitting there. I always put myself in their situation. If I was lying there having that I'd be just as scared. That's how I deal with a lot of my caring. Sometimes if I think of a situation and put myself in there, well, if that was me in that bed.**
> (Nurse T, Interview No. 1)

.....

The patients also perceive that the nurses are aware of their feelings. A patient describes his experience of receiving chemotherapy from a nurse in the following excerpt:

> **... they ask you "Is it hurting, is it alright?" and keep checking that the vein is alright and you have confidence when you know the nurse knows what she is doing** but all the girls that give chemo do know what they're doing because they have the special training. And you know that you're in good hands.
> (Patient W, Interview No.1)

.....

Attentiveness

The term "Attentiveness" is used to describe the nurse focussing her attention on the patient and the patient's surroundings in the situation, in order to gain knowledge about, and of the patient, and convey her understanding.

All of the nurse and patient participants in this study perceive "patient centered interest" as the form to convey caring. The nurses give their total attention to the whole being of the patients when they are with them.

A nurse working in an oncology ward describes how she creates privacy and prevents interruption when she is present with the patient, in order to focus her attention on the patient.

> I hand over any care and say to my nursing colleagues "I will be in Room such and such, do not disturb me....take a message if the phone rings. I will be five minutes, a quarter of an hour or whatever." I go in and tell my patient I've got time for you." **I switch everything off in the hospital or in my life and switch on totally to what the patient is saying.**
> (Nurse K, Interview No. 1)

A staff nurse working in a gynaecological ward describes her experience in doing nursing procedures by concentrating on the patient and not hurrying to do a job.

> **I try to concentrate all my attention to them when I'm talking to them. They know that I'm concentrating on them and that I'm not thinking of a hundred other things at the same time.** If I relax more they think that you're competent and you are there to help them instead of quickly doing what you're doing and whizz away.
> (Nurse Lu, Interview No. 2)

.....

In the following excerpt a nurse explains about giving her total attention to the patient, in order to gather information about the person:

> **At the time you just go into a room and you have these sort of antennae, like an insect, that are picking up signals all the time about people.** You might notice that their drips run through, but I also look and see how they seem to be feeling, whether they are comfortable in bed. It's just the whole thing, processing that whole myriad of information all the time.
> (Nurse Je, Interview No. 1)

The following two excerpts from patients, demonstrate the nurse focussing her attention on the patients.

> **They make you feel that you are the only person that they are dealing with at that time.**
> (Patient Bb, Interview No. 1)

.....

> **Nurses have the ability to make you feel that you are the only person in their spectrum at that time.** And that's a good feeling.
> (Patient H1, Interview No. 2)

.....

SUMMARY

The category of The Ongoing Interaction has been discussed with its concepts supported by the data. The actual caring process occurs within the continuity of nurse-patient interaction in their helping relationship. This process requires caring elements, five of which have been discussed in this chapter. These were: Being there, A relationship of trust, Participation in meeting needs, Empathetic communication, and Being mindfully present.

In Chapter 6 the discussion of this category - The Ongoing Interaction - will be continued with its last two concepts: Balancing knowledge-energy-time and Actualized caring moment.

CHAPTER 6

THE ONGOING INTERACTION (CONTINUED)

In Chapter five, five concepts which emerged from the data were discussed in order to understand how the caring process occurs. These five concepts, as the elements of the caring process are: Being there; A trusting relationship; Participation in meeting needs; Empathetic communication; Being mindfully present. In this chapter the last two concepts - Balancing knowledge-energy-time and The Actualized caring moment - will be discussed with their subconcepts indicated by the data.

Balancing knowledge-energy-time

The term "Balancing knowledge-energy-time" was developed from the data to describe the nurse integrating all patterns of knowing - ethical, empirical, personal and esthetic - in order to impart her energy and spending time to create a state of harmony for the patient and herself.

In the process of caring the nurse translates her knowledge which she gains from education, training and experience into practice to help patients. The main knowledge used in nursing practice is humanistically and scientifically supported knowledge. As the nurse cares for the individual person/family, she needs to know about every unique aspect of that whole person. In any situation of nurse-patient contact the nurse balances the knowledge she has gained from her training and experience together with the knowledge about, and knowledge of the person she is dealing with in that situation. She uses a problem solving method for her judgments and decision making. She therefore displays the appropriate knowledge with confidence in her technical competency to help the patients meet their needs at that moment of time.

In the following four excerpts, nurses reflect on their experience when they performed nursing procedures.

> I think about the actual technique, sterile field and things ... **I knew she was an anxious person, but I didn't know until I actually started doing it that she would be that anxious ... so even though the knowledge I had had beforehand**

... you are still renewing it at the time you're doing something ... It can change in those few minutes.
(Nurse Ke, Interview No. 2)

.....

Technical knowledge, certainly to begin with. You're doing it competently and in the way most comfortable for the patient ... And then knowledge of trying to relax and make it as less uncomfortable as possible, in their mind as well as in their body. They're very tense and anxious often when they feel something painful is going to happen. By that stage, normally, **you've nursed the patient for a few days and you'll know an awful lot about their personality so that you know any conversation that's appropriate and like I talk to people differently. I don't talk to people in the same manner because what's appropriate for one person, often another person might be a bit offended** if I joked about some things, which other people might happily joke with. Normally I know after a few days before I do major procedures and try and be appropriate for them.
(Nurse Lu, Interview No. 2)

.....

What you already know about them and how they've reacted before and how they've responded to previous care and that. I think you always assess people again and again to see how they are coping and how they are improving and recovering. **It's always ongoing. You're never doing the same thing for them. Not always in the same situation every day.**
(Nurse Lu, Interview No. 1)

.....

You have to really be alert to the things they tell you. You can be talking to a patient and you can assess that underneath they're a bit nervous. You can assess the things that they don't talk about and they may be extra shy. There's a lot of things they don't talk about and if you are a good nurse you can pick up these things during the eight hour shift when you are on. **So if you are going to do the procedure you can adjust it to suit the patient, the patient's needs come first and you fit in with all those needs. But everyone is different, the procedure is the same, but you just alter it slightly, so the patient is as comfortable as they can be.**
(Nurse Ly, Interview No. 1)

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A young staff nurse explained how she cares for each individual person.

> **It depends from one individual to another, one person needs or requires a different type of care than another.** One type of person who comes in here can be very scared about the word cancer, so for me then, the initial stage of care is to talk about cancer; what it is in their own words. A 60 year old woman I'm going to talk to differently from a 28 year old male. For instance, my language and body language will be different, but the message will be the same. **So, first I can see "who the person is", "what do they know about their illness", "where are they coming from" and from there I make my own judgment, and if I make mistakes in those judgments, I'll try a different approach.**
> (Nurse M, Interview No. 1)

One female patient explained that nurses care for each individual patient, knowing about each individual person's needs.

> **They look at all their patients, just seeing that individual patient,** like an elderly confined to bed, making sure that everything is within reach, because a lot of them can only reach to the side. They are pretty good at things like that. They move things forward. It's only small but it's big to the person who is confined to bed because it's frustrating to feel that you have to ring to get tissues.
> (Patient H, Interview No. 2)

Effective use of knowledge guides the nurse to balance her energy spent in helping the patient. To care for the patient, the nurse uses physical and mental energy. The nurse needs to harmonise herself by preserving and gaining energy input from her own selfcare and from other sources.

Time is required in the process of caring. The nurse spends time working with the patients to fulfill situational needs. Effectiveness of knowledge used directs the nurse to spend quality time with the patient.

Nurses are always responsible in caring for more than one patient. In order to meet the needs of every patient, the nurse uses a wide range of knowledge to direct her in apportioning appropriate time and energy. In other words, the nurse balances her time and energy by sharing them equitably among all her patients and also herself and her family. The following is an example of a nurse's statement.

> When you're caring for more than one patient you have to be able to meet the needs of however many your share is. **One might really need more care than another patient, but in order to share yourself fairly, you have to be able to work your time and energy levels out. So you're not giving everything you've got to one person. I think you also need to recognise that you can't do it perfectly and that you need to balance energy time in order to give everyone a fair share including yourself** and in the case of a lot of my nurses, their families. They've got a lot of other people to think about.
> (Nurse L, Interview No.1)

The concept of balancing knowledge-energy-time is explained by seven subconcepts generated from the data. These subconcepts are illustrated in Table 8 .

Table 8

Subconcepts of Balancing Knowledge-Energy-Time

Subconcepts
Assessing-interpreting
Priority setting
Anticipating
Maintaining dynamic complementarity
Consulting
Episodic continuity of spending time
Conserving- replenishing energy

Assessing-interpreting

The term "Assessing-interpreting" is used to describe the nurse's evaluation of a unique patient in his/her situation and clarifying the meaning of this. The use of the term 'interpreting' by Christensen (1988) is acknowledged.

The nurse uses her intellectual skills to identify the patient's problems and needs by gathering information from patients' reports obtained from nurse colleagues. She assesses the patient by observing, asking and listening. She then analyses and translates all the information for decision making to guide her actions.

At the beginning of each working shift, nurses gather information about the patients' prior twenty four hours period from nurse colleagues working on the previous shift who give oral reports. The following excerpt is an example of an oral report about one patient's information .

> First one Mrs H, 66, Ca breast ... history of TB and asthma. She is much brighter today. She's had her telemetry* stopped, because her sinus rhythm* was back to normal. Her four-hourly obs (ervation) are fine ... BP about 140 and 80 mmHg, it's been 150 but its coming down. Her pulse is regular, 76-80/minute ... her temp (erature) about 36.8 celsius, so her obs are fine. She's been drinking and eating quite well, not a lot of fluid intake but adequate ... I would say. She still needs digesic four-hourly, so she's been getting that. Her obs are four-hourly. She's had her hair washed ... she's been to the bathroom.

Nurses also gather information about their patients from the patient's records: assessment form, nursing care plan, and progress report. Each ward in each setting (hospital, hospice, community health) has its own recording format. The examples in Tables 9, 10 and 11 are parts of a nurse's record in an oncology ward in the hospital setting.

Table 9

Nursing Assessment Form

(See Appendix 9 for complete form)

Patient A
Date/ Time —

Assessment Headings	Patient Comments	Nurse's Assessment
Physical Appearance Head-Foot Assessment	Considerable weight loss loss now 37 kg Looks uncomfortable.	A very frail unwell-looking lady. Feels miserable
Mobility		Feeling very weak but stands and walks assisted
Intake and Elimination	Bowels	Not eating Drinking very little
Psychological State	Says she is not anxious or worried	Feeling very tired
Spiritual Needs		Roman Catholic Priest to visit please

Table 10

Nursing Care Plan

Patient B
Date/month/year

Nursing diagnosis	Nursing intervention	Evaluation
Pain related to gross hepatomegaly*	• M.O.* as charted via epidural catheter • 4/24 oral morphine • Note effectiveness of analgesia • Comfortable positioning	
Anxiety related to dying and fear of pain	• When possible spend extra time with him and his family • Encourage verbalisation of fear • Ativan* 1-3 mg tab as charted • Take time with care and explain care	
Poor appetite	• Family bring in some of his food • Patient enjoys icecream • Diet as desires	

It was not uncommon for nurses to leave the evaluation column of the nursing care plan blank. The evaluation was noted in the daily progress report.

Table 11

Daily Progress Report

Progress report

Patient C

Date/month/year
Miserable A.M. because of vomiting. Largactil* 25 mg given 8.00 ; 08.50 still vomiting.
Ativan* 1 mg given 11.00 hrs due 19.00 hrs if needed
Cyclizine* 50mg 8/24 due 19.00 hrs. I.V.
Maxolon* 20 mg 4/24 due 16.00 hrs.
Post hydration completed. Capped off*
Hep saline* flush due 21.00 hrs
No nausea, vomiting lunch time. Small lunch
Visit by daughter.

Patient D

Full nursing care given
Ate very small tea. Difficulty swallowing
Intake 200 mls
Sleeping 90% of duty. Up in chair till tea time
M.S.T.* 30 mg given 21.30hrs
Mouth and eye care done
Wash given. Visit by parents

The information from hand over and patients' records provide baseline data for nurses to make an interpretation. However, the patients' problems and needs are always changing. Nurses, therefore, continue gathering information and make an interpretation on immediate moment-to-moment interaction with the patients. Only the significant patient information is written down, not all of it.

> **It's a very fluid thing because it changes every day and it's also giving something of yourself in doing that.** I t's using a whole variety of skills and knowledge that you have yourself, because you give to different people in different ways, and a very big part of the caring is assessment which you do. Well I think I do it intuitively, like I don't actually write down everything that I think about people. I could if you asked me to, if somebody said, "What do you know about that person and what are you doing?" I could write it down, probably, but the reality is that mostly I don't, mostly you meet people and you make an assessment and your care is based on that assessment. **Like you write a formal assessment and plan for every patient but I still maintain that there's a great deal of knowledge and response to that person that you don't actually write down that probably you should write down, but we don't.**
> (Nurse Jn, Interview No. 1)

.....

The significant interpretation of patients' problems, needs, and nursing intervention are recorded in nurses' progress reports and nursing care plans as previously shown.

Another nurse gave a statement that besides gathering information during hand over and from patients' records, she needed to assess and interpret the patients' needs and problems from face to face interaction.

> **I had a new patient ... we got in hand over but it's hard to picture a person ... so I go in and see what they're like and say hello.** We weren't busy today ... so I was able to sit down and talk for quite a while. Then when I finish talking to them and have seen what they want to do **I usually go and check the charts and see what they're going to need ... and I'll leave them for a while and come back again.**
> (Nurse R, Interview No. 2)

.....

Nurses always make an assessment and interpretation every time they interact with the patients. Therefore assessment and interpretation are an ongoing process within the nurse-patient interaction. The nurse's ability to make a correct assessment and interpretation depends on her experience, as a nurse stated in the following excerpt:

> **Every minute of the day, every second, you know, you see an admission being wheeled in on a trolley, an acute admission, let's say to the ward ... and I know that if I**

> **walk up to that person within two minutes I've collected a whole myriad of data about the person but not all of it will ever be written down.** It's a very difficult thing to teach, what that assessment is and how you make it because **a great deal of it is born of experience.**
> (Nurse Jn, Interview No. 1)

.....

A staff nurse working in a surgical ward explained her experience in assessing and interpreting patients in the statement below:

> **You can see that she's got I.V.(intravenous drip) fluids ... she needs to keep that output going to a satisfactory level when they're assessed by reading and by measuring and taking observations, the physical sort of thing.** And then often I find just by being in there and being there, pottering around doing little things that you'll assess things by looking at her. **You're looking to see if she's pain free. If she's got any expressions you might say "yes, she's got no pain", but you know that when you move her and she cringes that she has got pain, so it's a sort of sight assessment. And in listening to her, as to what she's got to say, whether your care is being effective, she says "This is no good, I'm not comfortable", or "I feel unwell, I feel nauseated", or whatever. Evaluating the whole time as to what I'm doing. Is it the best, is it proving to help or is it no good, I'll try something else.** It seems to be an ongoing thing and often it's just done without realising you're doing it and probably at the end of the day to write the report, I always find as I'm writing the report I'm going over everything, yes, that's O.K but that's not, and perhaps making suggestions to the afternoon staff to try doing that and then assessing that. Again the trial and error thing, so I think it's a continual thing, you're always deducing. I could just take the observations, measure the urine out and they're all great so we know that physically things are going as planned, as they want them but I think mentally, I think physically, emotionally. When I walk past she's asleep lying well rested, husband is O.K., he's relaxed, so I know that things are going O.K.
> (Nurse Ke, Interview No. 2)

Priority setting

The term "Priority setting" indicated by the data is used to describe how the nurse organises her work. She compares and orders the patient's problems and needs based on the criteria of survival, safety, and welfare of the patient, and then acts on the most important task first.

You've got to really decide what's the most important thing.
(Nurse Ke, Interview No. 2)

.....

In everyday practice a nurse has to provide nursing care for more than one patient, and she is responsible for doing tasks which are both direct and indirect to patient care. She, therefore, sets priorities to cover all the tasks and her patients' needs.

The following excerpts demonstrate how two nurses explain the way they allocate priorities in their work.

What I do is get the report in the morning. You write up your five patients, you have your report, you write down and then straight after the report, it's a natural thing to do now, is to say what's top priority. You know the sickest on your list is always number one so that's the person you go to first and you assess them then and you think do they need me straight away, do they need anything else or can I see the rest of my patients and then come back. As far as the physical cares go, I think Mrs B is number one, she's bedridden virtually, bedfast, so she needs me more than, say Mrs C, who has a nose bleed but she is mobile with no problems so she can see to herself, for the meantime. But I always like perhaps to go on to the second patient then trip round all the rest, say "Hello, I'm your nurse, if you need me ring", but the priority is always with the sickest down to the person that's the most independent and also who seems to be quite stable physically, emotionally, and everything. But I still like to see them all within the first hour so they know there's someone there looking after them if they need help and then go back to the sickest, do them first. Or age is the other thing probably, the eldest, to get them up, comfortable, washed, fed, dressed, whatever they want done earlier on, instead of leaving them, especially if they are incontinent or anything like that or if they're expecting anyone special. That's why I like to see everyone first to see what they all want first and then work out the priorities from there. But it's obvious the sickest comes first and then if you're going to be short of time, if you're really pushed to see which things don't really have to be done and are not going to cause life threatening problems. This person had a shave so it doesn't matter if they have a face and hands wash today, are they happy with that. Yes, it's probably more important that bla, bla has extra time with you, really putting your time to what's important as you see.
(Nurse Ke, Interview No. 2)

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I usually get my independent patients organised first. I usually go in and say to them "Right, you're O.K. you can shower by yourself" and they'll say "Yes" and I'll say "Well, I've got to do your dressing", so first thing I might do is the dressing that day on them.

> I take the dressing down, have a look at it, send them off for a shower and then I've got two or three independent patients, do that for them and then that's them all taken care of and while they're doing their thing I can work on one or two dependent patients that need sponge washes or whatever, like this is a morning duty. And then when you've finished with that, that's everybody clean and ready to go and then after that I might do an extra bit, like if there's a person for removal of sutures or any Redivac* that have to come out. If it's a post-op (post-operative) patient I usually do the Redivac before I do the wash, but then other bits and things all fit around afterwards. But I try and get them all, at least their hygiene, organised first thing in the morning and then I'll come out and do my independent patients, well, the independent ones are organised and all this takes time.
> (Nurse Cl, Interview No.2)

For each individual patient in each single episode of caring, nurses always set priorities in the moment to moment aspect of the interaction.

> I could be thinking of the technique of what I'm doing as well as how she might be feeling. **And I think too, you prioritise in your mind what is most important and you think mainly on that theme.** If someone is very relaxed then I probably might be concentrating more on what I'm doing and when one's very distressed, they might have had very bad social problems and you know that there is an added stress to them. You might be thinking more of his social problems and feelings rather than just thinking of the procedure or what you're doing. **Your mind thinks out what's more important and you think on it.**
> (Nurse Ka, Interview No. 2)

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Patients also perceive nurses setting priorities in caring for the patients as shown in the following example.

> Well my dressing needs to be changed ... and it's quite a procedure and ... then the lines (intravenous) have to be changed every day ... and that time perhaps they wouldn't have with another patient. And that takes up extra time ... so you know they're probably run off their feet doing all the things ... **So what they have to do is monitor the most important things and do them first ...** like changing the beds ... they would do that late ... when they have time to do it.
> (Patient Bb, Interview No. 3)

Anticipating

This term arose from the data itself. It is used to describe how the nurse perceives what is likely to happen to the patient and she prepares for what will probably need to be done. The use of the term "anticipating" by Christensen (1988), in explaining the work of the nurse, is acknowledged.

> When you get to know a patient - **when they need a pan or whatever and just a bit before or about the time they're thinking it's needed ...** you go in and say ... right here's one here.
> (Nurse Sh, Interview No. 1)

.....

> We understand the situation, we know what the disease progress and prognosis is, and we understand why some of these things happen so therefore, we can educate the patient as to what is happening and why he is sick or why he gets constipation, which are very simple things on a day to day thing. **But if you are on pain medication you know that because you take pain medication you're going to be constipated, therefore you take medication or a suitable diet, if possible, towards alleviating that or preventing it.**
> (Nurse J, Interview No. 3)

.....

> Well administering drugs which takes expertise ... and making sure that their patient is comfortable and seeing ... **anticipating problems ... but also being able to talk to them sometimes and find out what's upsetting the patient.**
> (Patient H, Interview No. 2)

.....

> They're trained to be efficient, and also caring and thinking, like looking at me, I'm stuck in bed, so I can't get out to pull the curtain back and things like that. I can't turn the T.V. on. **Thinking ahead, I can't get out of the room, I can't get things for myself.**
> (Patient H1, Interview No. 1)

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> They know your needs ... they know your problems. I have heaps of I.V. and I can't get out of bed because I'm in isolation. **The other night I rang for the pan ... she came to get the**

used one ... and she brought the new one from under my bed ready for me and we laughed.
(Patient W, Interview No. 1)

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Maintaining dynamic complementarity

The term "Maintaining dynamic complementarity" was developed from the data to describe the action or series of actions the nurse takes to assist the patient to gain harmony by incorporating her compassionate intentions, technical procedures, and tasks in a synchronised performance with the patient on a moment to moment basis. She also continues to assess by interpreting and evaluating the patient's response to her action of helping, and decides whether the patient's situational needs are achieved. In so doing the nurse needs to comfort herself with courage, hope, and patience.

All the data supporting this concept comes from interviews and observational notes made by the researcher. To show how "dynamic complementarity" was maintained has necessitated the use of lengthy excerpts from both sources.

In the following excerpt, a nurse's description of her experience of a caring episode, demonstrates her conscious willing and deliberate action to help the patient as a person in a situation of discomfort. She first identifies the patient's bowel problem with the patient, and she then takes action by performing the technical procedure to give an enema, and finally she evaluates her intervention. The outcome is positive for both the patient and the nurse.

Mr G, today he's quite upset today because his nurse fobbed him off this morning about his bowels. I felt my duty to take over and give more care because something was missed out today. I just do what he wants. As a nurse cares for a patient - to do everything that I can for them to make them comfortable ... help them I suppose ... try to adjust to the hospital way which is very hard. Think about people differently ... individually ... we can't do something in the same way that you do for somebody else ... you have to look at them as a person. I went to them ... (Mr G and his wife) ... They were distressed for some reason ... so I asked what sort of a day they had had and their facial expression showed not very happy. It's all about his bowels ... he could not move his bowels. He mentioned it this morning but no one took any notice. They felt nobody cared about them. So I decided that I'd better do something ... not because somebody forgot ... but obviously he was in discomfort. Then I asked about what they usually do ... I gave him

> an enema. He felt much better afterwards. It takes a few minutes. I felt very good afterwards, obviously I did help them. Now he is happy.
> (Nurse L1, Interview No. 1)

The above description is an unstructured interview with the nurse which followed the observation of the incident by the researcher. The following is an excerpt from the researcher's observational notes concerning the same episode.

> After finishing the handover from the morning nurses, N first walked into Mr G's room. `He was lying flat on his back with an uncomfortable facial expression with his wife sitting close to him. Mr G was a terminal patient with a weakness of the whole body. When N first saw them her face appeared worried. She came close to them and sat on a chair near his wife. She smiled and greeted them, and carried on a conversation. She listened and nodded her head and she asked them some questions. She spent time talking to them and kept eye contact. She did not rush her work. Mr G's problem was that he could not move his bowels. After Mr G's problem was identified, N moved herself closer to Mr G and told him she would help him after she saw her four other patients and she then left them. Mr G and his wife appeared to be relaxed. After about fifteen minutes she came back to give him an enema with his wife helping. She gently handled him and finally Mr G moved his bowel. Both he and his wife appreciated N's help and they all smiled.

The following incident was explained by a female patient's husband who perceived nurses and doctors taking a series of caring actions for his wife's welfare.

> This Saturday night my wife began to develop a haemorrhage from the back passage and **immediately the nurses recognised these signs and immediately they called in a specialist doctor for another opinion ... They were then directed to keep a 10-15 minutes watch on her progress for the next one and a half to two hours ...** and I guess it must have been consultation between the doctors on duty and the nurses that the specialist was contacted and advised ... which they did. So we had Dr M came in at 1 o'clock in the morning ... I think. I guessed he must have been woken from his home. That for me showed that there was caring ... right through the medical staff. **Immediately they then saw the need to administer a transfusion which they did ... and this happened in two and a half to three hours. Close monitoring ... close dialogue and consultation ... and then actions.** Come midday Sunday she was beginning to pick up and now you see her almost back to where she was ... All of that chain actions ... from that time until now has to be an indication in the first instance of caring of the staff right

> across the board from doctors to nurses. They kept a close vigil on her all of that time. A good feeling ! ... It's a good feeling.
> (Patient G's husband, Interview No. 1)

The following description from the researcher's observational notes demonstrates a caring episode in which a nurse and a patient are perceived as experiencing caring and being cared for. The nurse maintains harmony for the patient by conveying congruence of verbal, nonverbal and technical competency.

> A lady patient, PA1, with breast cancer was admitted to an oncology ward for her fifth chemotherapy* course. She was sitting on a comfortable sofa in a quite pleasant room used as a chemotherapy clinic. While she was being interviewed by the researcher, a registered nurse with a label showing that she is a chemotherapy nurse came to her with a smile and greeted her. The nurse asked her whether she would like to have chemotherapy in this room or back on her bed. PA1 chose not to go back. The nurse then went to get a tray with 6 syringes of the chemotherapy and associated drugs (Adriamycin*, 5FU*, CTX*, Dexamethasone*, Maxolon* and Heparin saline*). She came back to PA1 and put the tray on the table and sat on a chair close to PA1 and asked how she was at home. PA1 smiled and said she was OK at home and she said "It's good to have chemo in this room. It's quite early this time, isn't it?" NG1 replied that there were two patients having chemo that day so she could make it early this time. She had eye contact with PA1 and used her hand to touch gently at PA1's I.V. site* on her right hand, and asked how PA1 felt. PA1 said she was alright. An enrolled nurse* came into the room and helped NG1 connect the I.V.* fluid to the I.V. site with NG1 connecting it. NG1 released the clamp to let the fluid flow into PA1's vein. She checked the I.V. to make sure that the needle was in the right position by holding the I.V. bag lower than the level of the I.V. site. At the same time she looked at the needle, seeing blood was drawn out to the cannula. This meant that the needle was in the right position. PA1 also looked at what NG1was doing. NG1 said "It's excellent" and smiled, PA1 smiled. NG1 told PA1 that she was going to inject Maxolon first. PA1 said "Yes", then NG1 connected the Maxolon syringe to the cannula then withdrew the blood to test that the needle was in the right position, then she injected it slowly into PA1's vein. She was looking at what she was doing, alternately looking at PA1's face, keeping eye contact, and asked how PA1 felt. PA1 said "I am alright, I'm used to it" and smiled. NG1 then started a conversation about herself that she was just engaged and so on. She also looked at what she was doing. She changed the other syringes and always checked to test that the needle was in the right position. When she started to inject Adriamycin (red syringe), PA1 appeared a bit anxious, and was looking at the I.V. site all the time. NG1 asked how she felt and said "We have to be more careful this time, haven't we?" "Yes, yes." PA1 said. NG1 slowly injected and she looked at PA1 and said "It's good." Then NG1 started a conversation about her holiday. PA1 shared her experience on holiday too. They were

laughing at some stages. PA1 enjoyed talking. When the injections were finished, NG1 took off the I.V. fluid and flushed the I.V. site with heparin saline. She tested again to make sure that the needle was still in the right position while she did the flushing. Then PA1 said "That's all" and smiled. She asked NG1 to support her I.V. site with a bandage. NG1 said "Yes, certainly." She went to get the equipment and sat close to PA1, held PA1's arm and gently bandaged it on for her. She had eye contact and smiled with PA1 and said "That 's all, thank you" PA1 said "Thank you".

The description below demonstrates a series of two caring episodes in which a nurse and a patient experience caring and being cared for. The first episode occurs when a nurse first meets a patient in the morning to offer medication and prepare for breakfast. The later episode shows the nurse assisting the patient with body cleaning and mobilising.

7.30-7.40 A.M.
Mrs T was lying in bed on her right side. There was a nephrostomy* tube from her left kidney connected to an hourly record urine bag. She appeared weak and a little bit sad. She could not manage her activities of daily living. Nurse K went into Mrs T's room with a smile and Mrs T smiled when she first saw Nurse K walk into her room. Nurse K looked at T, had eye contact, and said, "I am glad to come back again to look after you. How are you today?" Mrs T smiled "I am not too bad" and kept smiling. At the same time Nurse K held Mrs T's hands and told Mrs T about her holiday, then she went on to tell Mrs T that she was preparing her morning medication. She checked the medication, prepared and signed the form. Nurse K checked her tube and urine bag. Nurse K: "Breakfast will be ready soon. Would you like to have your head up a little bit." T smiled, "Yes, please." Nurse K adjusted the bed and asked how she felt. T: "That's good, thank you." Before K left T she put the electric bell near T and told her she would bring her breakfast. Nurse K took all the medication boxes and put them in the cupboard.

8.30-8.55 A.M.
Nurse K went to Mrs T's room again and told T she would give her a sponge. Nurse K asked the researcher to help. She stood on T's left side and sponged T's face, neck, chest, underarms, abdomen, legs, buttocks and back. Nurse K had eye contact with T and had a conversation while she was sponging T. Then Nurse K asked T which dress she would like to wear and T chose the hospital dress. Nurse K asked T whether she would like to sit on the chair for a while. T said, "I would love to," and smiled. Nurse K asked the researcher for assistance to help T to mobilize. Nurse K held T's right side by putting her arm under T's axilla while the researcher did the same for the left side. Then we lifted T to a sitting position. Nurse K then went to T's left side and moved T's legs slowly down from the bed. Then we assisted her to stand. Nurse K said, "That's it, excellent" and had eye contact with T. T smiled happily.

> Then Nurse K asked T to slowly move around and walk to the chair. With Nurse K holding her arm T slowly walked, sat down and leaned back. Then Nurse K bent her body down to face T at the same level and put her hands on T's shoulder and looking at T's face, had eye contact with T and T had a big smile. At the same time Nurse K said,"Wonderful! Wonderful!" T smiled and sat comfortably on the chair and looked happy and relaxed. Then Nurse K made T's bed, checked T's hourly urine, TPR and recorded them.

Consulting

In some situations, the nurse acknowledges her knowledge and skill limitations in helping the patient. She therefore seeks advice from other resources, such as the Charge nurse. When the patient's need cannot be met by her expertise, the nurse either consults or refers to more experienced personnel.

A staff nurse working in a surgical ward explained her experience in caring for a patient prior to having her operation. She consulted a physiotherapist to help prepare the patient for postoperative exercise.

> The biggest thing probably only on the physical caring that we did, which didn't seem like caring, was bowel-prepping* for her, that's why she came in so early, for the complete prepping her for the operation. She didn't know what was going on and really the rest was really the emotional build up, the psychological preparation. Otherwise she did everything else herself. Things like bringing the physio in and teaching her post-op(erative) cares and that and then probably post-op, well it's post-op today.
> (Nurse Ke, Interview No. 1)

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A Charge nurse described in the following excerpt how her staff nurse needed assistance from her to solve a patient' s problem.

> My young staff came to ask me to see her patient who rang the bell calling her many times ... because her patient experienced breathlessness ... When she was with her and talked to her she was O.K ... but she still kept calling. I went to see her ... I sat close to her and talked ... and I picked up that she wanted to talk openly with her husband about her imminent death. She had tried but he didn't want to talk ... so I offered to speak to him ... Then she appeared to relax and she stopped calling. Later that day I spoke

> to her husband and brought him to his wife and helped them to start a conversation ... and both understood the situation.
> (Nurse L, Interview No. 3)

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The excerpt below demonstrated that a nurse needed an expert opinion to complement her in caring for her patient.

> We had a lady patient ... she was very depressed about her cancer. She didn't want to talk ... she drew the curtain to isolate herself. We tried to talk to her... close to her... be friends with her... but she was still the same. We decided to consult a psychologist ... we asked her first and she accepted that.
> (Nurse Cl, Interview No.2)

Episodic continuity of spending time

The term "Episodic continuity of spending time" is used to explain the nurse's making contact, concentrating and spending time in assisting the patients in an irregular continual pattern.

The process of caring requires time. By integrating all patterns of knowing, the nurse spends an appropriate amount of time in establishing a trusting relationship with the patient as well as identifying and meeting the patient's needs and performing nursing tasks. Nurses used the phrase "quality time" to refer to the time they spend achieving the patient's needs, and they reach the point of mutual engagement with the patient. All patient participants said that nurses need time in caring for them. The following three excerpts, taken from interviews with female patients with breast cancer, show how the patients appreciate the time nurses spend with them.

> I know the time when I got tearful the nurses talk to me, they sit and talk. Usually they don't have a great deal of time, they've got lots of things to do, but they find time to talk to you.
> (Patient J, Interview No. 1)

.....

> They take the time, especially if you're feeling low. They'll spend that time talking to you and explaining what's happening as much as they can.
> (Patient A, Interview No. 3)

.....

> I know that sometimes you're just so busy in the hospital that if you've got a spare five minutes and see somebody really upset and depressed, you sit on the bed, hold their hands and give them a cuddle. I'll tell you what, it makes you feel an awful lot better.
> (Patient D, Interview No. 1)

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All nurse participants in this study emphasise time as one of the most important factors in practicing caring. The following are examples of this concern:

> Caring ... it is something difficult in a hospital situation because we haven't got enough time ... especially in this ward, patients need you to talk to them. You need time to spend talking to them ... to get to know them. Patients are so frightened of chemotherapy you need time to get close to them ... explaining to them.
> (Nurse S, Interview No. 1)

.....

> Putting in an N-G* (Nasogastric) tube is a painful, miserable procedure. It is difficult if you don't know them before ... usually I spend time to develop a rapport with the patient ... to get to know them before I start the procedure.
> (Nurse Cl, Interview No. 2)

.....

> I've got five patients to give chemo to ... I didn't have time to talk to Mr D, S (a staff nurse colleague) spent time sitting and talking with him ... they had a good quality time.
> (Nurse T, Interview No. 1)

.....

> Our patients need tender loving care ... we're quite lucky in here, we've got time to spend with our patients.
> (Nurse E, Interview No. 1)

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The amount of time the nurse spends varies in each episode of a nurse-patient encounter. The following table (Table 12) provides an example of a series of events and the amount of time a nurse spent with a newly admitted patient.

Table 12

Duration of Time in Episodes of Nurse-Patient Encounter

Episodes	Duration of time (Minutes)
Welcoming the patient and relatives and discussing any pain related problem	15
Giving oral Morphine elixir	4
Asking the patient's feeling and helping with toilet	10
Taking history to complete an assessment form in three series of episodes because of other activities interrupting	7 15 10

(Field note recording).

Based on field note records and nurse interviews, the following table (Table 13) demonstrates examples of the amount of time nurses spend in each episode of nurse-patient encounter in which both the nurse and the patient experience caring and being cared for.

Table 13

Duration of Nurse-Patient Encounters in Various Episodes of Caring.

Nurse-patient encounter	Duration of time (Minutes)
Stop and talk with a patient who appeared depressed (Hospital)	5
Admitting a patient (Hospital)	10
Giving chemotherapy (Hospital)	25
Bathing a terminal patient (Hospice)	40
Explaining pain control medication to the patient and her husband (Home)	30
Taking off tube drain (Hospital)	10
Taking out stitches (Hospital)	15
Assisting a patient to have a shower (Hospital)	20
Teaching a patient to flush the Hickman line (Hospital)	40
Spend time sitting and talking with the family (Hospice)	40
Spend time with a patient being told of cancer (Hospital)	35
Teaching a patient to change a colostomy bag (Home)	30

Conserving-replenishing energy

Conserving-replenishing is the term used to describe the nurse maintaining energy and replacing the energy used when assisting the patient. "Conserving" is defined as 'keeping from change, loss, injury', while "Replenishing" means 'to make full or complete again by supplying what has been used up or is lacking' (Collins, 1989). The use of the term "conservation of energy" by Levine (1989) is acknowledged.

Nurses expend both physical and mental energy to assist patients to meet needs during their working time. As nurses are human beings and caring for patients involves subjective feelings, they themselves become vulnerable. The nurses, therefore, need to conserve their energy level and replenish the energy used for their own wellbeing.

The following excerpts demonstrate nurses conserving their mental energy by being able to detach themselves from the patient situation when they finish their work.

> I used to worry a lot when I went home. I looked at my paper "did I do this, I forgot to tell them about that." Now I shut off after I finish my work, go home, do other things, sleep well.
> (Nurse B, Interview No. 2)

.....

> But there's still another factor there that we haven't touched on. Like you can go to work and you actually elect to be very caring for the eight hours that you are at work. But you don't actually go home, shouldn't and don't go home and continue feeling concerned for those people at eleven o'clock at night when you're at home with your own family. **Now if you were caring for one of your children, you would never stop caring. It comes from within. But there's another quality to that again, where I think that I can go into a hospital when I can care for a person in the same way that I might care for one of my own family but I can cut that caring off.**
> (Nurse Jn, Interview No. 1)

.....

> Nurses and doctors who care for cancer patients must be a special person ... it must be hard for them because they lose their patients. You know it's different from looking after patients with broken arms or broken legs. I think as a profession ... they have to be able to shut off when they finish their work.
> (Patient Do, Interview No. 1)

The nurse spends energy in the most effective way to assist the patients to meet their needs. By the process of priority setting, the nurse is able to group some of the tasks and procedures in order to perform them in the same period of time to conserve her energy. Conserving energy is well illustrated in the following example.

> I usually try to work with my dependent, like say it's the first day post op and they've had their operation the day before, they usually try to wait until the consultant comes round and says "Right the catheter can come out, the drain (tube) can come out, get the I.V. changed," and that way you can do everything all at once and you try and group all your cares to give them a break. So I'll go in and take the catheter out. I used to take the catheter out first, then give them their wash and look at the pain relief, then take the Redivac out and then, by then they've had enough, get them to sit up in a chair, make their bed, pop them back to bed, and they've had enough and leave them all alone until you have to come back and do the obs and then leave them in peace after that. Yes, so try and prioritise and group, like get everything done at once. Like there's no point in taking the catheter out and coming back in twenty minutes taking the Redivac out and then coming in another twenty minutes and giving them a wash because they would just be exhausted. You have to be able to be in there for a solid three-quarters of an hour and get everything done, instead of trooping in and out all day.
> (Nurse Cl, Interview No. 2)

Nurses also need to replace their energy by having a short interval during their working time, and caring for themselves in everyday living. The following excerpt demonstrates an example of one nurse replacing her energy by practicing her own religious faith.

> It's like a river or a pool, it's got an outlet that the water's going out, but if you're not getting anything in from anywhere else it soon dries up. I need an inlet as well. Like for me, God is very compassionate and I can move from him and be compassionate and do it, not just of my own strength myself but what He gives me too. If I try to do it myself there can be a selfish motive behind it or you can get very tired quickly and find it very hard, but if I see by reading the Bible, and talking with God, I can see how he cares for people and how he loves people and that helps me. And also his love for me makes me care for others. But I need to get my strength from him to be able to give out. And also the natural things, like if I don't get enough sleep I can feel like not wanting to work, or if I 'm really not well, it's those natural things as well that I need. If I am very busy and things are very stressful then I have to take time out to relax. But even if I'm tired and I spend time with God it gives me the physical strength as well, and it may not affect my work, but if I'm tired as well as not spending time with God, then it would. If I've spent time with God then I will, as much as I'm able to do that. But if I haven't, then I can be quite dry in myself sort of. It could

> be in everyday life too that if I haven't spent time with God I feel sort of dry, like there's something missing and anything I do, if it's at work, it's very different. But if I do spend time with God it's like getting a real charge and I am better in my work and everyday work, everything.
> (Nurse Ka, Interview No. 1)

The description below demonstrates one nurse replacing her energy by having her own faith, expressing her feelings to her colleagues and also getting support from them.

> I found that I often come home from work, and if I feel that I've been trying to be extremely supportive to somebody like Mrs A, when she first arrived, I feel really drained when I go home. Like her, I try and rely on God to meet my needs to help with other peoples' needs I think. But I think, in turn you need care from other people and support from your staff that you work with. So I think we often care for our patients, we care for each other. But this ward is really good because we do that, and whereas in other wards we don't as much. Yes I think that's quite important. Talking to each other, if you're feeling really depressed about something or maybe your knowledge isn't quite up to scratch or there's something that you're not very familiar with, and I've often sat down and grabbed one of the other girls and we thrash something out and I feel really good afterwards. We've really discussed something and, or I let out my feelings to them that I wouldn't to the patient if I was a bit annoyed with someone, you know you don't. You might be feeling a bit harassed and you go and tell one of the staff how you're feeling, or how things are going and they give you support to change that, keep your chin up, it's just good letting out how you feel.
> (Nurse Lu, Interview No. 2)

A highly experienced nurse working in the community explains the way she balances her energy by being away from draining situations during her working time when feeling drained. Working in the community, she has the autonomy to manage her own work.

> I actually have this strong feeling at times that I want to give something and, you know, if I went to, if I saw say in an afternoon, I went to three very sick people, I can feel then that I feel drained, as though I've run out of batteries. And then, maybe, if I had a fourth call to make, unless it was important, I would say to myself, you need time out, you need to do a call that's not quite so draining. So I would leave that other call until the next day because I feel that I mustn't go to somebody when I feel drained out, because then I've got nothing to give them, you know. Well I mightn't have enough to give them, is what I'm really saying. I'd have something to give them but I wouldn't perhaps have enough to help them. And in fact I might be, you know, on half power so they may sense that's so.

> What I want them to know is that I'm on full power for them and that I'm giving out of myself and my ability to them.. //.. I have to re-energise myself by, perhaps, coming into my office and resting from that draining situation. And from an output situation to an input situation, I may come back and do something that doesn't need such energy. I may write some notes up, I may read some articles, I go home and I put my work totally away, and read, and I garden and things like that. And I re-energise myself and I come back fresh. So I have to be able to put my work down and then I come back all re-energised for the next day and the next situation. I think it's important that you can relax and do other things and then you put back energy into yourself and if things weigh heavily on you and you can't get rid of them then you can't re-energise yourself so well, if you take it all home. I do lots of things and I try and avoid concentrating on my work situation. I do things that distract me and things I like doing, like growing flowers. Also I think sometimes you look for team support. You might go to somebody and talk about something so that you're sharing it with them and I think in sharing with a colleague you sometimes take some of the strain off yourself so that you gain some energy back, because you share with them and you talk about it and you then re-energise yourself that way. Sometimes it's hard to find the right person who understands what you're talking about. But we all have colleagues that do that and sometimes you might even just talk with them about something totally different but it helps you just in sharing.
> (Nurse J, Interview No. 2)

Actualized caring moment

The term "Actualized caring moment" was developed to explain the nurse and the patient's peak experience of real caring which occurs at a specific point in time. The data suggested the momentary aspect and the term "Actualized" came from its use in Maslow's (1954, 1980) work on Self-actualization. There it represents the growth potential which each individual person possesses to realize the fullest expression of their innate psychological, emotional, spiritual and intellectual capacities, "the human being at his best" (Arnold and Boggs, 1989, p. 57).

At a given point in time within the ongoing interaction process, the nurse and the patient know, and recognise the giving and receiving of caring. It is a connection from feeling and knowing each other as human beings. Both the nurse and the patient share feelings of comfort, satisfaction, appreciation, pain or sadness. This moment of connection gives meaning to self growth for both the nurse and the patient. It is the moment of interhuman unity in transforming healing and growing between the nurse and the patient and it occurs in a specific situation in an episode or series of episodes of the nurse-

patient encounter. Once the nurse and the patient have experienced the actualized caring moment, it is much more likely that such a moment will occur again.

The following excerpt is a description from field notes which illustrates a series of episodes of nurse-patient meeting where a caring moment occurred. The data indicated that when both the nurse and the patient reached agreement on what to do in the situation and they realised the true caring between them, then **this is surely their best moment as human beings in a situation.**

> A staff nurse prepared chemotherapy drugs by checking with the treatment protocol and confirming every step of preparation with her colleague. It took her twenty minutes for this preparation.
>
> She then came to a woman patient who was admitted for chemotherapy treament. The patient was the only person in that room. She spent about fifteen minutes talking with the patient, then asked her whether she would like to go to the toilet. The nurse also prepared a bed pan for the patient. She then gave the patient antiemetic tablets and ativan*. This patient was familiar with the experience of chemotherapy treatment.
>
> The nurse brought the prepared chemotherapy drug to the patient and tested the line competently. Then she started by giving an I.V. antiemetic drug while at the same time talking with the patient. She already knew this patient and knew that this patient was anxious. The patient looked at what the nurse was doing. When the antiemetic drug injection was finished, the nurse went on to inject the chemotherapy drug. The nurse performed the procedure gently and competently. About three minutes after she injected the chemotherapy drug the patient's vein became red from the irritation of the antiemetic drug. The patient looked apprehensive, whereas the nurse remained calm and confident of her knowledge. She explained that this could happen in some patients and it would be O.K. She would stop the injection for a while until the vein returned to normal. She touched the patient's arm and had eye contact and asked the patient "What do you think?" The patient nodded her head and said "Do what you think is best". The nurse still sat with the patient and initiated conversation. The patient shared her experience about caring for her sick child. They both alternately looked at the vein and had eye contact and the nurse said "We'll wait". Then the patient asked the researcher to get sweets from her bedside drawer and she gave one to the nurse, one to the researcher, and one to herself. The conversation continued. The nurse left the patient because her colleague asked her to check the medication.
>
> The nurse came back to the patient and looked at the vein and said "It's nearly gone ... that's excellent". The patient looked at her vein and appeared more comfortable and relaxed. The nurse continued giving the chemotherapy drug after the redness had disappeared.

> She spent about one hour on the whole process of the chemotherapy injection. The patient said to her "I believe in your expertise, thank you very much" and she smiled. The nurse said thank you and smiled.
>
> For some time afterwards the nurse kept coming back to check the patient - to monitor the I.V. fluid and the side effects of the chemotherapy drugs.

In the nurse interview, she said that she was very cautious at every moment. She was apprehensive but she tried to present calmness. Both the nurse and the patient knew each other's feelings of worry and knew that they cared for each other. The patient tried to alleviate worry by sharing sweets and the nurse initiated a conversation. At the end they appreciated the achievements of each other.

It was revealed from the nurse and patient interviews, that when they enter into a caring relationship they experience an intersubjective connection of caring moments between them, as demonstrated in the following statements:

> **You just click, you talk about things. You have things in common. They're able to pick up that I really do care and it does matter.** It's not just a job. I am just thinking of one woman in particular ... she was newly diagnosed in the fact that they could not do anything for her and she was to go home to die. For her it was sharing in her grief ... we didn't really get to talk much but **she was one of the ones that I 'clicked' with.** Just so that she knew I was there, I think, and if she wanted to talk it was fine. I took an interest in her kids and her family.
> (Nurse Sh, Interview No. 2)

.....

> I always think that we as people working with them get far more out of it than we ever can give the patient. They provide far more to us ... our lives long term. **But that ... you know ... that's part of the two way caring thing ... it's in your self, I guess the more you and the patient and their family click, the more both sides actually get from it.**
> (Nurse S, Interview No. 2)

.....

> **I know from my own work that I reach what you call great heights of intimacy with some people.** With others they have always kept a little back and it doesn't matter how hard I try with them and maybe there's something between us, we may reach a satisfactory level and it's not so with others. And I know that it's particularly rewarding and perhaps it also helps the energising when you reach these, really, and **it happens quite a**

> **lot in my work, that you reach this absolutely wonderful level of intimacy with people.**
> (Nurse J, Interview No. 4)

.....

Mr J, a terminal patient, and his wife described their experience of being cared for by hospice nurses as a personal touch so that they could feel a circle of caring among them.

> The hospice, K (a terminal patient) was actually down there, **there's that personal contact as if it's circling you, you do feel it, don't you. It's very, very close. Well, we feel it with the nurses that come here, you tend to live in a circle.** It was a while ago a circle of pain, even though I never felt any pain, I was still in that circle, **now they create a circle, a very comforting sort of circle.** (Patient J's wife) **They've eliminated the pain and replaced the pain with themselves and made the circle that way.** And it doesn't really matter what silly little things sometimes that I do, it's not silly to them. They give us an answer about that particular thing really.
> (Patient J, Interview No. 1)

The concept of an actualized caring moment was derived from five subconcepts which were indicated by the data. These are reciprocity, empowering, healing, self growth, and developing experiential knowledge.

Reciprocity

The term "Reciprocity" is used to describe the nurse and the patient relatedness in exchanging, giving, and receiving caring. In the dictionary sense "reciprocity" means 'relating to or designating something given by each of two people; mutual' (Collins, 1989).

A nurse transfers her warm feelings, positive regard and knowledge in helping a patient, and the patient receives theseand conveys back an appreciation, trust and knowledge about himself/herself to the nurse.

The following excerpts show the patients receiving a subjective feeling of caring imparted by the nurses.

You can actually feel it ... you can feel it through all sorts of areas ... it's a sensation.
(Patient M1, Interview No.1)

.....

You get the feeling ... you can feel it ... **you just feel and know.**
(Patient M2, Interview No. 1)

.....

I feel their feelings towards me, they're being kind ...you know. **I feel something glows out of them towards me as kindness.**
(Patient G, Interview No. 1)

.....

One of the main things with care when we went to the hospice last year, we were both very apprehensive. This is because the hospice, you know a lot of people think you go there to die, but J went for help with medication, help with the pain. **Like when we walked in they were waiting for us and there was about three nurses and you could literally feel the love possibly spiritual. You felt it radiating out and welcoming** "come, we'll get you right." It really was quite incredible. It over-whelmed me, I nearly burst into tears because we had never experienced this sort of really personal care, it was a touching thing.
(Patient J's wife Interview No. 1)

.....

Nurses know when they really care for the patient, and are not just doing a job. They receive positive feedback from the patients.

When you've got there and you've done a good job, when they recognise that you've been a good nurse to them, they do give you that feedback which is the reward in caring. That's not always when people get well and go home because we deal with a lot of patients who don't get well and go home, but it's really all the intangible things with communication. It's the way the patient looks, just the vibrations you get from someone and to know that you've made a difference with that individual is the satisfaction in caring. That you as an individual person have made a difference for that person. I think that's where I think I know I get a lot of satisfaction and the other nurses here do too. With the oncology patients it's very much nursing that makes a difference in outcomes and as an individual I can help someone in a different way to somebody else and your individual skills make a difference. It's not only any old nurse which could have done that, we all have different skills and we

complement each other and I think you can get a lot of satisfaction and caring from that.
(Nurse L, Interview No. 3)

.....

It's a warm feeling that you get from them when you know that you really care for them.
(Nurse C, Interview No. 1)

.....

When they know that you care for them ... **they trust you more.**
(Nurse P, Interview No. 1)

.....

You've got a positive response from them. **It's a good feeling and you feel satisfied with your work.**
(Nurse A, Informal interview)

A nurse explains her experience of satisfaction from work when she has enough time to spend in assisting the patient to be comfortable, and she receives positive responses from the patient. On the other hand she experiences frustration when she cannot assist the patient to be comfortable or meet her/his needs because of a heavy work load.

I feel really satisfied, that's when I get the most out of my job. Like when you do have the long termers in here and they're terminal. Like Mr M, over the last few days, his wife said to me, because I put him in his own pyjamas, because he'd just been dressed in the whites, and just something little like that and he said to me that he feels comfortable. And she said to me that he looked so settled and he was in his own clothes and I had wanted him to be in his own clothes for days but I hadn't wanted to intrude. Just little things like that and she's saying to me "thank you, he looks good", and he's saying that he feels good to know that, because **that's what I want to achieve, I want everyone to be as happy and comfortable as possible in the circumstances.** You know that he looks settled and he is settled. But if she walks in and sees him lying uncomfortably and he's in pain, he's unshaven and unwashed, he's uncomfortable and it's horrible and I'd feel that I'd just want to get in there and get on with it. That's why I find it frustrating when you have a big list and you're short staffed and you can't do anything you want to do, but at the moment it's good. Like this morning I felt that we had about an hour and gave him a change and she came in and he looked nice and he was settled and asleep. And you could see her relax visibly that he's relaxed ..//.. **Satisfaction probably, that I'm completing what I want.**

When you evaluate things then I feel that I've completed what I want to do but when I don't its horribly frustrating.
(Nurse Ke, Interview No. 2)

.....

Empowering

This term is used to describe the nurse and the patient's realization of power derived from each other. "Empowering" means 'to give or delegate power or authority to' (Collins,1989).

Both the nurse and the patient recognise that the caring moment occurring between them enables them to gain power from each other. The nurse realises her power in using herself as a therapeutic tool for the patient, and the patient also realises the regaining of his/her control as illustrated in the following excerpts.

I was worried about D's future. I've done a lot of things in financial and other practical ways to make it as easy as possible for her, things such as insurance policies. I've signed a couple of insurance policies over and in that respect it's certainly, by **giving D a bit of confidence, it's given her the opportunity of her talking to me and me talking to her, it's made our capability of being in contact with one another greater.** We're able to, well, D having lost her fears she can talk about practical things all the same.
(Patient J, Interview No. 1)

.....

It helps to keep my confidence up. It's nice to know that you've got that fallback. **It gives you a good deal of confidence.**
(Patient W, Interview No. 1)

.....

They answer any questions we ask ... and **I feel the more knowledge you've got ... the less frightening.**
(Patient A, Interview No. 2)

.....

It does you wonders. It boosts you. There's one other nurse on but she's not on today, and she's shown such caring and understanding that she would sit and talk with me and some one would call her and she'd say "in here". She wouldn't get up and rush out, she'd say "Yes, in here," and they'd come and she'd say

> "Excuse me, J", and she'd talk to them and get what they wanted but she never moved from me. She just sat there and that makes you, I'm sure, get well quicker. It all goes into your head and into your body and it gives you that good feeling of caring and it must generate something inside you to want to please that nurse and when the nurse says to you how well you're doing, even though you might not be doing as well as what they would like, if they tell you you're doing well, it makes you feel good that you are doing well and **it makes you try harder and it gets you better a lot quicker.**
> (Patient M, Interview No. 1)

.....

An ostomy nurse explains in the following excerpt that caring imparted from herself in teaching the patient to care for their colostomy, enables the patient to be in control of herself, and she gains satisfaction from what she has done to assist the patient.

> **I guess the satisfaction of seeing someone managing for themselves, being in control of their life again,** I guess that's a lot of the satisfaction and joy of caring for someone, well seeing them, well, in nursing I think to see them comfortable, I guess in their situation as much as they can be. And in particular if they are able to be in control again of their life, we are there maybe to help and give advice to a greater or lesser degree as to how much they are able to, their physical state allows them to be in control.
> (Nurse M, Interview No. 2)

.....

A staff nurse working in an oncological ward also describes that when she feels that she really cares for the patient, she gains satisfaction from her work in using herself as a therapeutic tool for the patient.

> Great satisfaction, the feeling that I could help someone. Feeling that I'm able to help someone. **Feeling that the time I spent at helping and learning and what I gained is useful and a job that I'm doing isn't pointless. I think, I get quite a lot of satisfaction out of it,** especially in this ward particularly. You spend a lot of time talking to them. **And you get quite drained but you feel you've achieved something maybe to put someone's mind at rest, especially if you can see a change in them, they tend to relax and you feel like you're being effective.**
> (Nurse Lu, Interview No. 2)

The statement below demonstrates that the nurse's satisfaction in caring energises her to continue working for the patient.

> In being a bit satisfied with the outcomes I get a feedback ... so **I'm re-energised for the next.**
> (Nurse J, Interview No. 4)

Healing

When the nurse and the patient realise the caring moment is occurring within their continuous interactive process, there is a therapeutic effect on the patient. Both the nurse and the patient perceive: the patient's improvement from dis-ease or distress; gaining physical or psycho-spiritual comfort; or gaining potential strength to survive the ordeal of living with illness.

All patient participants in this study confirmed that the caring by nurses makes a difference for them. The following four excerpts, explained by patients, illustrate the positive outcomes of caring on the patients.

> **You feel better, happier in yourself, you feel more important, more loved, and this makes you feel nice inside,** especially if you're a little bit scared of what's going to happen or what's going on.
> (Patient A, Interview No. 1)

.....

> **It makes me feel at ease.** I'm not tensed up.
> (Patient G, Interview No. 1)

.....

> It's just every time they come around ... **they make you feel so relaxed you know** ... smile ... they joke with you, you know ... treat you like, you know ... treat like one of them, as one of the staff of the building ... as if you're not a patient ... but a person here ... they're so caring you know.
> (Patient P, Interview No. 1)

.....

> Being cared for and you know they care is really a big thing. The word 'cancer' is frightening for everyone. I think "My God I'm going to die". The first thing that people think is how bad it is going to be. If you don't have that caring and support you can come out of the hospital and still be just as frightened as the day you went in.

> Knowing that they care and having that special treatment **makes you feel a heck of a lot better when you get out, and the follow up makes you feel at ease with yourself.**
> (Patient J, Interview No. 1)

.....

All of the nurse participants in this study state that caring from them makes a difference for their patients. Two nurses describe the positive outcome of caring in the following excerpts, the first of which comes from a community oncology nurse.

> **Well, it really pleased me the other day when he said to me, "I'm now feeling more confident." He said, "I feel better in myself, I feel I can cope now",** and so gradually I'm not seeing him as often. He knows I'm there, he knows how to get hold of me so he knows I'm still available but instead of seeing him daily I've said to him, "I won't see you so often, but I'm still there".
> (Nurse J, Interview No. 3)

.....

> **They feel the trust, safety. They feel very comfortable and their recovery is increased ...** is much more rapid if the proper process is adhered to.
> (Nurse Sh, Interview No. 2)

A staff nurse working in a gynaecological ward described her experience in caring for one of her primary patients having a mastectomy. She has developed caring moments with the patient since she was first admitted to the hospital and this has made an improvement in the patient, as she disclosed in the following excerpt.

> **On the second day she was extremely good when she came back and she was up and about the night of the operation, I was really amazed. She wanted to get up and do things for herself as soon as she could** and she found that she could do things and it sort of gave her a bit of encouragement. She then went for a walk around the ward and she got quite accustomed to Redivac drains and she had a bit of mobility on her right arm and I didn't do a great deal of the physical things. We helped her with a wash and brushed her teeth and things like that to make her comfortable physically, **but she wanted to do a lot for herself straight away.**
> (Nurse Lu, Interview No. 2)

.....

Developing experiential knowledge

Experiential knowledge is acquired by both nurse and patient. The nurse gains more knowledge about, and of, the patient and an understanding of how best to assist the patient. In return the patient gains specialised knowledge provided by the nurse. When nurses and patients engage in a relationship, they share knowledge and experience in order to improve the patients' situation and assist the patients to use their potential to care for themselves. The patients gradually learn from the nurses to help themselves. All of the patient participants stated that they had gained knowledge in how to deal with their illness. The following excerpt is an example of a patient describing his experience in learning to care for his colostomy*.

> When I got this, B used to come around ... she started off in the hospital and did the first couple herself, then she showed me what to do. She did two or three and showed me how to prepare the skin, the stoma (opening of the bowel onto the abdominal wall) and she did a couple like that and she was there when I did the first one. She told me what to do and what not to do. She came back for another two or three to make sure I'd done it properly and **I've had confidence after that, now I do it myself. I can do it nearly blindfolded now.** But she made sure that I'd done it properly, and had confidence before she left me alone to do it myself. She's very caring always shows concern.
> (Patient Be, Interview No. 2)

.....

All nurse participants in this study state that they gain practical knowledge and gain more confidence when they engage in a caring relationship with their patients. They reflect on their past experiences and use the knowledge gained in other situations. As one nurse stated:

> **We also learn more from each experience that we can use in another situation, so we are also learning** and not just the patient gains.
> (Nurse A, Interview No. 1)

.....

A staff nurse explains that she was not confident in talking to patients about the spiritual aspect of life, but after she had engaged in a caring relationship with Mrs M and developed caring moments, she gained more confidence in opening up herself with the patients.

> **I've learnt to be more open with people. I haven't talked a great deal to people about spiritual things because they often know I don't want to know, I let them know subtly, yet I'm deeper if they want to talk about that sort of thing, but she was keen to talk about spiritual things and I was quite open about it. You don't do that with a lot of people but with her it was good. And I felt there that I got her to relax in a way. I think that's the most important thing.**
> (Nurse Lu, Interview No. 2)

.....

In the second interview, Nurse K described her experience of learning when she cared for a young male patient.

> A young R (A male patient) who died not long ago ... he was twenty. **From him I learnt ... I watched the way he went through being a big active shearer ... and I watched and I learned his goals changed from making lots of money ... I saw his goals changed, changed from the first time he went into the hospital to things like ... he wasn't worried about materialistic things any more. He knew he was dying - what was after death - I watched his whole life take a total spin around. I learned from that ... everybody, no matter what their concept of death is. They believe in something. I find nobody by the time they get to the terminal stages of illness ... who have never thought of death who have never thought of religion, a god or any spiritual being, turn right round and say - "Surely I haven't lived for twenty years for nothing ... what is it all about ... there must be something else."** Then he started questioning ... what else there could be. I just gently said, "Are you a Christian or are you of any particular religion?" He said, "I think I was christened". He was christened as an Anglican and we brought in an Anglican and suddenly he wasn't afraid of death any more.

.....

She further explained her learning experience about the spiritual pain of patients in the following excerpt.

> Often a patient is in pain, not because of the physical pain. **I learned from my patients that we increase giving morphine but if they are still in pain ... and you know that their pain should be under control - why are they still in pain ... and then if you find out that they've got**

> **a spiritual problem which sometimes happens ... and you sort out the problem and worked through it or get someone with the knowledge to work through it ... suddenly decrease the morphine.**
> (Nurse K, Interview No. 1)

.....

Self growth

The term "self growth" is used to explain the nurse and the patient's stage of self development. When the nurse and the patient engage in a caring relationship, they learn from each other what it means to be a human being in the world and this increases the understanding of oneself in the situation as a human being.

The nurse and the patient participants said that caring relationships between them help them to understand the meaning of life. Nurses perceive that when they reach the stage of actualized caring, they achieve their goal of professional practice.

A highly experienced nurse described that caring is helping the patients and herself to grow.

> If somebody like myself, **comes in and can help them over that problem which is an impediment to their quality of life they are enriched in other ways, because they re-prioritise their life, their relationships and their whole view of the world.** And so I see my job as being part of that. But in being a bit satisfied with the outcomes, I get feedback so I'm re-energising for the next. **So it does help, but it also helps me as a person to grow in myself and I think that's important for us all and I think that if you can help somebody to grow, and also grow within yourself you are self-actualizing.** You couldn't have avoided, well perhaps in some cases, you could have avoided having cancer, but they didn't know that at the time. They might find that too late, they should have not smoked, but let's say it's something that's happened to them that was out of their hands. It is this particular time, it's happened, something they can now do nothing about and therefore you have to positively look at it and through the expertise of people like myself, we can help them through the nursing and what you say to people is, "We're here to help you with those problems and if you handle this positively it can be an enriching growing experience". But you don't necessarily use those words, that's what you tell them. And also you say "Trust me, I will help you and we will grow together". Because I feel that when somebody else grows within themselves, I do too. But my whole life has been enriched by the work I do. I feel that I've reached the

> ultimate in my nursing life and I feel very lucky for that. And I don't talk about it necessarily to a lot of people but I've found a lot of nursing things in my life, I loved it all and always thought it was the ultimate but **I feel that at the end of my nursing life that I have reached the ultimate in my nursing life and growth.**
> (Nurse J, Interview No. 4)

A staff nurse explains that her caring helps the patient to understand and accept his situation, and she can see self growth in this patient.

> **Today he is living quite normally for him and he appreciates what's going on now** - that we had to work through because **he was giving up and didn't want to live ... and he is now so grateful. He has only three months ... but in time he has learned openly to say to his family** ... he loves them ... he cares about them. He has time to get his own house in order ... For him that is very important ... just marvellous ... he openly talks now.
> (Nurse K, Interview No. 2)

The terminal patients perceive that caring from nurses assists them to understand their illness and try to live their life with inner peace.

> I've never known before that some nurses are so caring. They try hard to help me solve all sorts of problems ... They spend time talking with me ... **I feel a lot better now. Cancer can kill me any time. I've got to deal within myself ... that is life ... just enjoy myself for the day ... keep myself at peace inside.**
> (Patient V, Interview No. 1)

SUMMARY

In both Chapters 5 and 6 the category of Ongoing Interaction and its seven dimensions have been presented with supporting data. The process of caring occurs within the continuous interactive process between the nurse and the patient moment-by-moment. The patient and the nurse develop a relationship of trust, and they are co-participants in meeting the patient's health needs. The nurse conveys caring through empathetic congruency of verbal and nonverbal communication. In this process of caring, the nurse is being mindfully present in the patient's situation and she is fully aware of her

commitment in helping the patient. She is also aware of integrating all patterns of knowing in using her knowledge to help the patient by imparting her compassionate intention and physical energy and spending time with the patient. Both the nurse and the patient realise the true caring occurring between them.

In Chapter 7 the final category - The Situated Context - will be discussed with its subconcepts indicated by data.

CHAPTER 7

THE SITUATED CONTEXT

In this chapter the last category, The Situated Context, is presented with its dimensions indicated by the data. The discussion commences with the meaning of the category and follows with the meaning of its two concepts; the circumstance of the nurse-patient meeting, and the care-facilitating working conditions.

The occurrence of a caring moment depends not only on the nurse's readiness to impart her qualities of caring to help the patient who is in need of assistance, but also on the circumstances and the environment which enable the nurse to develop a caring relationship with the patient. In particular, the environment is an important factor for nurses to be able to balance knowledge-energy-time. The circumstances of the encounter and features of the environment comprise the situated context of caring.

THE SITUATED CONTEXT

In this study, the situations in health care settings where the caring process between the nurse and the patient is taking place are the hospital, the patient's home and the hospice setting. Two concepts were developed to explain the situated context: circumstances of the nurse-patient meeting, and the care-facilitating working conditions.

Circumstances of the nurse-patient meeting

The phrase "Circumstances of the nurse-patient meeting" is used to describe a particular time and place where the nurse and the patient make contact. The caring process is initiated when a nurse makes contact with a patient in a specific situation in a health care setting in order to meet the patient's needs. The nurse works in collaboration with other health professionals. Nurse-patient meeting may be planned or unplanned, however, planning has to be flexible. Planned meetings may have to be modified because of changes in the medical protocol, or the patient's condition.

Data from the nurse and patient interviews, from field notes and observation, indicate that the caring process is associated with five categories of circumstances of the nurse-patient meetings as shown in Table 14.

Table 14

Circumstances of the Nurse-Patient Meeting

Circumstances of the nurse-patient meeting
Being with the patient while medical procedure is being performed, e.g:
Proctoscopy*
Lumbar puncture*
Internal pelvic examination
Abdominal paracentesis*
Nursing procedures being performed, e.g.:
Wound dressing
Catheterisation*
Stitches off
Taking tube drain off
Administering medications
Retaining nasogastric tube
Vaginal douche
Giving enema
Assisting with daily activities
Eating & Drinking
Personal cleaning and dressing
Mobilising
Elimination
Sleeping
Recreation
Assisting the patient under dis-ease or stressful conditions
Physical discomfort such as pain, vomiting, incontinence,
Psychological discomfort such as apprehension, depression, fear of unknown
Psychosocial discomfort such as family problems, economic problems
Psycho-spiritual discomfort such as seeking the meaning of life after death, mode of dying
Giving information/Teaching
Clarifying doctor's information
Giving information about medications
Teaching colostomy* care
Teaching how to care for Hickman*
Teaching how to do wound dressing

In everyday practice a nurse always has the responsibility of caring for more than one patient. The following description from field notes demonstrates a nurse's planned and unplanned meetings with her patients over a period of three hours during a morning shift.

> After the night nurse handed over the work, NP, a staff nurse on morning shift, cared for her patients in the following way.
>
> Planned meeting
>
> 07.30: Prepared the morning medication. First went to Mr H, a terminal patient with epidural morphine pain control. NP said hello and talked to him. She checked the medication from the Doctor's prescription and filled out the nurse's drug administration form by putting in the date, time, and dose, then her signature. She put all the tablets in a container and asked the patient to have them after breakfast.
>
> Unplanned meeting
>
> 07.40: NP went to Room 2 where Mrs B, a female patient with cancer of the ovary was vomiting. Mrs B was on chemotherapy treatment. NP came close to her and touched her shoulder. She expressed understanding by facial expression, eye contact and talked to her and said, "It happens to nearly everyone at the beginning period of having chemo, an anti-emetic drug will help". NP prepared and gave the anti-emetic tablets and intravenous injection. She checked the drug and signed the form. She shared feeling by expressing understanding through her face and eye contact and said, "It is an awful feeling". Mrs B stopped vomiting and had eye contact with NP. NP came close to her and touched her shoulder. Before she left, NP told Mrs B that she would come back to see her later on.
>
> Planned meeting
>
> 07.45: NP went to Room 3 to see Mr He a patient with a terminal brain tumour. She checked his medication with the doctor's prescription and prepared tablets. She then recorded and signed the nurse's drug administration form. She brought the morning tablets to Mr He and said, "Hi! ... I'm looking after you today, I'll put your tablets here". She then looked at Mr He's face and touched his cheek and said "I'll come back to help you have your breakfast".
>
> Planned meeting
>
> 08.00: NP came to Mrs B, looked at her and checked her medication prescription. She told Mrs B she was going to give her a Maxolon* injection. She then gave the drug intravenously.

Planned meeting

08.10: NP checked the intravenous fluid prescription and prepared a bag so that it was ready to change when the previous one was finished. She came to Mrs B and asked how she was feeling and reassured her. She then assessed the vomit and recorded the amount on the intake/output chart and cleaned the vomit bowl.

Planned meeting

08.15: NP came to Mr He (Room 3) and said "I am going to help you have your breakfast". She positioned Mr He for breakfast and touched his head. He could not help himself. She started feeding him fluid by using a syringe and asked him to open his mouth. She reassured him and said "You're doing well. Good man". Then she fed him porridge. He responded well. Then she fed him prunes with porridge, and he finished all his breakfast. NP then asked him to open his mouth for his morning tablets.

Planned meeting

08.50: NP changed the I.V. fluid bag for Mrs B who remained asleep.

Planned meeting

08.55: She then came to Mr H (Room 1). She smiled at him, touched his shoulders and had eye contact. She sat near him and offered him a drink. Mr H could drink by himself, so NP allowed him to do that. She then gave him morning medication and asked whether he would like to have a shower. At first he said, "No". NP talked about his expected visitors. He said, "That's because I am on my way out, P", and he smiled. NP smiled and touched his shoulders, had eye contact. Both were silent for about one minute. NP asked "What do you think about having a shower?" Mr H "Yes, yes, P". NP: "I'll get the chair." She brought a chair and put a rubber ring on the chair before Mr H sat on it. (Mr H had tender buttocks). NP then took the patient to the bathroom and helped him to undress. She then asked the researcher to hold the syringe pump* while she showered the patient. They talked and laughed, with NP allowing Mr H to help himself as much as he could.

09.20: NP helped him to put on his clothes and took him back to his room. She covered the sofa with a sheet and asked Mr H whether he'd like to sit on it for a while. He said, "Yes, P, that's good and I'd like something to read." She gave him a magazine. Then she made his bed and gave him elixir morphine which had been prepared by another nurse.

Unplanned meeting

09.30: Walked past Room 2. Mrs B had vomited. NP came close to her and helped her clean her mouth. She also explained about the side effect of chemotherapy* to the patient's relatives who had just arrived. NP was with them for ten minutes.

Unplanned meeting

09.40: A patient in Room 4 has just been readmitted. She was a young teenage girl with osteosarcoma*. NP said "Hello", smiled, and came close to her explaining about the test she was going to have. She then shifted her from single side room to another room with five beds.

Uplanned meeting

09.50: Mr H's wife came to visit him. NP came to say hello to her, talked to her and helped Mr H get into bed. She adjusted the pillows and put a rubber ring under his buttocks. She asked how he felt.

10.00: NP checked and recorded narcotic drugs with one other nurse.

Unplanned meeting

10.20: The Charge nurse asked NP to be with a patient who had had Caesium* (radiotherapy) and was being transferred from the theatre. This patient was under the responsibility of another nurse who was not available at that time because she was assisting another patient while a doctor performed a technical procedure. NP greeted the patient, made eye contact and held the patient's hand. She discussed the patient's condition with a theatre nurse. She read the doctor's report and checked the patient's perineal area and urinary catheter. She was with the patient during the transfer to the ward. She assisted the patient into bed and covered her with a blanket. She put a lead screen near her at the level of the lower abdomen and buttock. NP explained to the patient what was happening to her. The patient was not fully awake, but nodded her head while NP was explaining. After that NP left the patient and wrote out the patient's progress report.

10.40: NP had morning tea break.

In everyday practice nurses always deal with immediate changing situations. The following two tables (Table 15 and Table 16) show examples of nurses planned actions and unplanned actions recorded from field notes.

Table 15

Nurses Planned Actions

Planned actions
Recording vital signs
Changing intravenous fluid
Greeting the patient at the beginning of the day
Assisting a patient to have a shower
Wound dressing
Positioning the patient
Preparing the patient to go home
Admitting a patient
Monitoring of intravenous fluid
Assessing patient's discomfort and pain
Sitting with patient and reading the Bible for her
Sitting and talking with the patient about pain control
Accompanying the patient to the theatre

Table 16

Nurses Unplanned Actions

Unplanned actions
Helping when:
Patient's intravenous fluid stopped running
Patient bleeding from a wound
Patient vomiting
Newly diagnosed cancer patient is getting depressed
Patient's relative makes a request because of the patient's restlessness
Patient requests bed pan
Patient requests talk with nurses
Patient's position is uncomfortable
Patient looking worried

Care-facilitating working conditions

The term "Care-facilitating working conditions" is used to describe the work environment in health care settings which enable nurses to develop a caring relationship with the patient. There are four patterns indicated from the data which are identified as care-facilitating factors. These are: private space; valuing continuity of care and patient orientation; supportive collaboration; and continuing clinical teaching and learning.

Private space

The term "Private space" is used to describe a place or surrounding which is necessarily restricted for the nurse's working place and the nurse-patient meeting. The nurse and the patient require a space in which to be together without interruption or interference. The following excerpt shows that both nurse and patient need privacy in their meeting.

> I was talking to a lady yesterday and she was in a four bedded room and I know she's quite distressed about a whole lot of things and I said to her "Is there anything in particular that you'd like to talk to me about?" and she said "Yes, there was". **But then she started looking round the room to see who might be listening and I said to her quietly "Do you think somebody might hear us?" and she said "Yes" and I said "Well, I don't think they can because we can talk very quietly". And so I spoke softly and she spoke softly.** So I was able to assure her that other people were engaged in conversations and things, so I got very close to her and we talked and she was able to tell me some of her problems.
> (Nurse J, Interview No. 3)

In the hospital situation, as she attends to the patient's personal daily activities, the nurse attempts to create a private and relaxed environment in her contact with the patient in order to develop a close relationship.

> If I go into a hospital ward, for instance, I might say, "Do you mind if we pull the screen?" Then **I ensure that to a certain degree we've got privacy.** I talk quietly so that other people can't hear because I don't want to create any embarrassment for this person if they feel I'm talking loudly and telling the whole world about it.
> (Nurse J, Interview No. 3)

A staff nurse in an oncology ward gave a statement about creating privacy in her contact with a patient:

> Basically my way is the patients who I know or do not know before **I just go into the room ... close the door or pull the screen.**
> (Nurse K, Interview No. 1)

Table 17 contains examples of private spaces where nurses have their own space, and spaces where they can meet with patients as recorded from field notes.

Table 17

Private Space

Private space
Nurses' private space
A separate private room for discussion, meeting, and giving a report
A separate private room for a coffee break and a short break from work
Nurse-patient meeting space
Hospital
Patient's single room
Patient's sitting room
Private room for a nurse and a patient to have a discussion e.g. an interview room
Patient's bathroom
Hospice and home
A patient's room
The lounge
The garden
The bathroom

Examples of nurse-patient meetings in a private atmosphere where caring moments occur are exemplified in Table 18. (Recorded from field notes and from nurse and patient interviews).

Table 18

Nurse-Patient Meetings in a Private Atmosphere

Nurse-patient meetings
In the hospital
A nurse and a patient being together in a quiet room with no interruptions while chemotherapy is given.
A nurse talking with a patient and his wife in a private quiet room about the patient wanting to stop chemotherapy treatment.
A nurse sitting on a chair close to the patient in the patient's side room (single room) talking about being terminally ill.
A nurse sitting on the patient's bed in a patient's single room taking off the tube drain.
A nurse in a patient's single room sitting on a chair very close to the patient who is lying on the bed. The nurse was with her while a doctor was telling the patient of the cancer diagnosis. The nurse was with the patient for forty minutes after the doctor had left the patient.
A nurse giving an enema to a male patient while his wife was with him in a four bedded-room. The nurse created a private boundary by drawing a curtain.
In the hospice
A nurse assisted a terminal patient to have a bath in a quiet pleasant bathroom. They talked about the patient's life history during which time he expressed his fear of dying.
Two nurses comforted a terminal patient at bedtime in the patient's room which was a home-like situation.
A nurse brought a patient to the garden and they talked about various things and shared life experiences.
Two nurses welcomed a patient and his wife on his first admission to the hospice. They were together and able to talk in a room without interruptions.
In the patient's home
A nurse teaching a patient in the bathroom how to change a colostomy bag.
A nurse talking with a patient and her husband in the lounge about the patient's pain problem.
A nurse with a restless terminal patient, his wife and his daughter in his bedroom with the nurse talking to him about the need to retain a urinary catheter.

Valuing continuity of patient-centered care

The term "Valuing continuity of patient-centred care" - is used to explain the moral principles and beliefs, or accepted standards of the health care system in the delivery of nursing service.

In this study the values underlying the care delivery system are a patient-centred approach and continuity of care. Primary nursing is a system of nursing care delivery based on these values. It has the specific objective of being continuous, coordinated, individualised, and patient orientated. This method of nursing care delivery encourages nurses to develop a caring relationship with the patient.

The majority of health care settings in this study had implemented primary nursing. In this mode one nurse is assigned to plan continuous nursing care for a certain number of patients, and is responsible for planning and evaluating the care of these patients. This nurse is called the primary nurse and the patients under her care are called primary patients. When a primary nurse is not on duty there will be another nurse who substitutes in planning care for these patients. This nurse is called the associate nurse.

The nurses and patients in this study were satisfied with primary care nursing as it allowed all of them to be involved with one another. A staff nurse working in the oncology ward explained that primary nursing allowed her to spend time getting to know the patient and develop a trusting relationship.

> **With primary nursing you could spend more time talking. Especially in this ward you could spend more time talking, assessing the patient, and working out together how to solve the problems.** We've got a young girl. She has got osteosarcoma and she has also been sexually abused ..//.. **A primary nurse is able to spend time with her. There's just no way she can develop a decent relationship because they're both such big problems. They're not something you open up with overnight. You've got to gain trust.**
> (Nurse S, Interview No. 2)

.....

A Charge nurse explained in the following statement that primary nursing facilitates caring because the nurse and the patient have the opportunity to become involved.

> **I think the things that do facilitate caring are primary nursing.** A nurse is responsible for assessing someone, devising her care and working with someone. We've had some patients through this ward that I've found it very difficult to care for. They haven't been very nice people but I usually find a nurse who will all of a sudden say **"I'll be his primary nurse", they've just got that level of involvement, they've clicked and they'll do it.**

She further explained that a nurse continuing to be responsible in caring for the same patient gives the nurses opportunities to learn to know the patients quicker in developing a caring relationship.

> **Having to have contact with someone, with the same patient, for a couple of days, they start to get to know a bit about the person and they start to become involved with what's happening to them.** ..//.. It's certainly the time phase and the level of involvement. If you had a different patient every day for a week, I don't think you'd feel that you'd developed a caring relationship with anybody, because you wouldn't be looking at them as individuals, you'd just go along to a different set of patients tomorrow anyway. You wouldn't develop the same sort of commitment to those people, but you do when you know that you'll be with them until the next week or whatever, and that you're going to work out their goals with them and you start to know what their goals are and start to work with them. It's a shared experience really ..//.. That's the other thing **with having primary nurses or some form of it where you're having the same persons, you feel you've the commitment to give your energy.**
> (Nurse L, Interview No. 2)

A male patient described in the following statement that he was satisfed with the system of care which focused on one nurse being continuously responsible for the same individual patient, as it allowed the nurse to know the uniqueness of that patient.

> **That nurse there who just did the temperature ... she's been my nurse in the morning since I've been here. She's my nurse.** This is her first day on afternoon shift ... that's why I've had the male nurse this morning. **And they know your history and different things about you. It makes a big difference. This way they have it now, a nurse is allocated a certain number of patients and she'll come around and say "Good**

> **morning or afternoon, my name is Mary or Joan, I'm your nurse or I'm your nurse for the day".** They concentrate on those few patients whereas years ago you'd have one nurse who'd give you a glass of water, half an hour later another nurse would come and take your temperature ... they weren't allocated certain patients. And **it's far better this way that they have it now - the nurses are allocated certain patients and they know what treatment they're having, and it makes a big difference.**
> (Patient Be, Interview No.1)

A female patient stated that she was satisfied with having one nurse caring for her continuously, which was different from her past experience of discontinuity of care from nurses. She described how continuity of care enabled nurses to know more about the patient.

> Usually at the beginning of the day the nurse would come and introduce herself and she'd say **"I'm going to be your nurse for today." And so each day when she was on duty she would be your nurse. And previously whoever was there came and there was no continuity. But I like the idea of the same nurse coming each time. When she was on duty and as the duties changed at night you'd get a different one, but you would still get that continuity. And that was helpful because she got to know you.**
> (Patient D, Interview No. 1)

The following excerpt demonstrates that continuity of care by one nurse provides nurse-patient involvement which facilitates the occurrence of the caring process. The nurse is able to know the patient's perceived needs.

> You could have an off day where you're really upset and it's a personal thing for a woman to have breast cancer and I think **if you don't have the same nurse you might get very depressed and another one comes on the next day and she knows nothing about what happened the day before. Whereas if it's the same one she knows to spend a bit of time and the nurses have got to be able to do that.** I've had off days where I've woken up in the morning and all I wanted to do was cry. **Well it was very lucky being in a small hospital too, a lot of them were very caring. They would sit on the bed and give you a cuddle. It might sound stupid but it made you feel better and you felt that another woman knew how you felt.** Whereas if they just walked in and said "Oh, yes, a bit of an off day" and walked out of the room again, well you just felt a number and perhaps in a very large hospital this is

> what happens so I am very lucky being in a small hospital. And I think it makes a big, big difference.
> (Patient J, Interview No. 1)

Supportive collaboration

The term "Supportive collaboration" is used to describe the situation when the nurse is given strength in working with other nurses as a team member. Supportive helping of each other among nurses in the same ward facilitates nurses' ability to balance knowledge, energy, and time.

Nurses working in a particular nursing unit such as an oncology ward, surgical ward, gynaecological ward, or hospice unit have a common objective in providing care. Though each individual nurse is allocated a certain number of patients to care for, they work as a team knowing what is going on in the ward during the entire twenty-four hour period. Nurses working in each shift hand over the work, by giving reports to those in the next shift to ensure the continuity of care. Every member in each shift knows every patient in the ward and the important events during the twenty-four hour period. Each individual nurse knows in detail a certain number of the patients under her care. To achieve the common goal of patient safety and welfare, nurses "work together as a team", "help each other", and "share feelings, experience, knowledge and skill with one another".

A staff nurse working in a surgical ward gave a statement about the assistive cooperation among the nursing staff in her ward:

> **It eases the day to be able to say to each other "Gosh you did a good job with Mr such and such" or "He's said to me how much he likes having you as a primary nurse."** If you hear good things, tell the people, don't keep them back, especially when things get hard. Do this instead of pulling apart and saying "I've got a bigger list than you and I'm busy". it's pulling together and saying, **"I'm going to get through this and then I'll give you a hand with it." It's binding together and supporting each other and that's the big thing and that's where this ward is good, the staff do work well together, but you need to work on it all the time. The worst thing you can have is staff that all want sympathy. A good rapport between, and you know you can yell out to them,** like I just said to her "Look my list is going well" and be able to say "Can you take an admission?" I said to L (a nurse colleague) "I know you're a bit heavy, I'll start the

> admission and if I get tied up, you take over, fine", it's just working with each other, yes it's a good ward for that and A (The Charge nurse) is really good, she really cares about us.
> (Nurse Ke, Interview No.1)

In everyday practice one nurse is responsible for caring for more than one patient. When a nurse makes contact with one patient in a particular circumstance, she needs to give total attention to that patient. She, therefore, needs assistance from her colleagues to give attention to her other patients during that time. A staff nurse in an oncology ward made the following statement:

> **I hand over my work to my colleague** by saying "I'll be in room such and such ... do not disturb me, take a message if the phone rings. I'll be in room ... twenty minutes to half an hour".
> (Nurse K, Interview No. 1)

A Charge nurse described in the following statement how, in her ward, nurses "understand each other's work load" and "being there to help each other". When one nurse needs to spend more time with one patient, another nurse takes over caring for her other patients, allowing the nurse to develop a caring process with that patient without worrying about her other patients.

> **They each are working as teams and being there to help each other means the other nurses are understanding of each other's work loads and they're also caring for each other.** I often notice **if someone happens to have a particularly heavy work load or they have a patient who has deteriorated and they need to spend a lot of time with the family, I don't have to ask the other nurses to start looking after their patients. It just happens automatically** and I hope that helps the individual cope with their changing work loads and care more intensively for some than for others that **they can rely that their other patients will still get looked after by other team members, that they can occasionally devote a lot of their energy in caring for one person.**
> (Nurse Li, Interview No. 2)

She further explained that when a nurse cannot give fully enough of herself to care for her patient because of a personal barrier, another nurse is willing to take over her work and allow her to be away to regain energy.

> **A few times we've had people who have had families at home and their work performance hasn't been so good for a short term. The other staff recognise that and fill in the gap for them.** They only come to me complaining about it if it seems to be something that's going on for ages or if they don't know why. But if they can understand, say, that someone has got sick children at home and **they'll look after each other and they'll say to me "Oh, we're alright now, off you go, you go home".**
> (Nurse Li, Interview No. 2)

Hospice nurses described how they always support each other and receive support from the nursing director. The following excerpts are two examples.

> We're very lucky working with M (The nursing director). Sometimes the situation is very stressful and you know yourself that you cannot give good care ... **you need a break, we're allowed to be away from work and still get paid.**
> (Nurse J2, Interview No. 1)

.....

> **A** (a senior hospice nurse) **always keeps an eye on all the girls. If someone feels very drained, we'll take over her work and she can go home early. We always support each other.** Though the situation is quite stressful, M (The nursing director) says we've got to be able to laugh.
> (Nurse L2, Interview No. 1)

In some situations a nurse is not able to care for a patient by herself, particularly when a patient needs full assistance from the nurse. Other nurses then are willing to help her in lifting and turning the patient as shown in the following excerpt.

> **When someone has had a particularly hard patient to care for the others tend to volunteer their help with that person, like "I'll just do Mr so and so and then I'll give you a hand with Mr whatever", so that the nurse doesn't always have to go looking for help with a particularly difficult patient.** We've had a few that have been really unpleasant to look after with some cancer patients, smelly and oozy and we can't always keep them perfectly comfortable. And just the fact that a nurse looking after them knows that she's not going to have to go round looking for a nurse to help her, that someone will actually say "I'll give you a hand with that man today." That sort of thing shows caring for each other on the ward.
> (Nurse Li, Interview No. 2)

Continuing clinical teaching and learning

The term "Continuing clinical teaching and learning" is used to describe the nurse's carrying on the educational process in everyday bedside practice. As the nursing practice repeatedly deals with a dynamic specific situation for an individual patient, new knowledge is continually being developed to improve patient care. Therefore, each nurse is always in the process of learning.

Individual nurses working in a nursing unit have different experiences, personal and professional caring qualities. In this study nurses in the wards always assisted and supported each other to improve their knowledge and skills. When a nurse is not confident in providing care to a patient or in performing a technical procedure, the fellow nurse who is more confident and competent in doing so, is willing to teach or give information to that nurse, and willing to be with that nurse while she is providing the care. When the nurse feels confident and competent in carrying out a technical procedure, she can focus her attention on the patient's response in an immediate moment.

Supportive clinical teaching among nurses is always happening in everyday practice. As one senior nurse pointed out in the following example:

> **If you don't feel happy with something you can always get someone experienced to go with you ...** so I wouldn't advise anyone to just go along. It's always better to have someone just there ... and either they can just chat with the patient and they help you indirectly, but you feel more confident. **I try and teach really all the time.** We often have students in the ward ... and I try and keep in the back of my mind if I'm going to do something ... go and see if a nurse wants to observe. **So that helps train all the young inexperienced ones coming up. It provides all the time a certain level of experience in the ward.**
> (Nurse Ly, Interview No. 1)

The following excerpt is an example of a staff nurse working in a gynaecological ward who describes her experience in being supported by her fellow nurses and the atmosphere in sharing feelings, skills, and knowledge in her ward.

> **I think, in turn you need care from other people and support from your staff that you work with. So I think we often care for our patients, we also care for**

> **each other.** But this ward is really good because we do that and whereas in other wards we don't as much, I think that's quite important. Talking to each other, **if you're feeling really depressed about something or maybe your knowledge isn't quite up to scratch or there's something that you're not very familiar with. I've often sat down and grabbed one of the other girls and we've thrashed something out and I've felt really good afterwards.** We've really discussed something and, or I've let out my feelings to them that I wouldn't to the patient if I was a bit annoyed with someone, you know you don't. You might be feeling a bit harassed and you go and tell one of the staff how you're feeling, or how things are going and they give you support to change that, and keep your chin up. It's just good letting out how you feel.
> (Nurse Lu, Interview No.1)

The following statement from a community oncology nurse, who acts as a supervisor, explains being with a district nurse to give advice and support to her.

> **I've been there for T** (a female district nurse) as much as, I've also been there for the family and I've visited them but I've also been there for T because T relates to them so well I'm sort of standing behind T, really wanting to support her in what could be a stressful situaton. **Also when things have gone bad, or she's needed advice, I've gone round to sort of help define the situation and work with them as well so that we can utilise both our skills.** I think they've seen me as a person of expertise who has been there for T and for them and also as somebody they could utilise in an emergency.
> (Nurse J, Interview No.3)

In everyday practice nurses need to have a nurse resource person to advise them in their practice, in particular for nurses who have little experience in the clinical area. In this study, in one setting nurses described a "study day", which is a day when nurses who train to be mentors are allowed leave from the ward for their study. They reflect on their practice and keep up their knowledge by sharing experiences in a group. These nurses were preparing themselves to supervise new nurses. They were satisfied with their study day, as one nurse described in the following excerpt.

> **Study days are excellent. They're time out from the ward.** You get to meet other people, you get out of your area, because you get quite narrow in your area. **But it does, it gives you time to sit back and evaluate the things from the outside and when you talk about things, like now, and you think back on things, and you think, well, I did alright there, or I could improve there or**

> **hearing other peoples' points of view and you think "Oh, they go through that too, I thought it was only me that felt like that."** Oh no, study days are a must and they've got to keep them up, even though we've got no money and all this, we need to keep going. With the education you never know, and there's so much new stuff going on, I try and grab as many as I can and A (The Charge nurse) is excellent about that, by trying to get us away. **Like yesterday I went to a Mentors, it was just an update on having someone you wanted to train.** I'm going to have new staff next year, so it was just an update and between the six of us we just chatted about last time when we had a meeting and what we would like this time, what problems we struck, and what were the good things. Just a couple of hours of talking about it has made me pleased about doing it again. **All staff, who have been trained as Mentors, about three or four of us on the ward, have done a full study day on how to buddy a new person and how to bring them through the orientation programme.** We've just been and had an update yesterday.
> (Nurse Ke, Interview No. 2)

Hospice nurses explain that in caring for patients they learn from each other and complement their skills as shown in the two following statements.

> I always observe while other nurses are caring for patients ... **and I learn from that.**
> (Nurse Ji, Interview No.1)

.....

> Nurses here have different skills ... caring for the terminally ill **we always complement our skills.** Someone is very good in listening ... someone has a very good sense of humor, and someone is good at music.
> (Nurse A, Interview No. 1)

SUMMARY

Throughout this chapter, the discussion has focused on the category of the situated context with its two dimensions: circumstances of nurse-patient meeting and care facilitating working conditions. This situational context provides for the occurrence of the caring moment within the ongoing interactive process of an interpersonal helping relationship between the nurse and the patient which was discussed in Chapters 5 and 6.

In Chapter 8, the integration of the theoretical framework and the emerging grounded theory of "The gestalt actualized caring moment" will be presented with reference to other theoretical accounts of caring in nursing practice.

CHAPTER 8

THE GESTALT ACTUALIZED CARING MOMENT:

A THEORETICAL FRAMEWORK

Integration and interpretation of the theoretical framework is presented in this chapter. It begins with a summary of the conceptual categories with their concepts and subconcepts which have been presented in the previous four chapters. The presentation then moves on to integration of the theoretical framework, including diagrammatic representations and an explanation of the emerging theory. In conclusion, theoretical statements which describe the characteristics of caring in nursing practice are proposed.

SUMMARY OF THE DEVELOPED CATEGORIES AND THEIR CONCEPTS

The four categories generated from the data were: The nurse: personally and professionally prepared to care; The patient: person with compromised health and wellbeing; The ongoing interaction; and The situated context. The following table (Table 19) demonstrates these categories with their concepts and subconcepts.

INTEGRATION OF THE THEORETICAL FRAMEWORK

As discussed in Chapter 3 grounded theory methodology provides an approach for creating theories of social process in relation to identified human situations. Using the constant comparative analysis, the researcher scrutinises the data and identifies core categories that are descriptive of events, themes, processes, and social structural conditions of the human situation being studied (Glaser, 1978). Glaser and Strauss (1967) refer to a core category as accounting for most of the variation in the pattern of behaviour and integration of other categories. Hutchinson (1986) points out the essential characteristics of a core category or variable in the following quotation:

> The core variable has three essential characteristics: it recurs frequently in the data, it links the various data together, and it explains much of the variation in the data. This variable becomes the basis for the generation of the theory. (p. 118)

Table 19 Developed Categories with their Concepts and Subconcepts

Categories, concepts and sub-concepts
1. The nurse: Personally and professionally prepared to care
Benevolence
Commitment
Clinical competency
2. The patient: Person with compromised health and wellbeing
Uniqueness
Vulnerability
Experiencing a life crisis
Experiencing uncertainty
Being in a state of dis-ease or distress
Needing assistance
3. The ongoing interaction
Being there
A relationship of trust
Participation in meeting needs
Sharing information
Helping
Being an advocate
Negotiating
Teaching and learning
Empathetic communication
Facing
Listening
Engaging in dialogue
Being mindfully present
Awareness
Concern
Attentiveness
Balancing knowledge-energy-time
Assessing-interpreting
Priority setting
Anticipating
Maintaining dynamic complementarity
Consulting
Episodic continuity of spending time
Conserving-replenishing energy
The actualized caring moment
Reciprocity
Empowering
Healing
Self growth
Developing experiential knowledge
4. The situated context
Circumstances of nurse-patient meeting
Planned meeting
Unplanned meeting
Care-facilitating working conditions
Private space
Valuing continuity of patient centered care
Supportive collaboration
Continuing clinical teaching and learning

Chenitz and Swanson (1986) suggest that the analyst should ask questions in order to find the core categories.

> Which of these categories seems to explain the major action in the phenomenon under study? If no category stands out or if two or three seem to be of equal importance, the analyst might ask the following questions: How do these categories relate to one another? Is there a higher level concept which might explain them all? How then do the other categories relate to it? (p. 118)

In this study, initial categories and their properties were compared with each other in order to search for their relationships. Data were then re-examined to describe categories and their properties. The four emerged categories and their concepts were compared in a search for the core category. "Actualized caring moment", a concept explaining the category of The ongoing interaction, appeared to be the centre linkage of all the categories and their concepts. It was closely interrelated and interdependent with other categories and their concepts which were equally important. Therefore the higher concept of "gestalt" was applied to link these categories, and the grounded theory of "The Gestalt actualized caring moment" was developed to explain them all. Selective sampling of literature and data were carried out to compare and contrast the emerging concepts. Saturation of data was identified.

When generating a grounded theory, rather than using linear steps the researcher works within the matrix in an ongoing process. In this study when all categories and their properties were integrated in a meaningful relationship and a diagrammatic representation of the theoretical framework was developed, the researcher further refined the framework. The two categories - The nurse: personally and professionally prepared to care, and The patient: person with compromised health and wellbeing, were collapsed to a higher level of abstraction to demonstrate the underlying preconditions. Therefore the emerged theory consists of three main components: The Preconditions, The Ongoing Interaction, and The Situated Context.

The existing theory of "Gestalt" is used to explain the emerging theory. Gestalt, a German word, was first used by Max Wertheimer, the German psychologist, to describe whole systems in which the parts are integrated. Wertheimer's statement reads in this manner: **"A Gestalt is a whole whose characteristics are determined, not by the characteristics of its individual elements, but by the internal nature of the whole" (Wertheimer, cited Katz and Tyson, 1951, p. 91).**

In nursing, Pyles and Stern (1983) discovered the grounded theory of a nursing gestalt in critical care nursing to explain the cognitive process used by experienced critical care nurses in making assessments and judgments to determine that a patient was developing cardiogenic shock. The grounded theory of "Gestalt Actualized Caring Moment" developed from this present study explains how nurses translate caring into nursing action. In other words it explains how the caring process occurs in nursing practice.

As described in Chapter 6, the actualized caring moment is the moment of intersubjective caring transaction recognised by the nurse and the patient occurring within their ongoing interaction. Therefore, the existing nursing theory of transpersonal human caring proposed by Watson (1985) was used to support the emerging theory:

> In transpersonal human caring, the nurse can enter into the experience of another person, and another can enter into the nurse's experience. The ideal of transpersonal caring is an ideal of intersubjectivity in which both persons are involved. (p. 60)

Watson explains an actual caring occasion in her human caring theory in the following way:

> Two persons (nurse and other) together with their unique life histories and phenomenal field in a human care transaction comprise an event. An event, as an occasion of human care, is a focal point in space and time from which experience and perception are taking place, but the actual occasion of caring has a field of its own that is greater than the occasion itself. (p. 59)
>
> An actual caring occasion involves action and choice both by the nurse and the individual. The moment of coming together in a caring occasion presents two persons with the opportunity to decide how to be in the relationship - what to do with the moment. (p. 59)

EXPLANATION OF THE THEORETICAL FRAMEWORK

"The Gestalt Actualized Caring Moment", the outcome of the research, is a conceptual framework explaining the wholistic dynamic process by which nurses translate caring into nursing action to assist a patient to achieve either potential wellbeing or peaceful death.

The Preconditions are the prerequisites for the caring process to occur. Nurse and patient are ready to be in contact and each brings unique capacities and expectations into the situation. The nurse brings her personal and professional qualities of caring, and the patient brings his/her personal uniqueness with a specific life situation of health related problems.

The Situated context is the situation of the nurse-patient contact in a specific place and time in the environment of health care settings which promote the occurrence of caring processes.

The Ongoing Interaction is the actual caring process which evolves from the preconditions and the situated context. The actual caring process is the nurse-patient interaction in a continuously changing pattern. The nurse is fully aware of her commitment to give of herself to assist the patients to achieve their personal needs within the reality of the patient's situation. She is physically present with the patient and promptly responds to the patient in the immediate present moment. She develops a trusting relationship with the patient and coparticipates with the patient to identify needs and to meet these needs.

As the nurse and the patient are human beings, feelings are involved in the process. The nurse conveys empathetic understanding to the patient through verbal and nonverbal communication. In this process of caring the nurse is aware of integrating all patterns of knowing in order to use an appropriate approach for the particular patient in the particular situation. The nurse maintains her complementary position working with the patient moment-by-moment by imparting her compassionate intention, physical energy and spending time with the patient, with the awareness of preventing over-emotional involvement.

The process of caring is continually moving forward. At any moment of the interactions, both the nurse and the patient realise their intersubjective connectedness. This is the moment of actualized caring which is relevant to the actual caring occasion of a transpersonal caring relationship proposed by Watson's nursing theory of Human caring (1985). The actualized caring moment, which is dynamically changing occurs within the wholeness of the three components converging together. The diagram representing the theoretical model is illustrated in Figure 1.

The actualized caring moment does not occur in a regular pattern of the nurse-patient interaction. It may occur once or more in an episode of a nurse-patient encounter, or it may occur only once in many episodes of the nurse-patient encounter. However, once it occurs there is a likelihood that it will reoccur. A diagram showing caring moments in an ongoing process is presented in Figure 2. The definition of the developed concepts and subconcepts of the theoretical framework is explained in the following pages.

THE PRECONDITIONS

The concept of precondition is defined as the antecedent required for the caring process to occur. The nurse brings the qualities to enable her to be caring, and the patient brings the expectation of being cared for into the situation. Two subconcepts explain the preconditions.

The nurse: personally and professionally prepared to care. A nurse personally and professionally prepared to care is described as possessing the qualities to be caring. These are benevolence, commitment, and clinical competency. These developed concepts were generated from the data as demonstrated in chapter 4.

Benevolence is defined as the nurse's wish to do good in assisting the patient by imparting from oneself the qualities of compassion and helpfulness towards mankind. The nurse values and desires to help other human beings who are in trouble or in need of help. These personal qualities come from her beliefs, values, and life experience.

Commitment is defined as the affirmation of an individual nurse to put a human care value into her professional practice, as human care is a professional value and moral obligation.

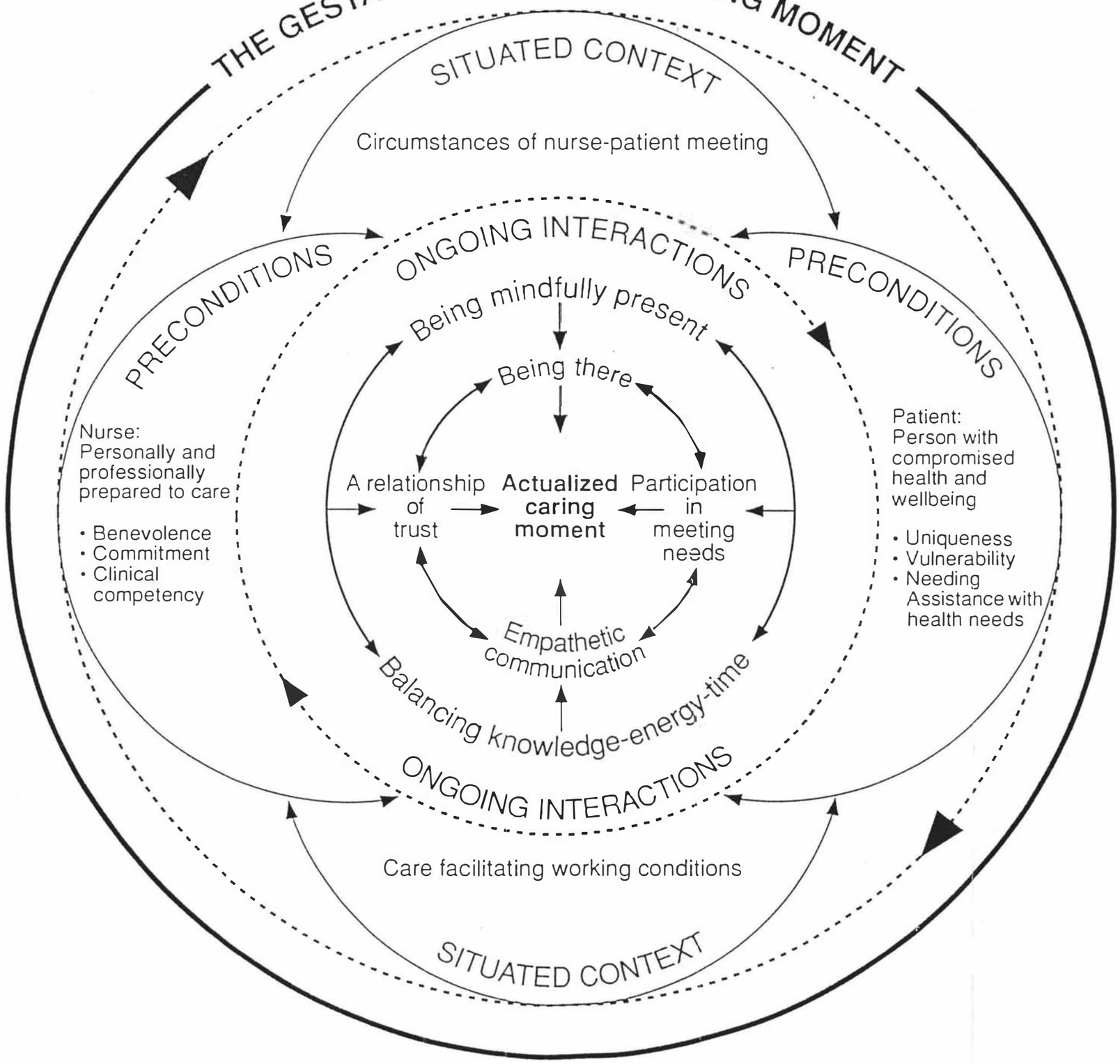

FIGURE 1 THE GESTALT ACTUALIZED CARING MOMENT: A CONCEPTUAL MODEL OF THE NURSE CARING PROCESS

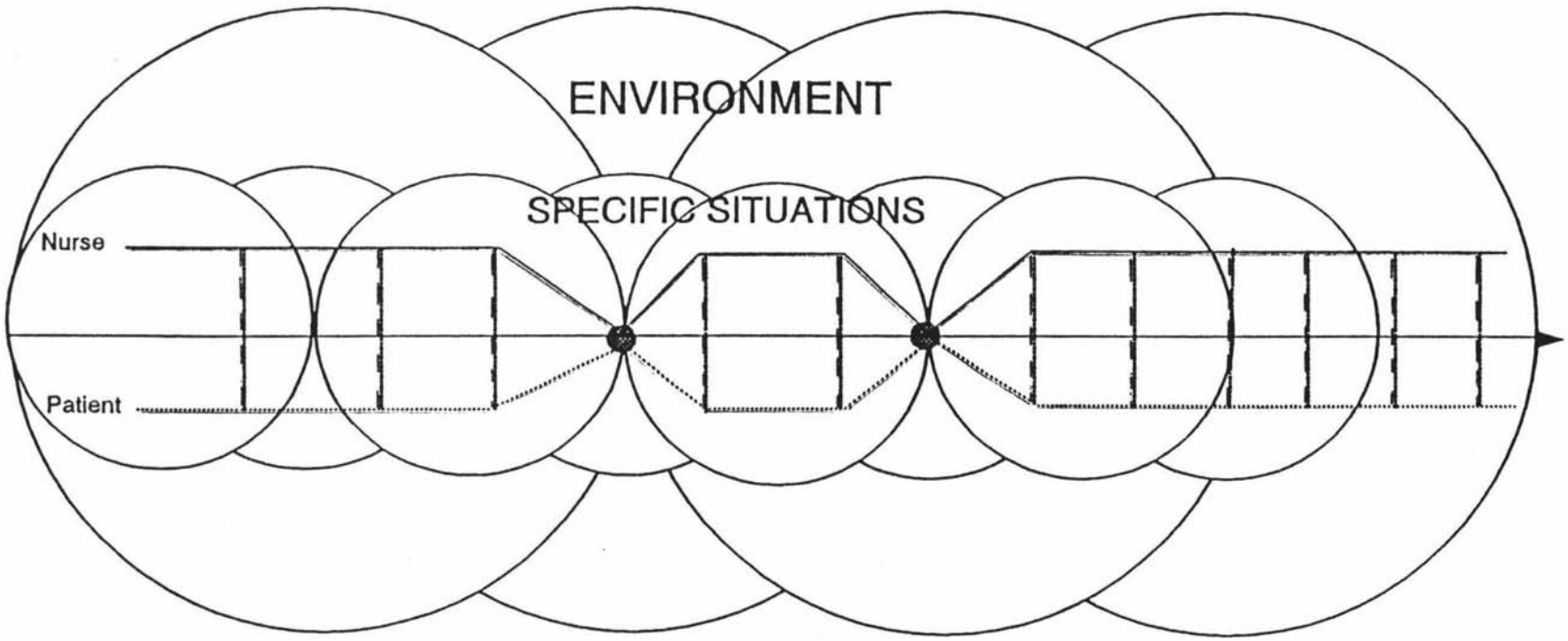

FIGURE 2 CARING MOMENTS WITHIN ONGOING PROCESS

Clinical competency is the ability of the nurse to integrate various kinds of knowledge, then apply the knowledge in her practice with skilled performance. To be able to care for the patient with particular health-related problems, the nurse must have experience in clinical practice in that area for a period of time sufficient for her to develop clinical knowledge and technical skills.

Patient: person with compromised health and well-being is defined as a person whose health and wellbeing are threatened so that he/she is in need of assistance from nurses. Three concepts are explained in this definition of the patient: uniqueness, vulnerability, and needing assistance. These developed concepts are generated from the data demonstrated in chapter 4.

Uniqueness is defined as the whole being of a person - physical, psychosocial, cultural, and spiritual aspects. This whole being cannot be divided into parts or reduced to an object.

Vulnerability is defined as the state of a person exposed to danger or liable to be hurt. Patients with cancer are vulnerable because they experience an interruption in their wellbeing. They perceive the disease as life-threatening in an uncertain situation which erodes, to some degree, their self-comprehension, self-control, and capacity for self-help. There are three subconcepts explaining vulnerability.

Experiencing a life crisis: When the patients are first told that they have cancer, they are in a state of psychological shock. The whole person responds to the perception of their life being threatened. If the disease continues to progress and the medical treatment fails to control it, the person/family face the crisis of dying.

Facing uncertainty: Due to the progressive nature of the disease and the differing response of each patient to medical treatment, a prognosis is made difficult. Therefore the patient always fears the unknown future.

Being in a state of dis-ease or distress: During the moment to moment experience of illness or when undergoing medical treatment, the patient experiences a period of dis-ease or distress situations. These situations are constantly changing.

Needing assistance is defined as the patient needing assistance from the nurse to satisfy his/her situational needs perceived by both the nurse and the patient. These needs include all aspects - physical, psychosocial, and psychospiritual which are dynamically changing due to changes in the response to illness and medical treatment.

THE ONGOING INTERACTION

Ongoing interaction represents the continuous interactive process of an interpersonal helping relationship between The nurse and The patient. The nurse translates her human care values and knowledge into the action of helping the patient to achieve situational health needs.

There are seven separate but interrelated concepts explaining The ongoing interaction: Being there; A relationship of trust; Participation in meeting needs; Empathetic communication; Balancing knowledge-energy-time; Being mindfully present; and Actualized caring moment. These developed concepts are indicated by the data demonstrated in Chapters 5 and 6.

Being there is defined as the nurse making herself available to respond promptly to the patient's needs. There are two aspects of the nurse being there.

Physical presence is identified as the nurse being physically present with the patient to respond to the patient's needs either face to face or by phone contact.

Being available is described as when the nurse makes herself available to be contacted by the patient when needed or wanted.

A relationship of trust is represented as the nurse and the patient engaging in a relationship building on trust. The patient due to limitations of self-knowledge and self-help needs assistance from a professional nurse. The patient is ready to trust in professional knowledge and the nurse seeks to establish interpersonal trust. The nurse opens herself and allows herself to come close to the patient, respecting the patient as a uniquely valued person with dignity. The nurse shows her genuine willingness, attention, and her competence in knowledge and skill to help the patient. Therefore mutual trust is developed.

Participation in meeting needs is defined as knowledge and experience shared between nurse and patient. Both the patient and the nurse work together discovering and setting goals to achieve the patient's needs. In any situation of nurse-patient contact, the nurse uses her specialised knowledge to identify all kinds of patient needs - physical, psychosocial or psychospiritual - and with the patient's participation to meet these needs at that time. The nurse gives the the patient control and choice, and endeavours with the patient to meet those needs. Six subconcepts were identified to explain the theoretical construct of participation: sharing information; helping; being an advocate; negotiating; and teaching and learning.

Sharing information: The nurse and the patient share their own knowledge and experience in order to identify problems and needs.

Helping: The nurse responds to the patients' needs by either assisting them to do something, or doing it for them if they are unable to do it. On the basis of the agreement between the nurse and the patient, help can be given and received.

Being an advocate: The nurse acts as a support person or an intermediary in situations where the patients are unable to act for themselve.

Negotiating: In a situation when the patient and the nurse do not agree, both negotiate a compromise or mutually acceptable solution.

Teaching and learning: The nurse uses the process of teaching and learning to convey the specialised knowledge the patients lack in order to help them meet specific needs.

Empathetic communication is defined as the nurse conveying caring through the congruency of verbal and nonverbal behaviour to the patient. It is human-to-human contact between nurse and patient via touching: physical touch through body contact; emotional touch through eye contact and facial expression; verbal touch; and other body language. Three patterns were identified to demonstrate verbal/nonverbal communication: facing, listening, and engaging in dialogue.

Balancing knowledge-energy-time: is defined as the nurse exhibiting four modes of knowledge: ethical, personal, empirical, and esthetic, to maintain complementary working with the patient to gain harmony in a dynamic changing situation.

There are nine subconcepts which explain the concept of balancing knowledge-energy-time: assessing-interpreting; priority setting; anticipating; maintaining dynamic complementarity; consulting; episodic continuity of spending time; and conserving-replenishing energy.

Assessing-interpreting: A cognitive process in which the nurse uses her intellectual skills and nursing knowledge to identify the patient's problems and needs by observing, monitoring, analysing, translating, synthesising, and making decisions.

Priority setting: The nurse compares and orders the patient's problems and needs based on the criteria of survival, safety, and welfare of the patient, and the nurse acts on the most important first.

Anticipating: With her knowledge and experience the nurse knows what is likely to happen to the patient. Therefore she prepares for what will probably need to be done.

Maintaining dynamic complementarity: The nurse takes actions to assist the patients in meeting their needs and evaluates whether these needs are achieved by incorporating her compassionate intention, technical procedures and tasks in a synchronizing performance with the patients on a moment to moment basis.

Consulting: In some situations the nurse acknowledges her skills and knowledge limitations in helping the patients and therefore seeks help from other resources such as the Charge nurse.

Episodic continuity of spending time: The nurse expends an appropriate amount of time in establishing a trusting relationship with the patient as well as identifying and meeting the patients' needs in an irregular although continuing pattern.

Conserving-replenishing energy: The nurse expends energy in assisting the patients to meet their needs in the most effective ways. The nurse replaces this energy

utilisation by taking a time break during the work period; carrying out self care in everyday living; and being supported by colleagues.

Being mindfully present: This represents the nurse's constant awareness of her thoughts, feelings and actions when being involved with the patients in any situation. Three subconcepts were identified to explain the concept of being mindfully present: concern, awareness, and attentiveness.

Concern: The nurse places herself in the patient's situation. She empathises with the patient and is concerned for the patient's welfare and dignity.

Awareness: The nurse is conscious of her own feelings, thoughts, and actions in helping the patient as well as the patient's feelings, thoughts, and actions.

Attentiveness: The nurse focuses her attention on the patient and the patient's surroundings.

Actualized caring moment is defined as a point in time when the nurse and patient know and realise the giving and receiving of caring. They share warm feelings, a positive regard, satisfaction, achievement at participating in meeting the patient's needs or coping with sadness. It is an intersubjective connectedness between the nurse and the patient of their best as human beings in the situation. This moment is a moment of transforming healing and growing. Five subconcepts were identified to explain the concept of actualized caring: reciprocity; empowering; healing; self growth; and developing experiential knowledge.

Reciprocity/transaction is defined as the exchange of warm feelings, positive regard, and satisfaction experienced by both nurse and patient.

Empowering is described as the nurse recognising her power in using herself in a therapeutic manner for the patient, with the patient also recognising and gaining strength from this.

Self growth is described as an increased understanding in knowledge of oneself in the situation as a human being.

Healing is described as the patient perceiving some improvement or relief from disease or distress, and gaining physical or psychospiritual comfort and the potential strength to survive the ordeal of living with his/her illness.

Developing experiential knowledge: This occurs for both nurse and patient. The nurse gains more knowledge about and of the patient, and an understanding of how best to assist the patient. The patient gains from the specialised knowledge provided by the nurse.

THE SITUATED CONTEXT

The situated context describes the conditions of nurse and patient in their contact at a specific time and place. Two concepts were identified to explain the situated context: circumstance of the nurse-patient contact; and care-facilitating working conditions.

Circumstances of the nurse-patient contact: This encompasses situations of nurse-patient contact, for instance, a nurse admitting a patient, or a nurse giving chemotherapy. Two patterns were identified to explain the conditions of the nurse-patient meetings: planned meetings and unplanned meetings.

Planned meeting: Consistent with medical protocol, the nurse plans actions to assist the patient to meet needs.

Unplanned meeting: The patient's problems and needs are continually changing. Treatment protocols, therefore, must change according to the patient's condition. The nurse attends to both the patient's response to illness and medical treatment moment-by-moment. Unplanned meetings which require immediate actions are constantly occurring.

Care-facilitating working conditions: This represents the environment in the health care service which allows nurses to practice caring. Four components were identified: private space; valuing continuity of patient-centred care; supportive collaboration; and continuing clinical teaching and learning.

Private space is described as the space in the health care setting which the nurse and the patient require for their meeting in order to give and receive care.

Valuing continuity of patient-centred care is explained as the values underlying the nursing care delivery system which places emphasis on the continuity of one nurse providing care for patients as a whole person.

Supportive collaboration is described as assistive cooperation among staff members in a nursing unit which allows nurses to balance knowledge, energy, and time in providing care for the patients.

Continuing clinical teaching and learning is explained as the assistive sharing of knowledge and experience among nursing staff members by formal/informal teaching and learning in everyday practice.

THEORETICAL STATEMENTS DEFINING CARING IN NURSING PRACTICE

A summary of the partial theoretical description of the characteristics of caring nursing practice which emerged from the study is proposed in the following statements.

> Caring nursing practice is a situational-specific dynamic process which is actualized by the nurse and the patient who engage in the helping relationship.
>
> Caring nursing practice is a series of actualized caring moments occurring within a gestalt configuration of three main components: the caring preconditions, the actual caring process, and the caring situational context.
>
> The caring preconditions are the prerequisite for the caring process. These are the nurse's capacities or qualities of caring, that of human care, value and knowledge, and the patient with a specific health-related problem who is requiring assistance.
>
> The actual caring process is the continuity of the interactive process between nurse and patient. The nurse translates caring into an action of helping the patient with the patient's

participation in the care. Both the nurse and the patient realise their intersubjective connectedness at a given point in time.

The situated context is the circumstance of the nurse and patient meeting at a specific time and place in an environment which allows the nurse to practice caring.

The actual caring process in nursing practice consists of six caring elements: being mindfully present; balancing knowledge-energy-time; being there; a relationship of trust; participation in meeting needs; and empathetic communication.

The actualized caring moment occurs briefly at a given point in time and place of the nurse-patient transpersonal lived experience. It brings a positive outcome for both the nurse and the patient - growth for both, and potential healing for the patient. It may occur once only, or at many points in the interactions. Sometimes the circumstances may be such that it does not occur at all.

SUMMARY

In this chapter the presentation has been centred around the integration and explanation of the theoretical framework. The generated categories with their theoretical constructs were compared to identify the core categories. Two existing theories of transpersonal human caring and the gestalt theory were used to support the emerging theory of "The Gestalt Actualized Caring Moment". The integrated theoretical framework was presented in diagrammatic form and the emerging theory was then explained. Theoretical statements defining caring in nursing practice were proposed.

In Chapter 9, emerged supplementary findings - obstacles to the occurrence of the caring process will be presented.

CHAPTER 9

SUPPLEMENTARY FINDINGS:

OBSTACLES TO THE OCCURRENCE OF THE CARING PROCESS

In this chapter the account moves to supplementary findings which emerged from the study. There were several other themes which, although they were not incorporated into the model, actually support it, albeit in a negative way. Three major factors were identified as inhibiting to the occurrence of the caring process.

OBSTACLES TO THE CARING PROCESS

In the previous chapters (chapters 4-8) it was demonstrated that the caring process occurs from the continuous interactive process between the nurse and the patient in a specific situation which brings about the integration of caring components: the preconditions, the ongoing interaction, and the situated context. However, in the real world of everyday practice, the reverse side of caring also exists as there are factors obstructing the occurrence of the caring process. In this study three sets of factors were identified as obstacles to the occurrence of the caring process: nurse limitations with respect to caring qualities; unreceptive patients; and a care-inhibiting environment.

Nurse limitations with respect to caring qualities

Nurses who do not value human care, and have inadequate nursing knowledge and clinical competency are ill-equipped to initiate the occurrence of the caring process. As a result of inadequacies in caring qualities or capacities nurses can only provide nursing care of limited effectiveness.

Most of the patient and nurse participants in this study indicate that there were a few nurses who lacked caring qualities, and the patients described these as nurses who were "just doing a job". For example:

> You know when you come across an odd nurse. **She is not meant to be a nurse, she just comes to do her job.**
> (Patient Ju, Interview No. 1)

In the first interview with Patient Bb, she explained that most nurses she has had experience with are caring nurses. But one or two lacked caring qualities.

> **There is one or two that shouldn't be in the profession that you come across.**
> (Patient Bb, Interview No. 1)

In providing care, nurses have nursing tasks and nursing procedures to perform, for instance, making beds, recording intake/output, monitoring intravenous fluid, wound dressing. A nurse who has limited caring qualities gives her attention to the tasks she is performing rather than adopting a patient-centered focus and integrating her attention to the patient and the task in a synchronised way.

Although the nurse performs her task completely and competently, the patient does not have a feeling of being cared for as a person. The following excerpts express this lack.

> **She was not interested in me, but her job.** She was very competent ... she explained things to me ... it's quite a cold feeling.
> (Patient P, Interview No. 1)

.....

> These days some nurses enjoy doing technical work more than looking after the patients.
> (Patient A, Interview No. 2)

.....

> Some girls, their very nature is not really making them suitable nurses because **they like to be more interested in technical things rather than the caring side of it.**
> (Patient D, Interview No. 1)

A female patient explained her experience with a nurse whom she did not feel cared for her as a person.

> There was just one woman during the day time, that was rather brusque. She was the old type nurse ... she would have been well into her fifties ... had been brought up where the patient doesn't ask questions. The patient does as they're told, but on the other hand she was very efficient. So you could say that what she didn't have in one area she had highly developed in another area.
> (Patient R, Interview No. 1)

Nursing practice is always dealing with an immediate changing situation. When nurses are not fully aware of themselves being involved with the patients, they cannot get into the patients' perception of immediate situations. As a result they cannot meet the patients' needs or assist the patients to solve problems.

The nurse and patient participants perceive that the nurse who cannot empathise with the patient, and is not sensitive to the patient's needs, cannot convey genuine caring to the patients. In the following excerpt a woman describes her experience of not being cared for by a nurse because that nurse left her in pain.

> When I had my spleen out I was in ward X. The nurse that looked after me there wasn't caring. She didn't, I was in a lot of pain, and she didn't do anything about it. **She didn't make me more comfortable and she was very unsympathetic, actually I nicknamed her Atilla the Hun in the end! But that's unfortunate.**
> (Patient Bb, Interview No. 1)

The same patient also explains her experience in the hospital with a noncaring nurse.

> I've had bad, some bad experiences. One was when I was very ill, I'd had an infection and I was on chemotherapy and I was very weak. I had a really bad infection. I had a high temperature, you name it, I had it and one of the nurses put me in the bath and went away and left me and I was there for a couple of hours, and I rang and rang and I was angry, because I couldn't get out of it. But anyway somebody else came along and fixed me up and that was the first bad experience I'd ever had and that was about the first year that I was in the hospital. So I made a point of never being in that situation again where I couldn't get out by myself. I lost a bit of trust then.

Another female patient described her experience of not being cared for in the hospital because the nurse could not understand her situation and her feelings.

> I had a big abdominal surgery ... I felt sick and vomited, I needed a tissue but it was moved and I couldn't get it. One day they asked to do my bed and I was up half way out of the bed, then she told me that she would like to look at my abdominal wound. "Can you imagine how I felt?" I think little things are important to show caring.
> (Patient M, Interview No. 1)

.....

In assisting the patient to meet needs or solve their problems, nurses need to be confident in technical knowledge and perform procedures competently in everyday practice. However, a nurse who has practiced in a specific area of nursing for only a short period of time cannot be confident in technical knowledge. When she provides nursing care, her attention is focused on the technical procedure she is performing rather than on the patient. She, therefore, cannot comprehend the patient's immediate situation, and cannot reach out to the patient's feelings.

In the following excerpts a female patient describes how she feels not cared for by a nurse because that nurse is not competent in a technical procedure.

> To be honest **I had a nurse do it this morning who wasn't used to working on this ward at all and she was apprehensive and actually asking me and I wasn't quite sure so I said "Oh, you'd better go and ask the other nurses about the procedure". I'm used to the competent ones, and they've been up here for ages and they're just zing zing straight through it.**
> (Patient H, Interview No. 1)

.....

> You don't feel safe if the nurse is not quite sure about what she is doing.
> (Patient D, Interview No.1)

.....

Nurses and patients mention a range of nurse behaviours that convey noncaring as shown by examples in Table 20.

This section has illustrated the factors of the nurse that obstruct the caring process. The nurse who has limitations in caring qualities - benevolence, commitment, and clinical competency - is not ready to care for patients. There is an absence of caring preconditions, on the part of the nurse, to initiate the actual caring process. The interaction between the nurse and the patient occurs without the actualized caring moment. The nurse with limitations of caring qualities can only perform tasks, but cannot transform herself as a therapeutic effect for the patients.

Table 20

Nurse Noncaring Behaviours and Activities

Nurse noncaring behaviours and activities
Verbal
Speaking with a sharp voice
Speaking in a way that reduced the patient's dignity
Speaking in a judgmental way to a patient
Speaking without attention in conversation with the patient
Nonverbal
Express unwillingness to help the patient via facial expression
Busy-hurried walking, though there is no emergency situation
Hurrying to get the job done
Bustling in and bustling out
Not attentive in listening to what the patient is asking/saying
Technical
Perform technical procedures in an incorrect way
Perform technical procedures in a clumsy way
Give the patient wrong information
Unsure in explaining technical knowledge to the patient
Not being gentle in performing a painful procedure
Handling the patient unwillingly, mechanically, and roughly leaving the patient in discomfort/pain

Unreceptive patient

Nurses have difficulty initiating the caring process for patients who do not value caring and are not ready to trust the nurse as a professional person. Nurses described their experiences in providing care for various types of patients. They label one group of patients as "difficult patients". This group of patients does not work with the nurses.

> **With some patients I sometimes feel like ripping my hair out and I can't give them the care that they need, because they, it gets to the stage when they're very difficult to look after and I couldn't look after them for more than one day, or I'd just be tearing my hair out.** You know yourself that while you're looking after her that you know, that sometimes even though you're doing, often you're doing the same cares, like your basic cares like get them washed, get their drugs, you're answering their questions but there would be another patient in another room you would be going about it differently, **so there's cares as actions but there's not actually caring behind it, like in the same sense of caring and nurturing.**
> (Nurse C1, Interview No. 1)

.....

> **A very, very difficult patient.** I know we're not meant to classify patients like that, but if you said black was black, she'd say it was white and nothing you could do for her was right. She seems hard to look after.
> (Nurse J1, Interview No. 2)

.....

Some patients also perceived that patients could make it difficult for nurses to show caring.

> Sometimes when you're a patient **you can sometimes feel that another patient is being difficult, you feel sorry for the nurse really.**
> (Patient H1, Interview No. 1)

.....

> Some patients give them hard times. **I was amazed when I saw one man actually slap a nurse, she never turned a hair. She still went back to him.**
> (Patient Ba, Interview No. 3)

As both patients and nurses noted that there are some patients who do not value caring from nurses, perceiving nurse caring as just a job that nurses must do for them. They do not appreciate assistance from nurses.

> **People sometimes take nurses for granted, you know, they are only human ... I think if the patient is nice to the nurse, then, you get that reciprocal, um, because some of the time people do expect too much from the nurse.**
> (Patient H1, Interview No. 1)

.....

> People don't actually know what nurses do ... they think nurses are doctor's assistant. **When they come to the hospital they expect that nurses will do everything for them.**
> (Nurse K1, Interview No. 1)

.....

> Some patients never say thank you for what you have done for them. I think they might not experience being cared for by their family. Some have a hard time in life.
> (Nurse D, Interview No. 2)

.....

> **A man who is always grasping us. "Come here nurse ... do this ... do that." He's a very demanding patient. Sometimes grasps our dress ... spits on the floor ... sort of thing.** We hate him. We do what we've got to do with him and that's it ... we walk out.
> (Nurse J1, Interview No. 2)

.....

> The main obstacles are when I think the patient could do more for themselves. If I'm not busy then I allow them to run all over me and I'll fetch and carry. That's one of the greatest obstacles. It doesn't stop me from doing things for them, but it stops me from feeling for them. **My feelings are not in what I'm doing. I'm just doing it because it's a job mechanically ... it is not caring. Caring is warmth ...warm feeling.**
> (Nurse T, Interview No. 2)

.....

As caring is a mutual human process, patient factors are also important for the occurrence of the caring process. This section shows that it is difficult for nurses to

develop a caring moment with a patient who is unreceptive though the nurse is ready to impart her caring qualities. The nurse perceives four types of patient responses that make it difficult for them to develop the caring process: aggressive; demanding; constantly grumpy; devaluing caring.

Care-inhibiting environment

In the real world of everyday nursing practice there are two sets of environmental factors affecting caring practice. These can be summarised as a care promoting environment and a care inhibiting environment. The care promoting environment is made up of a situated context which allows nurses to initiate the caring process.

On the other hand, the care-inhibiting environment prevents nurses from the practice of caring, though the nurses are ready to impart their caring values and knowledge to assist the patients. Six factors were identified from the present study as care inhibiting: heavy workload; limited collegial collaboration; knowledge gaps and inadequacies related to caring practice; limited autonomy; limited facilities; and everyday work stress. To a considerable extent they represent the reverse or lack of facilitating factors described in chapter seven.

Heavy workload

When the amount of work assigned to an individual nurse in a limited time becomes a heavy workload, she cannot meet the patient's needs in an effective way. All nurse and patient participants in this study indicated that "To be a nurse is not an easy job. Nurses have too much work to do, but low pay". The present study took place during reconstruction of the health care delivery system which faces budget cuts. Nurses had to face staff shortage problems. Both nurse and patient participants perceive that "overworked" appeared to be the major obstacle for caring practice.

> **In New Zealand with the government having to cut costs in health,** it has been noticeable that perhaps with that, they're not replacing the nursing staff, so **the nursing staff are just going to be that much busier.**
> (Patient H1, Interview No.2)

.....

I've been coming eight years and notice the difference between when I first started coming and what is happening now. They're overworked now and it's a shame and it's not their fault. They are still as caring you know, they've got heaps more patients. It's not fair on them and they need more staff. I feel they are being placed under stress levels that they shouldn't be placed under because they've got so many patients and they do such a demanding job and they always manage to remain cheerful you know. I feel it unfair they don't get the support that they should have.
(Patient H, Interview No. 2)

.....

Nursing practice is always dealing with constanting changing situations as the patients' problems and needs are always changing moment-to-moment. Therefore nurses cannot always plan to do nursing tasks in a certain time. Nurses must be ready to act on immediate situations. When they are overworked it is difficult for them to balance energy and time to meet individual patients' needs. In the following excerpts five patients talk about how overloaded the nurses were and the consequences of this for the patients:

The government is trying to cut back ... say nurses should be more efficient, but with hospitals, you don't know when a person is going to be sick, need care, you can't say to them "Well I can't come back to you until 11 o'clock". You've got to attend to them right there and then. And while you're attending to them you can't attend to somebody else. And you could have somebody just as bad in the next bed. So it's really got, as far as I'm concerned, it's got to an impossible stage for those nurses. I don't know how they stick it.
(Patient B 1, Interview No. 1)

.....

The nurses are very good but they were very overworked. There weren't enough nurses to go around and they couldn't deal individually with the patients.
(Patient B2, Interview No. 1)

.....

I found that the nurses were so busy that they would never get to change the drip*, you know. It would fill up the tube first and they would never, so I got that way, until I

learned it myself, so I controlled the drip myself to save them time and I was doing that for all the time I was there.
(Patient B1, Interview No. 2)

.....

They come rushing in, do half the job, and rush out to see another patient and rush back again. And rushing here and there.
(Patient B, Interview No. 1)

.....

If you needed help they would come, but it was delayed before they came because **they were always tied up, they seem to run that ward very very short staffed.**
(Patient B, Interview No. 2)

.....

In the following excerpts nurses state that when nurses are under the pressure of a heavy workload, they cannot manage to spend the appropriate amount of time for each individual patient. Consequently they miss out some of the patients' needs which they wish to care for.

Sometimes on this ward we can't give all the care we need to give, we miss out on a lot of the emotional side of it because we're running around like a "mad man" trying to do things and sometimes you'd just like to sit down and talk but we haven't got that time.
(Nurse T, Interview No. 2)

.....

Last night with chemotherapy, that second lady that I gave chemotherapy to, it was her first time, and because I was busy I couldn't go and see her before because L (nurse colleague) had to draw it all up. **I introduced myself very quickly but I would have liked to have sat down and had a long talk and say, you know, this is what I'm going to do rather than just bowl in there and give it and as I was giving it I was telling her all about it whereas it should've been before. I know the nurse before did it, I would've liked to have done it, but I just didn't have that time which is sad.**
(Nurse T1, Interview No. 1)

.....

The fact that there's a shortage of staff, I think that stops you from giving a lot of care like actually sitting down and talking with your patients.
(Nurse T, Interview No. 1)

.....

The following description is an example of a nurse's work during a morning shift which lasted from 6.50 A.M. until 3.30 P.M. She dealt with planned and unplanned meetings with the patients, and it was quite a busy day for her which was always happening in most of her work days. She was 30 to 45 minutes late going off duty nearly every day because she could not finish her work in the allocated time. In the interview with her, she said that she felt horrible that she did not have the time to meet the patients' needs. Her nursing work was task oriented, especially in the afternoon. She would like to have been spending time with a newly admitted terminally ill patient, but she could not. The layout of the ward in which this nurse worked is shown in Figure 3.

06.50:	Participated in patient allocation for nurses
07.00:	Participated in hand over from night nurses
07.10:	Finding more information about patients from a day nurse who read report of all patients in detail
07.30:	Prepared the morning medication. First went to Mr H (Room 1), a terminal patient with epidural morphine pain control
07.40:	Went to Room 2 where Mrs B, a female patient, was vomiting.
07.45:	Went to Room 3 to see Mr He, a patient with terminal brain tumour.
08.00:	Came to Mrs B to give injection
08.10:	Checked Mrs B's I.V.
08.15:	Came to help Mr He (Room 3) with breakfast
08.50:	Changed I.V. fluid bag for Mrs B
08.55:	Spent time talking with Mr H (Room 1) and helped him to have a shower and to get dressed.
09.20:	Gave Mr H oral medication
09.30:	Helped Mrs B who has a vomiting problem
09.40:	Came to a patient in Room 4 who has returned from home, and moved her to Room 10
09.50:	Came to talk with Mr H's wife
10.00:	Checked and recorded narcotic drugs with one other nurse.
10.20:	Came to transfer a patient from theatre to Room 5.
10.35:	Break for morning tea.
10.45:	Came to see Mr H
10.50:	Admitted a patient, Mrs E, to stay in Room 4
11.05:	Discussed patient's pain medication with a doctor and the patient's relative
11.20:	Gave oral pain medication
11.30:	Came to Room 2, Mrs B, to check I.V.
12.00:	Break for lunch

12.30: Came to Room 2, Mrs B, to check I.V.
12.35: Checked medication for a polytech nursing student
12.37: Stopped at Room1, talked with Mr H's relatives
12.40: Prepared I.V. for Mrs Th
12.50: Changed the I.V. bag for Mrs Th (Room 11)
12.53: Cleaning C.V. set (Helping other nurse who was busy)
12.55: Gave medication to Mr H
01.10: Took responsibility in caring for Mrs Th whose nurse was away for lunch. Checked her I.V.
01.20: Checked medication for Mr He
01.22: Talked to Mr H's wife
01.28: Came back to give medication to Mr He
01.32: Discussion with the Charge Nurse
01.40: Read a patient's report and discussed with a doctor
01.46: Came to Mrs E (Room 4) to give medication, checked vital signs, helped her to get out of bed to pass urine
02.15: Did urine analysis for Mrs E as a newly admitted patient
02.20: Writing report and progress notes
02.30: Checked Mrs B's I.V. and recorded I/O*
02.32: Gave attention to Room 1
02.38: Came to Mrs E to take history and filled in nurses assessment form
02.40: Giving report to afternoon nurses
02.55: Continued taking history of Mrs E
03.05: Took off Mrs B's I.V. and injected heparine saline.
03.10: Writing progress report for five patients under her care until 3.30 P.M.

(Field notes record. See detailed description in Appendix 10)

In everyday practice, besides a nurse focusing her caring on the individual patient as a person, she is responsible for performing various kinds of tasks which are not directly related to patient care. These tasks are time consuming. Both nurse and patient participants perceive that these tasks are taking away the time for the patients.

> ... there's still all the paperwork the housekeeping type duties that they have to do.
> (Patient H1, Interview No.2)

.....

> ...**these women or men are still expected to clean out the rubbish bins and do non-nursing duties which is stupid. And they're not doing, using their expertise for the patient.** You can get a ward assistant or someone to do those non-nursing duties.
> (Patient B, Interview, No. 3)

.....

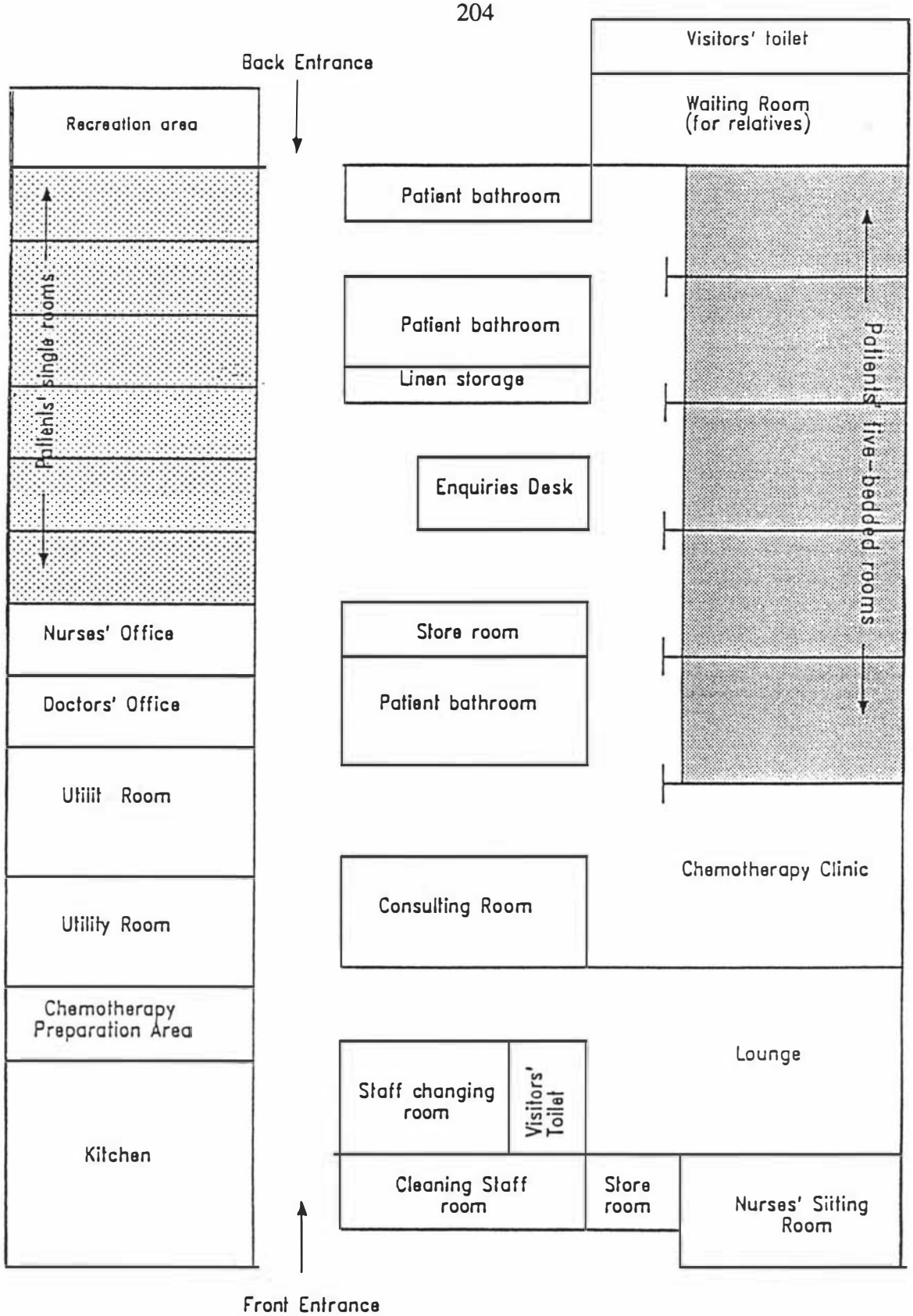

FIGURE 3 LAYOUT OF THE WARD

Making beds, giving out meals, teas, tidying up, just generally tidying the rooms and so on. I mean we have rest from nine to three but the rest of the time we do it, emptying linen bags, rubbish bags, the general just cleaning, I think, you know, keeping stock supplies, ordering stocks and so on, I mean some administration office can do that, **you know ordering and all that jazz, anything that's not a direct interaction with the patient is a non-nursing job and it pushes time away ... //...** The emotional side I think is harder and that is why if we can cut out some of the physical side of things eventually, the non-nursing jobs and things like that then we have a lot more time to work on our skills of looking after them emotionally. I'm not saying that I want someone else to go and wash all my patients because that's a good time for you to talk to them and find out what's going on, I don't want that taken away, **but the non-nursing jobs like meals and cleaning up, things like that. If they were taken away we'd have so much more time to work on the rest.**
(Nurse Ke, Interview No. 2)

.....

We do a lot of task things which are not caring oriented like giving out meals, awful, I don't think nurses should have to, okay you still should be seeing what your patients are eating ... how they are drinking. I do not think the nurses should have to give out the food or morning or afternoon teas, they're there enough to know whether they're having fluids or not. **They should not have to empty rubbish bins or things like that. They should not have to tidy up rooms or things around the place. They should not have to answer phones all day, all night.** These are task oriented things which I think are time consuming. I still believe in total patient care. I wouldn't say that people could come in shower, do those kinds of things, I'd rather do all that, but I certainly do not like doing ordering of stock jobs.
(Nurse C, Interview No. 2)

.....

Limited collegial collaboration

In a nursing unit there are a number of nursing staff: the Charge nurse; staff nurses; enrolled nurses; nurse aides and ward assistants. These staff work as a team to achieve their common goal of providing care to patients. In addition nurses also work in cooperation with other health professionals, such as members of the medical profession. From the present study, some nurses perceived that there is limited support among staff which causes them difficulties in delivering caring practice.

The study revealed that in one nursing unit there was a rapid turnover of staff nurses with new staff continually entering the unit. Each individual staff member struggles to learn new skills to fulfil their responsibilities. Therefore the awareness to help each other was submerged as a staff nurse stated in the following excerpt:

> I think, too, **with the recent changes of staff, having temporaries, we haven't had that support of each other because we've had so many people just learning what's going on, so they can't automatically see "Well, this person's tied up, I'll just go and do such and such with another patient". So once again, everyone's missing out on that caring role, you know, we're not caring for each other.** We have so many new staff.
> (Nurse Su, Interview No. 2)

.....

Some nurses perceive that their colleagues sometimes are not supporting each other, as is revealed in the two statements below.

> ... looking back, I was a staff nurse for three years in an intensive care unit, and I don't think I was ever particularly supportive to other staff nurses who were having difficulties or struggling. If other people are not coping that makes more work for the people who are coping. The system simply isn't structured in a caring way. It starts at the very top. Nurses have never felt in an institution that they are valued or cared for, therefore in some ways they don't reflect that same caring to their own colleagues which is a pity. But I think you could set up all the meetings and all the theories that you like and it wouldn't actually change it. I think the bottom line is that if the nurse said "Look, I've had an accident, it's been an atrocious day and three of my patients have died and I feel absolutely terrible and I'd like to go home an hour earlier. Could you finish off my work?", I very much doubt that the other staff nurse would cheerfully say "That's fine, I quite understand, you go" Would she? And yet ideally that's how we would operate. If we really did care for each other, that's how we would do it. We would be more comfortable with each other's strengths and weaknesses.
> (Nurse Je, Interview No. 1)

.....

> Some are pulling apart ... saying "I've got a bigger list than you and I'm busy."
> (Nurse Ke, Interview No. 2)

.....

Some nurses find that their fellow nurses give negative criticism rather than constructive criticism which make them discouraged in their practice.

> Last year I worked on ... ward. There was just no support, there was backstabbing and cattiness. Staff support is really essential.
> (Nurse Sh, Interview No. 2)

.....

> I don't mind constructive criticisms, and you need to have it because you need to keep updating yourself, you need to know, everyone needs to know and have to work on it but negative reinforcement which happens a lot here, when you only hear about the bad things when you've done something wrong, does not help in your caring at all.
> (Nurse Ke, Interview No. 2)

Knowledge gaps and inadequacies related to caring practice

There is a continuous demand for teaching, learning, and supervision in everyday practice. Nurses need to update knowledge, and new or inexperienced staff need to acquire more knowledge in certain areas. Nurses in this study perceived that gaps in some important types of knowledge needed in practice, such as patient response to illness or medical intervention, cultural value perceptions and practices, interpersonal relationships, are not adequately addressed in the work situation. This limitation is reinforced by the heavy workload which limits time for self reflecting and sharing experiences among staff. In addition in most nursing units, there is limited scope for documenting and researching new clinical knowledge from everyday practice.

> I think there are important areas, **especially with this particular ward, psychosocial areas are very important priorities. And there are no resources to facilitate them. I don't think nurses are well enough equipped to cope with them because we don't get any type of in-service education on this ward in helping people to deal with grief or deal with possible death. We don't get enough in-service education for this particular ward. Just little things that help - how to communicate, and what ways and**

to give you the confidence to know that you're on the right track ... Culture and religion are other things we're not geared into very well which we should be schooled up on better here.
(Nurse Cu, Interview No. 1)

.....

This ward is drug oriented. **We've not got the time to sit and talk to each other sharing our experience. Like I'd like to know what is happening to the patients, are they sick at home. We don't really know while they are at home before the next treatment. I think we need to research things like this, but it is difficult, too much work load. You just work day by day.**
(Nurse Cu, Interview No. 2)

.....

There is not enough on-going education, or the on-going education tends to be specialised very much about disease processes and we don't pay enough attention to people's social atmosphere or being as a person ... how the person experiences being in the hospital. I think more education in that area is needed.
(Nurse R, Interview No. 1)

.....

We never have time out of the ward, like talking to you, I think it is really good and it makes me think back. When I work I just do, and after talking with you I ask myself and think more why I do this and why I do that.
(Nurse B, Interview No. 2)

Limited facilities

The process of caring requires private space for the nurse and the patient in their meetings, and appropriate equipment/material is required for technical procedures. Some nurses perceive that limitation of private physical conditions, necessary equipment and materials are obstacles for their caring practice.

Our physical structure is not good, I think it's still clinical like all hospitals. I'd like to have a much more relaxed atmosphere. I'd love to have single rooms, things like that.
(Nurse C, Interview No. 1)

.....

> Your obstacles as far as everyday things may be that you don't have the equipment. There are so many I.Vs, I think safety is a prime concern.
> (Nurse C, In terview No. 1)

Everyday work stress

Nurses use their intellectual skills and expend a high level of physical and mental energy in caring for the patients. Some conditions of their work environment place them at risk of health hazards, such as nurses who administer chemotherapy drugs. In addition to a heavy work load, these nurses are also at risk of both physical and emotional stress. This is especially true for new nurses who are concurrently learning difficult nursing procedures, familiarising themselves with a new environment, and coping with their emotional responses/reactions to terminally ill patients. Therefore, it is difficult for them to balance their energy levels under stressful working conditions, and this can prevent them from developing caring moments.

All nurse participants state that work stress inhibits their everyday caring practice. In the following three excerpts nurses describe their experience.

> **Sometimes I just go home and I'm really tired, exhausted, and I'll have a good cry or you might ring up a friend and talk about what's happened during the day** or when a patient hasn't done what you would've expected them to do. The treatment hasn't gone to plan and there's nothing you can do to stop it. Say with a chemo, and they've had their anti-emetics and they're still chucking, you just can't do anything, especially if it makes you sick yourself.
> (Nurse Sh, Interview No. 2)

.....

> Coming from polytech I really, in fact I still don't have much knowledge concerning the cancer patient and **when I first came here I really hated it and I was so frightened. It must have taken me four to five months just to settle down. And it was really hard for me to work, my stomach used to be churning all the time, never used to want to come to work. I'd go home and I'd dream about it and I'd wake up in the middle of the night and I couldn't go back to sleep because I was just having nightmares.** But I've settled down a lot.
> (Nurse T, Interview No. 2)

.....

> In the early days I couldn't shut off things from work. It will still all be walking round and round in my mind. **I go home and think "Did I do this, or did I do that". I wouldn't sleep.**
> (Nurse S, Interview No. 1)

.....

Although nurses need to have an altruistic value system as a framework of life, they are human beings who need to maintain their wellbeing by earning an income for their living. The nurse and patient participants in this study perceived that nurses receive an unfairly low salary and that this might have an effect on the satisfaction which nurses gain from professional practice.

> **You work late a lot of times and you're not being paid for it, so they're really making good use of you for nothing.** You're giving a lot of your time for nothing. **One weekend we were working, we had no morning tea and we had five minutes for lunch.**
> (Nurse S, Interview No. 2)

.....

> **A lot of times you'd be very lucky to get off at 11 o' clock. It's terrible being a nurse because when you're not doing anything you feel guilty. When you go off early, you feel guilty. And yet we shouldn't because it equals up the fact that you're flat out and you get off late 9 times out of 10. But because we're nurses, we feel guilty.** And all you're doing is running around for people. You're not sitting down and talking to them and getting to know your patient. It might take a couple of weeks to find out about one person because you're short staffed.
> (Nurse T, Interview No. 3)

.....

> I often tell them I don't need much attention. They apologise if they haven't been to see me because I know what it's like, get busy. **One nurse had to work two hours over, extend her shift but was not paid, isn't it awful? She is still cheerful and is a lovely person.**
> (Patient H, Interview No. 2)

.....

> Another thing that I've noticed ... **nurses aren't paid any extra for the extra qualifications they get. It's not recognised in the hospital system,** which is bad and yet these women or men are still expected to clean out the rubbish

bins and do non-nursing duties which is stupid. And they're not doing, using their expertise for the patient. You can get a ward assistant or someone to do those non-nursing duties.
(Patient B, Interview, No. 3)

Limited autonomy

Nurses are independent professionals working in association with other health professionals, in particular with medical professionals. However, when the medical professionals do not perceive nurses work as being of equal value, it is difficult for nurses to work independently. Both nurse and patient participants perceive that limiting autonomy prevents nurses from achieving caring practice, especially, in the institutions.

Actually this morning I was very rude. I got quite angry with Dr.. because when she gives you something to do she wants it done now. Yesterday while I was giving Mrs T a shower, she stopped me and said Mrs D needed a drip and I said "O.K. I 'll finish Mrs T and then I'll put it up". "No!" she said. I was angry and walked away.
(Nurse T, Interview No. 2)

.....

We're so drug-oriented that our schedule runs to drugs rather than to people. Once again getting back to the chemotherapy thing, if you had pharmacy staff coming in preparing the drugs at least it would give us more time for the patients.
(Nurse S, Interview No. 1)

.....

... the staff seem to be moving very briskly to undertake patient care to meet directions given by medical staff, such as intravenous therapy, antibiotic management. The nurses are always in a hurry to meet that aspect of care. I know that the nurses would actually like to spend more time with the patient, just talking because the patients need to express their feelings, need to know more about the chemotherapy protocols that they're having. It's very hard for the nurses to give them all the information.
(Nurse K1, Interview No. 1)

.....

District nurses are marvellous, very caring. They work independently, managing things, they don't have to follow routine like in here. They do have certain things to do but it's different from nurses working in the hospitals. They are very busy in here, they have a lot of routines to do, follow what the doctors want. Most of the time they cannot do what they want

> to do for their patients. It is very hard for them, very difficult job. I don't like being in the hospital.
> (Patient G, Interview No. 1)

SUMMARY

Three major factors identified as obstacles to the occurrence of the caring process were discussed in this chapter with supporting data. Nurse limitations with respect to caring qualities and unreceptive patients were two of the factors. The third main factor preventing nurses from the practice of caring was the care-inhibiting environment, and this has been subdivided into: heavy workload; limited collegial collaboration; knowledge gap and inadequacies related to caring practice; limited facilities; everyday work stress; and limited autonomy.

In Chapter 10, the outcome of the research will be discussed in relation to existing literature. Limitations of the study, and implications for practice, education and research will also be presented.

CHAPTER 10

DISCUSSION AND CONCLUSION

In this final chapter of the thesis there is firstly an overview of the findings, then the research outcome is discussed in relation to existing literature. Following that implications for nursing practice and education are presented. Limitations of the study are indicated and directions for further research are recommended, and the chapter concludes with a brief summary statement.

THE RESEARCH OUTCOME

The present study examined the phenomenon of caring in everyday nursing practice with the aim of elucidating the invisible aspects which characterize nursing. The question was posed - What is the process of caring experienced by patients with cancer and nurses who care for them? The phenomenological approach used in the study has enabled a rich description of the lived experience of the nurse caring for the patient and the patient's lived experience of being cared for. The grounded theory strategy has provided a fresh perspective in theorizing the human experience of caring - "grounded theory focuses on the discovery and generation of parsimonious theory to describe a substantive area of human experience" (Haberman and Lewis, 1990, p. 80).

The nurse's and the patient's lived experience of caring and being cared for is theorized as **"the actualized caring moment"** which is conceptualised as a gestalt configuration, and as such provides a partial explanation of how the process of caring occurs in nursing practice. The nurse and the patient engaging in the caring relationship recognise true caring as it occurs in the continuous interactive process. There is a moment-by-moment interpersonal helping relationship in a specific situation. The actualized caring moment is a gestalt configuration of three main caring components: the preconditions, the actual caring process, and the situational context.

Caring preconditions

The elements of the caring preconditions which are prerequisites to the actual caring process are associated with the nurse who is caring, and the patient who is being cared for. The nurse has within herself the capacities for caring which are a combination of

benevolence, commitment and clinical competency. The person who is the patient has compromised health, and therefore has the potential to be assisted by the nurse in regaining wellbeing.

The actual caring process

The actual caring process in nursing practice brings together six caring elements for the nurse. These are: being mindfully present; being there; a relationship of trust; participation in meeting needs; balancing knowledge-energy-time; and empathetic communication. They are interdependent and interrelated in a cohesive whole pattern to achieve the actualized caring moment.

The actual caring occurs in the following manner: The interaction between the nurse and the patient begins when the nurse who is ready to care, and the patient who is in need of care, meet in a specific situation. The nurse then translates her qualities of caring into the action of helping the patient to meet health needs by the nurse **being mindfully present** to **be there** with the patient. That is to say, she is aware of deliberately putting into action her compassionate intention and her knowledge, energy, and time for the patient. She focuses her attention on the patient. The nurse and the patient develop **a relationship of trust** and actively **co-participate in meeting the patient's needs.** In doing so the nurse uses the appropriate knowledge, energy and time for the particular patient at that particular time. That is to say the nurse continues **balancing knowledge-energy-time** in her moment-by-moment presence with the patient. The nurse expresses her caring through **empathetic communication** which can include a variety of activities and behaviours. Within the continuity of the interactive process, the nurse and the patient realise the moment of their intersubjective connection as human beings, and this initiates potential healing to the patient and growth for both the nurse and the patient. This is the peak intensity of the nurse-patient interaction - **the actualized caring moment.**

The caring context

The actual caring explained above is not suspended in a vacuum. It occurs in a specific situation which is comprised of the circumstances of the nurse-patient meeting and care-facilitating working conditions. The circumstances of the nurse-patient meeting allow

the interaction to occur while the care-facilitating working conditions allow both the nurse and the patient to develop a caring relationship. In particular, the care-facilitating working conditions are important for the nurse to enable her to balance knowledge, energy, and time.

Once the actualized caring moment has occured there is a greater likelihood that such moments will occur again as the nurse and patient have been sensitized by the experience. The degree to which caring preconditions are present also increase readiness for emergence of the actual caring process, given that the context is favourable to caring.

RELEVANCE OF THE RESEARCH OUTCOME TO EXISTING CARING AND NURSING LITERATURE

The grounded theory of the **gestalt actualized caring moment** is developed from the nursing data. It includes both the more and the less visible aspects of caring nursing practice, particularly the latter. It clearly captures what is actually happening when the nurse and the patient engage in the caring relationship as it explains how nurses care for the patients in everyday nursing practice. The essence of such caring has not been clearly demonstrated in the existing nursing literature.

However some of the findings of this study validate, and are relevant to, existing nursing literature. Some of the findings are also relevant to the existing literature in other disciplines.

In the discipline of philosophy, the general meaning of caring provided by Mayeroff (1971) supports the emerged meaning from the present study as reviewed in chapter two - caring is a process of helping another grow and actualize. Some of the caring elements from the present study are similar to Mayeroff's ingredients of caring: "knowledge, trust, and alternating rhythms". The nurse must have knowledge about the person she is caring for, and she develops a relationship of trust with her patient. The concept of "Maintaining dynamic complementarity" from the present study is described as the nurse performing actions to help the patient to achieve needs, and evaluating whether the needs are achieved. If not, the nurse develops new approaches. This is similar to the meaning of Mayeroff's alternating rhythms.

Caring in nursing commences when the nurse and the patient meet in a helping relationship as human to human. The nurse does not reduce the patient to an object. This supports Buber's meaning of care as a sense of concern for others, and a fundamental form of man to man entering into a relationship which is expressed as "I-Thou", not "I-It". Nodding's theory of caring states that caring relationships between human beings involve three parts: the first person condition or the one caring; the second person condition or the one cared-for; and the third person dimension or the third aspect of caring which can be observed. However, observable action alone can not determine whether or not one is truly caring for the other. The preconditions - the nurse caring and the patient cared-for - in the present study are similar to Nodding's caring relationship between the first person condition and the second person condition. Nodding also states that commitment and a continued interest in the person being cared for, are the essential elements of caring which is supported in the present study.

Marcel (1981) presented the view that "existential presence" is a framework of the caring relationship. The concepts of "being there" and "being mindfully present" from the present study provide a similar meaning to Marcel's idea.

In psychotherapy, Carl Rogers (1958) showed that empathy is a component of care, which is related to the finding in the present study that the nurse has the ability to perceive the patient's personal inner world and communicates this understanding through verbal and nonverbal means.

From the nursing discipline, the most closely related is the existing nursing theory of human caring (Watson, 1985). The actualized caring moment is relevant to an actual caring occasion of transpersonal human caring proposed by Watson. Watson's theory is highly abstract as it developed from philosophical analysis. It is a grand theory of human caring which prompts and stimulates further investigation and development. The grounded theory of the Gestalt Actualized Caring Moment is less abstract than Watson's theory as it is grounded in data. It is a mid-range theory developed from practice (Bottorff, 1991). Indeend, the Gestalt Actualized Caring Moment corroborates Watson's theory of transpersonal human caring and it further clarifies how the actual caring occasion occurs in the real world of nursing practice. It clearly demonstrates that caring is actualized by the nurse and the patient who engage in the helping relationship. This occurs moment-by-moment in their interaction. In nursing practice, the actualized caring moment occurs as a gestalt configuration of caring components - the

preconditions, the actual process, and the context. The occurrence of the caring moment requires not only a good interpersonal relationship between the nurse and the patient, but also an environment which allows the nurse to impart her caring qualities. In other words, a good interpersonal relationship by itself is not sufficient for nurses to develop the caring moment because nursing practice is a complex phenomenon comprising social, cultural, and political factors (Ray, 1984; Paterson, 1989).

Questions arising from Watson's theory point to a broad gap between the nurse caring process and the clinical reality (Morse, 1990). The present study captures episodes of caring from the real world of nursing practice and so begins to close this gap. The caring elements emerging from this study are relevant to most of Watson's carative factors but less abstract. In this study the linkage or the relationship between the caring elements are developed to demonstrate the nurse caring process more clearly. The evidence from the present study demonstrates that caring moments do exist in everyday nursing practice, even when the nurse-patient contact is brief such as when a patient's temperature is taken.

The present study further illuminates the phenomenon of caring in nursing by capturing the episodes of caring in everyday nursing practice in selected clinical settings in which the nurse and the patient experience caring and being cared for. It uncovers the actual process of caring between the nurse and the patient, explaining what is actually happening when the nurse perceives that she is caring for the patient and the patient perceives that he/she is being cared for by the nurse. In this study it is claimed that the nurse and the patient recognise that a series of caring moments occur within the continuity of their interaction. This moment is the peak intensity of the interaction in which both the nurse and the patient recognise their intersubjective connection as human beings. It is the moment at which the nurse and the patient are united to achieve their best in the situation, and this brings positive outcomes for both nurse and patient.

A number of concepts which were developed from the present study retain meanings which are related to existing caring literature in nursing. As mentioned earlier, in the past decade there has been a vast amount of literature on the phenomenon of caring in nursing as nurse theorists have proposed caring as a paradigm unique to nursing. It is not possible to discuss the findings from the present study in relation to all that literature. However, the study findings are relevant to five conceptual categories of caring proposed by Morse and others as reviewed in chapter two. Both the nurses and

patients who participated in this study perceived that caring is a personal quality, that is, they supported the category of caring as a human trait (Leininger, 1978; Roach, 1981; Benner & Wrubel, 1989). They also perceived that caring is a moral standard which is relevant to the category of caring as a moral ideal (Watson, 1985; Gadow, 1985; Brody, 1988). Both the nurse and the patient state that "Caring is a warm feeling"; "You cannot care for your patient if you do not genuinely want to do it". This is relevant to caring as an affect (Bevis, 1981; Forrest, 1989). The nurse and the patient make contact based on a helping relationship, during which they interact and develop an interpersonal relationship. This is relevant to the category of caring as an interpersonal relationship (Gadow, 1985; Weiss, 1988). The nurse performs actions to assist the patient in meeting needs by giving her energy and spending time which is relevant to the category of caring as a therapeutic effect (Brown, 1981; Gaut, 1983; Swanson-Kauffman, 1988).

Both the nurse and the patient recognise that giving and receiving caring reaches the peak of intersubjective connection, and this brings a positive outcome to both the nurse and the patient, which is relevant to Morse's additional category of the outcome of caring.

Moreover, the study findings suggest that caring in nursing involves active participation by the nurse and the patient. This aspect of caring in nursing practice is affirmed by Watson's (1985) description of a caring nurse as a co-participant in the human care process. In addition, it is supported by Christensen's (1988) grounded theory of the Nursed Passage describing the nurse working as a partner in practice with clients. The clients are not passive recipients of care, but active participants. In other words the nurse and the patient are working together, the patient is not passively receiving nursing care.

The study also illuminates nurses expressing caring through certain activities and behaviours which correlate with previous studies (Brown, 1981; Rieman, 1983; Hernandez, 1987; Weiss, 1988). In particular it is congruent with Weiss's component of nurse caring behaviours: verbal caring, nonverbal caring, and technical competency. Weiss perceives nurse caring as a wholistic process which occurs when the nurse harmoniously demonstrates three components of care: verbal caring, nonverbal caring, and technically competent behaviours. The present study complements Weiss's model in further explaining how the wholistic caring process occurs.

Most of Hernandez's themes of professional nurse caring are also relevant to concepts and subconcepts which emerge from the present study, such as, being there, listening, communication, time, technical competency. Hernandez's study suggested that professional nurse caring is a direct intentional process. The process differs from natural caring in that its practice is wholistic as the nurse identifies the patient as a whole person (Hernandez, 1987; Rogers, 1970).

Another aspect of the present study is that the caring process in nursing practice is a gestalt configuration, a wholistic process in which the nurse blends her personal and professional value of human care with knowledge integrated from many sources to bring about the nursing action of assisting the patient in a specific life situation. The study not only confirms that nurses perceive a patient as a whole person with all aspects of human needs (Rogers, 1970; Watson, 1979), but also suggests that caring in nursing is a dynamic unique wholistic situation.

The nurse translates the quality of being into doing (Paterson & Zderad, 1976). The nurse qualities of caring namely benevolence, commitment and clinical competency, are relevant to Roach's attributes of caring: compassion, competence, confidence, conscience, and commitment. At the same time the nurse translates the qualities of caring into nursing action, which is a mixture of values, knowledge, process, and product. This is a starting point, a means which is an end in itself. The actual process of caring is a dynamic continuity of interactive participation between the nurse and the patient moment-by-moment.

The concepts of "being mindfully present" and "being there" are explained by the nurse's authentic active presence with the patient in a specific situation (Paterson & Zderad, 1976; Parse, 1981). In other words, the nurse is fully present with her body-heart-mind when responding to the patient. The concept of "a relationship of trust" explains the foundation of the relationship between the nurse and the patient (Watson, 1979). The concept of "participation in meeting needs" is explained by the nurse and the patient being coparticipants (Watson, 1979; Christensen, 1988). They are actively working together to satisfy the patient's needs or to solve the patient's problems. "Balancing knowledge-energy-time" is explained when the nurse integrates the whole pattern of knowing - ethical, personal, esthetic, and empiric (Carper, 1978; Chinn & Jacobs, 1987) in performing an action of helping the patient in a specific situation by

exerting appropriate physical energy and spending an appropriate amount of time, and drawing in relevant knowledge.

Ethical knowing motivates the nurse's state of moral awareness of helping the patient as a valued dignified person. Personal knowing facilitates the nurse's entry into the patient's personal world. Empirical knowing allows the nurse to reflect on scientific knowledge to understand the particular caring situation and make decisions to act on helping the patient. As Boykin and Schoenhofer (1990) state:

> With this personal knowing in place, the nurse detaches from the situation and reflects on the relevant empirical knowledge to enhance understanding of caring in the particular nursing situation. Competence on the part of one caring is essential in order to extract relevant meaning from empirical generalizations. (p. 153)

Esthetic knowing allows nurses as artists to create a unique approach to the individual patient in a specific situation. Within the process of balancing knowledge-energy-time, the nurse conveys certain activities and behaviours through empathetic touch communication. The nurse and the patient reach the point of mutual engagement. They recognise the true caring between them - "the actualized caring moment". It is the state of intersubjective connectedness between the nurse and the patient. This discovery validates what the previous nurse scholars have mentioned in the literature (Travelbee, 1971; Paterson & Zderad, 1976; King, 1981; Parse, 1981; Roach, 1984; Benner, 1984; Watson, 1985). Roach states that "Caring is expressed in specific 'moments' as particularised in concrete caring behaviors" (p.13). Nurses experience such meaningful moments with patients in their professional practice. As it is an intangible aspect of nursing, it is difficult to communicate in the nursing community. Fulton makes that point: "I have experienced warm and generous relationships with patients, but like Miss Henderson, find them difficult to name. They are born, somehow of a willingness of both to give and receive" (1987, p. 3).

Recently Boykin and Schoenhofer (1990) analysed the work of Mayeroff (1971), Watson (1985), Roach (1987), and Paterson & Zderad (1988) to answer the question posed by Roach - "What it means to be a caring person" (Boykin & Schoenhofer, 1990, p. 150). The answer, which is relevant to the present study, was that the nurse's and the patient's experience of caring is actualized by both.

> Living the meaning of one's life actualizes the capacity to be a caring person. As a person more fully experiences being-in-the-world, the ability to express caring behaviors with self and others is enhanced. Therefore, caring in nursing is an actualizing experience for the nurse as well as the client. (Boykin and Schoenhofer,1990, p. 15)

The actualized caring moment, as the outcome within the process of caring itself, potentiates healing for the patient (Watson, 1985); empowerment for both the nurse and the patient (Benner, 1984); and growth for both (Peplau, 1952; Bevis, 1981).

In the real world of nursing practice, the actual caring process occurs in a specific situation in an environment which facilitates the practice of caring for nurses. The present study indicated the situational context as a component of caring nursing practice. The environmental factors have a great impact on caring practice as the additional findings from the present study indicated that certain working conditions prevent nurses from the practice of caring. This environmental aspect is relevant to Ray's (1984) study on institutional caring. Ray stated that "... in many ways, the political, legal, and economic system of the bureaucracy, although not negative in themselves, dwarfed the more universal, positive elements of ethico-spiritual-humanistic caring" (p. 110).

The study's findings demonstrated what McFarlane (1976) claimed, namely caring cannot be separated from nursing. A number of the characteristics of caring nursing practice which emerged from the study are similar to those by which nurse scholars and researchers have tried to capture the phenomenon of nursing.

> That nursing is fundamentally a moral art has previously been pointed out ... As I see it, this view means that the basis of nursing consists of a set of values, and that the nature of those values is moral (p. 462) ... Nursing consists of interaction between unique individuals with unique experience, and it always takes place in unique situations. (Sarvimaki, 1988, p. 465)

> The work of the nurse is dynamically variable and situation-specific as nursing responds to the immediacy of the patient situation as he negotiates his Nursed Passage. (Christensen, 1988, p. 223)

> Nursing practice must change with each patient, each situation, even each heartbeat. The discipline of nursing is the constant attention to difference and regularity of unpredictability. (Diers and Evans, cited Kozier and Erb, 1988, p. XI)

THE RESEARCH FINDINGS IN RELATION TO RELEVANT EXISTING NURSING LITERATURE IN THE NEW ZEALAND CONTEXT

Caring is a philosophical basis for nursing practice in the New Zealand context as caring in nursing is made explicit in the definition of nursing adopted by the New Zealand Nurses' Association (1984) - "Nursing is a specialised expression of caring..." (p. 3). In addition, the previous preliminary studies of the present author (Euswas, 1989) showed that nurses perceived caring to be a central theme for their practice. Moreover Bassett-Smith's (1988) study also confirmed that caring is an essential ingredient of midwifery practice.

The studies by Christensen (1988) and Paterson (1989) attempt to clarify the phenomenon of nursing. The present study further illuminates the phenomenon of nursing practice focusing specifically on caring practice. The findings from the present study are relevant to, and complement, the above-mentioned three studies as they are all grounded in actual practice.

Bassett-Smith's conceptual framework of midwifery practice, "Authenticating the experience of childbirth", strongly supports the present study by demonstrating that caring is an essential element of midwifery practice. The "Mutually engaging" phase of the Authenticating process which Bassett-Smith defines as an intense reciprocal involvement shared by two people that forms the basis for a special expression of caring, is congruent with the "actualized caring" finding from the present study.

> Mutually engaging means being connected with and caring about each other, and fuses 'thought, feelings, and action' (Benner and Wrubel, 1989). It indicates a special kind of rapport, shared understanding and mutual respect for each person's contribution to the accomplishment of a safe and satisfying birth. (Bassett-Smith, 1988, p.128)

Paterson's (1989) study uncovers the nurse's role of experience in developing and expanding "clinical expertise", and the "notion of good" which is an expression of the benevolent intent central to the nurse. These two factors were identified as making a difference to the patient's welfare. This finding supports the present study in which

benevolent intent and clinical expertise are identified as the qualities of caring embedded in the nurse which are a precondition of the caring process.

In the theoretical framework of the Nursed Passage developed by Christensen, nursing is perceived to occur within a synergistic relationship between the nurse as the agent of nursing and the patient as a recipient of nursing. The nurse and the patient work as a partnership within the context of mutual benevolence. The study illustrates the distinctive work of both parties. However, the manner in which the patient's passage is optimally beneficially progressed by nurses needs to be clarified. The outcome of the present study goes some way towards filling this gap of knowledge. The nurse with qualities of caring and the ability to translate her qualities of caring into nursing action makes a difference to the patient's welfare. Some concepts developed from the present study are similar to that of the framework of the Nursed Passage. For instance, some concepts explaining the actual caring process are similar to the concepts explaining negotiating the Nursed Passage: the work of the nurse - being present, listening, anticipating. In addition, the present study indicates that the actual caring process is an interactive process between the nurse and the patient as coparticipants to achieve the patient's situational needs, and the process is continued moment by moment within the episodes of the nurse-patient contact. This is relevant to the Nursed Passage framework.

> Nursing is translated into action by the individual nurse in the presence of the patient or nursed person. By being present the nurse is able to "nurse" the patient in the immediacy of his situation. She adjusts her nursing to the moment-by-moment circumstances of the patient in a way that an unqualified person cannot do. (Christensen, 1988, p. 227)

The present study further shows that the peak intensity of the nurse-patient interaction - "The actualized caring moment" - provides maximal benefit for both the nurse and the patient. To achieve this moment the nurse uses the processes of cognition, affect, and psychomotor skills in a gestalt configuration to translate her qualities of caring into nursing action in the patient's immediate situation. The theoretical framework of The gestalt actualized caring moment provides greater understanding of the caring process in nursing practice. It is complementary to the Nursed Passage framework (Christensen, 1988) in explaining "nursing as it is".

The present research was conducted during a period of political unrest in which there were internal 'coups' resulting in three changes of the Prime Minister, the sacking of the Minister of Finance and a change in the Minister of Health. These events took place during continued economic recession which gave rise to radical and rapid legislation which changed the welfare state, created a rise in unemployment, and depressed trade increases concern about overseas debt (New Zealand Official Yearbook, 1990). This gave rise to real stress on funding the health service under the welfare state. Both hospital and community health services were under pressure to contain costs and voluntary health services were having more difficulty in finding funds. As a result health providers and consumers were experiencing dissatisfaction and uncertainty. Nurses faced problems of heavy workloads which was a major obstacle to caring practice as indicated by the supplementary findings presented in chapter nine. These obstacles to caring practice were overt in the New Zealand context during the time this research was conducted.

IMPLICATIONS FOR PRACTICE AND EDUCATION

Implications for practice

In their professional life nurses experience special meaningful moments with their patients, but there are very few detailed accounts of these moments as they are usually brief and invisible. Nurses, although they know these moments occur, find it is difficult to relate them. As a result this important aspect of nursing is not usually made explicit in efforts to communicate the essence of nursing both to nurses and to others.

The present study illuminated the details of this moment from actual nursing data, and conceptualised it as "The gestalt actualized caring moment". The theoretical framework of the gestalt actualized caring moment provides a basis for assisting nurses to understand their practice more fully and be able to articulate the essential nature of nursing. It is hoped that nurses who choose to use this theoretical framework will be helped to increase their therapeutic use of self to potentiate the patient's healing and growth and to also gain satisfaction from their practice. Most importantly it assists nurses to achieve personal and professional growth so that they can act as advocates to preserve humanity in a high-cost technology-driven health care system. As one writer notes "Perhaps the most critical element in cost-effective hospital care is the precious, magical, sensitive interaction that occurs between the nurse and the patient" (Fulton,

1987, p. 8). Therefore this framework is offered to nurses to use as a model for them in effective nursing practice.

The practice of nursing is based on values and is knowledge-oriented. The framework provided by this study offers nurses a philosophical foundation to preserve "human caring" as a professional value and moral commitment. As suggested in the following quotation, this value guides nursing action in assisting a unique person with related health problems to achieve potential wellbeing. "Caring as a professional and personal value, is of central importance in providing a normative standard which governs our actions and our attitudes toward those for whom we care" (Carper, 1978, pp. 11-12).

The framework contributes to the understanding of the actual caring process which provides guidance and a means by which nurses can transform the qualities of caring into a therapeutic effect for the patient. By increasing the intensity of the interaction with the patient, nurses would be able to provide a greater therapeutic effect. In order to do so, the nurse must increase her awareness so that she focuses on the patient at the immediate present moment, as well as integrating within herself all patterns of knowing in order to impart the appropriate energy and spend an appropriate amount of time. In this way the nurse achieves a therapeutic harmony of verbal and nonverbal behaviours, and technical competency.

Nursing knowledge is embedded in clinical practice. By engaging in a caring relationship with the patient, nurses gain more experiential knowledge which assists them to develop professional expertise (Benner, 1984) and achieve personal and professional actualization.

The framework also has the potential to assist nurses to gain more understanding of the collegial collaborative nature of nursing practice in providing care. Sharing knowledge-energy-time among nurse team members is required for the process of caring in nursing practice to be effective. In addition the process of caring requires an ongoing development of clinical knowledge. The additional findings from the study suggest the need for more knowledge development in the area of human lived experience of specific health and illness, cultural perceptions of health and illness and the caring needs.

The gestalt actualized caring moment framework illustrates an essential element of nursing which potentiates healing and growth to the patient. Therefore implementation of the framework could be used to generate criteria for assuring quality patient care.

Although nursing has been recognised as a necessary human service for a long time, its image to the public is not clear, and not always valued greatly. Quite often patients say "I never knew before what the nurses do. I thought they were just doing beds and pans, and what the doctors say". Nurses always say "most people don't understand what we actually do". The public image of nursing is that it is not far from being subservient. The theoretical framework of the gestalt actualized caring moment provides a medium through which the public may gain more understanding of the nature of nursing as caring professional expertise in a partnership role with patients.

While the actualized caring moment is at the heart of nursing practice it may not be limited to nursing. However there is no other profession which is so much predicated on achieving the preconditions to the caring moment as is nursing.

Implications for education

The grounded theory of "the gestalt actualized caring moment" which emerged from the present study is a broad framework describing the actual process of caring in nursing practice involving patients with cancer. The phenomenon may have been more readily identified in this setting but is not assummed to be exclusive to this setting. Therefore it is likely to be applied by the nurse practitioner and nurse educator for use in nursing education at a basic and post-basic level. The framework could contribute to nursing education because the knowledge concerning the characteristics of caring nursing in practice is uncovered from everyday nursing practice. This knowledge could be offered as a "core tool" in providing nursing service. It offers student nurses theoretical knowledge - "know that" - to enable them to get the picture of the essence of nursing practice. Student nurses would gain from this clear account of how nursing "makes a difference" for patients. Therefore, it would be worthwhile making this theoretical knowledge more explicit in the nursing curriculum.

Nursing is a practice discipline. Therefore, to be able to practise nursing, nurses must have practical knowledge - "know how" (Benner, 1984). The framework provides better understanding for educators in organising learning experience for the students to

know how to practice caring. It is indicated by the framework that to be able to use themselves as a therapeutic effect in the process of caring, nurses must have the qualities of caring embedded in themselves. These qualities are cultivated by direct experience of mutual human processes - being cared for and caring - from life experience and professional experience. Therefore, to teach students to "know how" to care for patients, it is necessary to allow the students to have direct experience of actualized caring with others. One way to achieve this is to create a caring environment or "caring culture" in the teaching and learning process among teachers and friends in both the classroom and the clinical setting. A second means is to allow the students to engage in a relationship with an individual patient to develop a caring moment. A third means is to allow the students to reflect on their own practice and document critical incidents to share knowledge between students and the teacher.

The process of caring in nursing requires four modes of knowledge: ethical, personal, empiric, and esthetic. These could be collapsed into two major components - moral art and science. The framework provides the selection and organisation of knowledge for curriculum development. In addition, the study indicates that "caring " is a strong value and moral commitment for the professional practice of nursing. Therefore, this value as a moral standard needs to be made explicit for the philosophy of nursing education.

The supplementary findings of the study indicated inhibiting factors to caring practice. The following recommendations are offered to minimise some of the inhibiting factors. Firstly, each specific area of nursing requires an expert nurse resource person - clinical specialist - to assist nurses in balancing knowledge-energy-time. As caring practice in nursing requires collegial collaboration among nurses, this expert nurse will be the resource person to facilitate the sharing of knowledge, energy and time among nurses. Secondly, the qualities of caring in nursing, which are embedded in nurses are an ongoing developmental process occurring during professional education and practice. It is necessary to have a mentor to be a role model in training nurses who first start to practice in a new area of nursing practice. Thirdly, caring practice requires ongoing inservice education in order to update knowledge. Significant components of the knowledge needed for caring practice are: patient response to illness and medical intervention; cultural value perceptions and practice; and interpersonal relationship. In addition nurses need to have time out of work for self reflection and sharing experiences among staff. Finally, ongoing clinical knowledge development is required

for caring practice. It is necessary to set the scope for documenting and researching new clinical knowledge from everyday practice.

LIMITATIONS OF THE STUDY

During the research period several limitations were recognised. Firstly, the researcher came to undertake research in a different culture and used English as a second language. It was acknowledged that there might be some limitations of cultural sensitivity and language barriers. Nevertheless, in the health care system in the New Zealand context there is a mixture of health professionals from various cultures. Before conducting research the researcher was well prepared to understand the New Zealand context and developed effective language skills for communication. In addition, the researcher had a period of time for gaining access to and developing rapport with the participants. Moreover the researcher also had a period when she practised the techniques to be used for obtaining the data before initiating actual data collection phase. Most importantly, the data were validated by the participants, and the researcher was closely supervised during the entire period fo data collection. Therefore, any misunderstandings or misjudgements due to language differences were minimised.

Secondly, to identify both visible and invisible aspects of caring in nursing practice, it is necessary to observe and take fieldnotes of every single detail of the nurse-patient interaction in a nursing situation. The researcher identified herself as a researcher participating in the field as an observer, and she was not eligible to provide nursing care to the patients. However, as the researcher is a nurse, in some nursing situations the nurse participant needed some assistance from the researcher to help her patient, for instance, to assist the nurse to mobilise the patient. Therefore the researcher might have missed some details of observation while she was assisting the nurse and the patient. She tried to minimise this by interviewing the nurse and the patient as soon as possible after an event. However, the nature of nursing practice is unpredictable and changing, so that the nurse and the patient were not always available to be interviewed as planned.

Thirdly, time constraints are always an obstacle for students when undertaking research. In this study grounded theory strategies were selected for analysing the data. Time limits can result in premature closure of data analysis and theory generation. In this case data collection and analysis were conducted over a period of ten months. This time period may seem limited for investigating and theorizing such a highly abstract

multidimensional concept as caring. However, during the process of concept development the saturation of data (theoretical saturation) was identified as explained in Chapter three. In addition, in conducting the present research, the researcher has made every attempt to achieve the criteria for rigour and standards of qualitative research offered by Sandelowski (1986) and Burns (1989) as discussed previously in Chapter three.

It is believed that the study has achieved the criteria for rigour outlined by Sandelowski (1986) and Burns, and the credibility of a grounded theory, suggested by Glaser and Strauss (1967), and Hutchinson (1986) in the following ways:

> Data were collected in a variety of settings: hospital, hospice and community.
>
> Data were obtained from multiple sources: nurses, patients and documents.
>
> Multiple methods of data collection called triangulation, were used to examine the congruency of data. These were interviews, participant observation with field note records, and documents.
>
> The core variable surfaced, and the theoretical framework was integrated in a clear diagrammatical representation.
>
> The theoretical framework was returned to the participants in the study and it was confirmed not only by the participants but also by other nurse clinicians and nurse educators. These nurses recognised the fittingness of the framework derived from the data, and the application of the framework for their practice and education.

This study initiates the use of grounded theory strategy to develop a partial theoretical explanation of the phenomenon of caring nursing practice in the New Zealand context. As time is limited, the study has been terminated at this stage in order for a report to be written explaining the emerged theoretical framework. Development of propositions is

the next step as grounded theory is always in the process of development (Glaser & Strauss, 1967).

RECOMMENDATIONS FOR FURTHER RESEARCH

Both tangible and intangible nursing practice, particularly the latter, is captured by the present study. The grounded theory of the gestalt actualized caring moment is proposed. It clearly elucidates the actual process of caring in nursing practice. The elements of caring in nursing practice which emerged from the study provided possibilities for additional research.

In the present research the researcher selected to investigate the phenomenon of caring in nursing practice involving cancer patients. The characteristics of caring in nursing practice emerged from this specific context, which may limit how far the theory will be found to be meaningful in other practice settings. Further investigation in other areas of nursing practice are needed. Although the present study focused on the phenomenon of caring nursing practice involving cancer patients, the study did not directly investigate the caring needs of cancer patients. The questions still remain - Are there any specific caring needs for these cancer patient categories: those undergoing investigative procedures; those newly diagnosed; those with ongoing treatment; and the terminally ill?

Findings from the present study showed that both nurses and patients perceived the positive outcomes of caring. The study illustrated that a means by which caring makes a positive contribution for patients' health, needs to be further investigated in order to confirm the positive outcome of caring.

To be able to practice caring, nurses must have specialised knowledge gained from professional education and professional practical experience in assisting patients to achieve their situational health needs. The present study indicated that in the actual caring process the nurse must be able to balance knowledge, energy, and time. By means of this balancing the nurse is able to use appropriate approaches for each individual patient in each situation. Although the study uncovered subconcepts explaining how nurses balance knowledge-energy-time, further questions arise - as to how nurses can be more effective in doing this. Also, as the nurse and the patient are

co-participants in the caring process, further study is needed to explore - Whether patients balance knowledge-energy-time? and, if so, How?

The phenomenon of caring nursing practice is dynamic and changing moment by moment. Nurses must have the ability or capacity to be fully alert to the patient's present situation, fully aware of themselves and the patient's self in the present moment. This study indicated that the concept "being mindfully present" is an element of the actual caring process. Each individual nurse has a different capacity for awareness/mindfulness. How nurses can be assisted to cultivate the capacity of awareness/mindfulness is an important area for further investigation.

Working conditions are important factors which allow nurses to practice caring. Although the present study uncovered some aspects of working conditions which facilitate caring practice, further indepth study is needed. In addition, the obstacles to caring practice are also presented in the study as supplementary findings. In the real world of nursing practice these obstacles prevent nurses from practicing caring. These obstacles need to be explored critically. As nursing practice is a complex social, cultural, and political phenomenon, further investigation using other research paradigms such as a critical social theory will provide more understanding of the caring practice obstacles.

The nurse and patient participants in the present study were Western people. However, New Zealand is a multicultural society with an explicit bicultural juxtaposition of Western and Maori cultures. Therefore, cultural implications cannot be ignored. More specific explanation of the theoretical framework in relation to Maori culture is necessary in New Zealand.

The phenomenological perspective and grounded theory used in the present study were considered as most appropriate for the generation of theory to describe human lived experience of caring. Indepth interviews and participant observations provided a rich description. However, to capture both the visible and invisible aspects of caring, it is neccessary to document every single detail of the nurse-patient interaction: verbal, nonverbal, and technical behaviours and activities. There is some limitation of recording while the researcher is engaged in activities, such as helping nurses in assisting the patients. It is recommended that besides participant observation, use of a video camera in recording the nurse-patient interaction in the nursing situations would

be very appropriate. The images are then available to be reviewed during the process of data analysis.

RECOMMENDATIONS FOR THE DEVELOPMENT OF A KNOWLEDGE FOCUS FOR THE DISCIPLINE OF NURSING

The study confirms the belief expressed in contemporary nursing literature that caring is the central focus of nursing. Newman, Sime and Corcoran-Perry (1991) assert that caring and health emerged as central concepts in nursing in the past decade. Therefore they propose caring in human health experience as the focus of the discipline of nursing:

> We submit that nursing is the study of caring in the human health experience. This focus integrates into a single statement concepts commonly identified with nursing at the metaparadigm level. This focus implies a social mandate and service identity and specifies a domain for knowledge development. The social mandate and service identity are conveyed by a commitment to caring as a moral imperative. (p. 3)

Besides the specific recommendations for further research previously stated, the researcher suggests that there is need for further knowledge development in the area of caring in specific life situations throughout the life span and specific illnesses within the socioeconomic, political and cultural context.

CONCLUDING STATEMENT

The theoretical framework of "The Gestalt Actualized Caring Moment" which comes from the reality of nursing practice settings, demonstrates the actual caring process in nursing. It indicates clearly that not only is caring an essential component of nursing, but that nursing in the full sense cannot be separated from caring.

"The Gestalt Actualized Caring Moment" gives a fresh perspective on the phenomenon of caring in nursing as a harmonious dynamic movement moment-by-moment of interhuman contact which transforms healing-growing so that suffering is transcended in a unique whole situation. This framework challenges nurses to reflect upon their practice and offers an aid to realizing the wholistic nature of nursing.

EPILOGUE

A nurse searches for meanings
A journey has started
Years and years pass by

Questions still remain
After four years intensive searching
A little miracle is found

It is a beauty inside oneself
which all can see, feel, and know
What is it?

A hope is there
When the nursing circle comes together
with a pure heart, head, and hand

To search for our "spiritual bond"
Investigating "what really nursing is"
A journey continues

CARING EPISODES

Taking temperature

Having lymphoma, Mr B
Computer engineer is his career
He needs explanation of things

Temperature high for two days
Staying in a ward for investigation
Moment of worrying, he experiences

A nurse comes for temperature taking
Chatting away with him, his worries
Telling him her finger hurt, she shares

Reading the scale 37.5'C
"I don't think it's long enough" he says
"Could you put it in longer" he asks

The nurse smiles "Alright we'll do it again"
Three minutes thermometer is in his mouth
Silence, eye touch, she waits

The scale shows 37.8'C
"Oh it is not high as the other times", he says
"Have you had a cold drink", she asks
"No" he smiles, she smiles

In the hospice: Bed time

Mr K lies stretched in bed
His wife sits close by
Waiting for the nurse to come

Two come with a smile
Close to him, his wife
Eyes touch, soft speech, they listen

"I.....I.....feel.....al.....alright"
Slow speech, stuttering, he speaks
The nurses listen, talk, wait

Cleansing touch, soothing hand, they minister
He talks about his garden, his wife shares
The nurses share talking, and all laugh

Comforting him with pillows
Puff the pillows...No he says, Add a pillow...No he says
Tilt the pillow to the left...Yes ...that.. that...right

"I....I....heard....you.....you.....sing.....this...this...morning
Could...could...you....sing..sing...please" he asks one nurse
She smiles, eyes touch.....silence

Close to him, arms around his wife, they move
"Edelweiss song" begins, they sing
A circle of four in oneness
He smiles...eyes close

When I was first told of cancer

A lump was in my breast
The biopsy was done
I could not sleep well

Two forces pulling apart
I might get it... my mother had it
I hoped.. I prayed... It would not happen to me

One morning I heard the word "cancer"
It ran into my body, my mind
Like a thundering storm...a shock

Nothing could I hear or see
Cold and darkness
My life was ending

Suddenly.. a warm touch was creeping inside me
Like a light spreading out
A whispering of soft voice at my ears

She shared and guided me round
When I went home
I reflected on what she said to me
"Try to think of one thing at a time"

She told my daughter
"Your mother needs more love and caring"
I gained the strength to have my breast off
The caring from that nurse I remember

Having a shower

A big operation, I had
They helped me slowly down to the stool
And gently let me down

They could feel what I felt
"You are doing well" they reassured
I felt good and tried harder

When I went into the shower
I told them I could do by my self
They listened to me and believed me

They let me do it
They're always there
"Are you alright? Are you alright?", kept checking

I felt really confident in myself
I felt I 'd achieved a really big miles stone
"I can do it"

CANDLES ~ CARING MOMENT

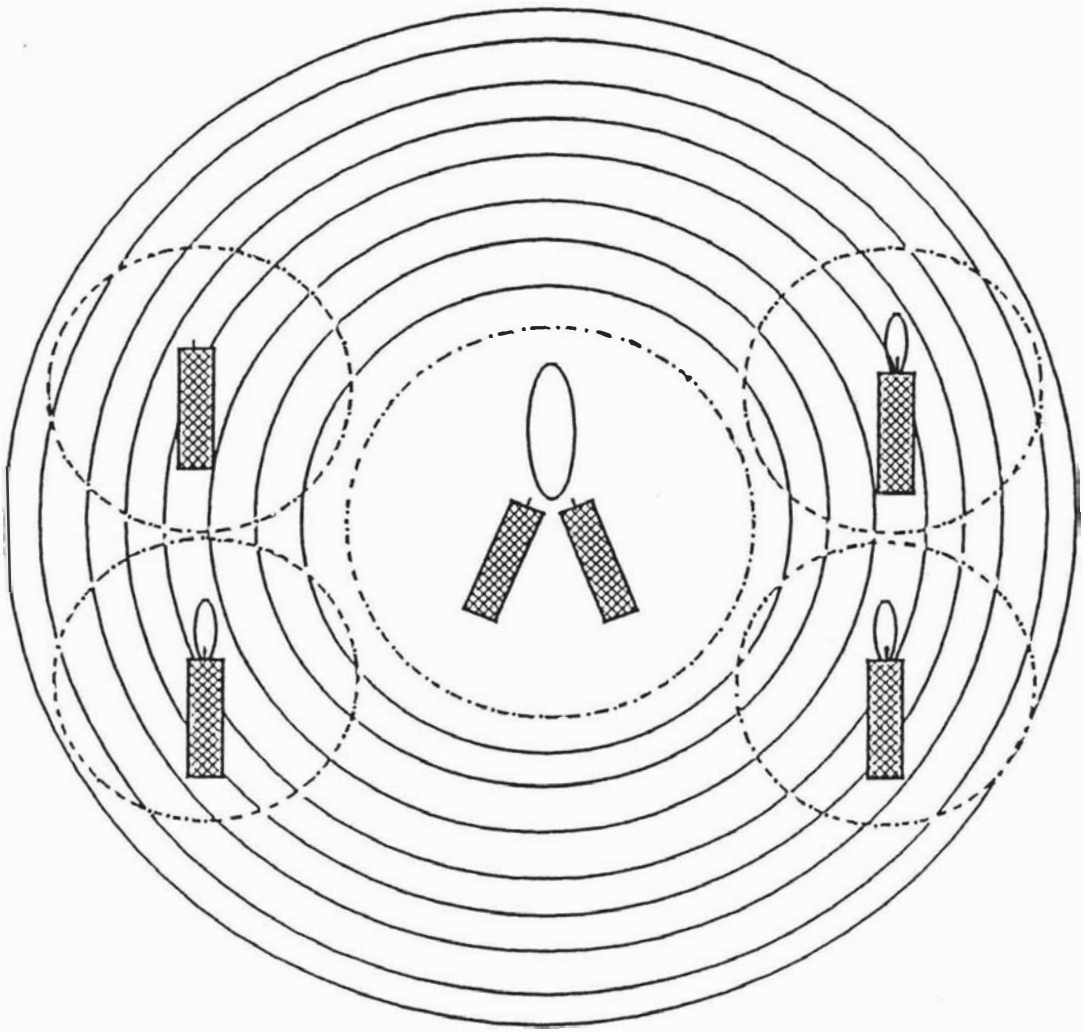

FIGURE 4 AN ANALOG PICTURE OF THE ACTUALIZED CARING MOMENT

APPENDICES

APPENDIX 1

GLOSSARY

Drugs

Anti-emetic : A drug to prevent/relieve vomiting

Adriamycin: An anti-tumour antibiotic drug used for treatment of cancer

Ativan : An anti-anxiety drug (Benzodiazepine)

CTX: Cyclophosphamide is an anti-tumour drug which acts by damaging DNA of the cell

Cyclizine: A drug used for prevention of motion sickness, and nausea and vomiting from side effects of chemotherapy treatment

Di-gesic: A non-narcotic antipyretic/analgesic drug

Dexamethasone: A steroid drug (corticosteroid), used in cancer treatment to alter hormonal levels and suppress cell growth

Heparine: An anti-clotting agent, given to prevent blood clot formation

Hep saline: Heparinised saline is a solution of heparine and saline used to prevent clot formation in intravenous and atrial lines

Largactil: An anti-psychotic drug (Chlopromazine), also used as a tranquilizer

Maxolon: A drug used as an anti-emetic to reduce gastrointestinal motility

M.O.: Morphine sulphate is a narcotic pain relieving drug

M.S.T.: Long acting oral morphine

Saline: A solution containing sodium chloride

5 FU: 5-Fluorouracil, an anti-tumour drug which acts by interfering with cell metabolism

Nurse

Cubicle nursing: A system for delivery of nursing care by allocating patients to nurses according to room

District nurse: A nurse who works for community health service in providing care for patients at home.

Enrolled nurse: A nurse who has completed a one year hospital-based nursing programme and is legally required to be under the supervision of a registered nurse

Hospice nurse: Nurse who provides care for terminally ill patients either in a specially designated institution, or at home

Oncology nurse: A nurse who specialises in caring for patients with cancer

Ostomy nurse: A nurse who specialises in caring for patients with stomas (artificial openings, usually into the small or large bowel to allow drainage of body excreta)

Primary nursing: A system for delivery of nursing care in which patients are assigned to one nurse who plans the nursing care and other nurses follow that plan while the primary nurse is off duty

Staff nurse: A registered nurse in a first level position

Staff nurse - Chemotherapy: A registered nurse who has special training in giving of chemotherapy drugs in order to be able to administer them to the patients

Nursing education

Advanced diploma in nursing: A post-basic qualification in nursing education in New Zealand involving one year full-time study at a polytechnic

Hospital training: A basic nursing educational programme undertaken within a hospital school of nursing. This type of programme has been phased out since nursing education has been shifted into polytechnics.

Polytech/ Tech: A technical institute (in which nursing education programmes are offered)

Polytechnic diploma: A basic comprehensive nursing educational programme in New Zealand undertaken within a Technical Institute or Polytechnic

Technical procedures and terms

Abdominal paracentesis: A medical procedure performed by insertion of a hollow needle to draw off fluid from an abnormal abdominal cavity

B.P.: Blood pressure

Breast binder: A piece of cloth used to support dressings (for an ulcerating wound of the breast)

Bowel-prepping: Emptying the bowel for investigative or surgical procedures in the abdominal area

Ca breast : Cancer of the breast

Caesium: A radioactive substance used in radiotherapy for cancer

Capped off: Discontinuing of intravenous infusion, but keeping vein opened for intravenous injection by placing a rubber cap on the end of the intravenous line.

Catheter: Usually, a urinary catheter used for draining of urine and other fluid

Catheterisation: A procedure for draining of urine by inserting a catheter into the bladder through the urethra

Chemo: Chemotherapy is a form of cancer treatment involving the use of a number of different drugs which may be given orally or intravenously

Colostomy: The surgical diversion of a bowel to the abdominal surface. It allows excretion of body waste into a bag covering the opening. Performed when a disease (eg cancer) necessitates surgical removal of rectum or anus.

C.V.: Central venous line for intravenous drug delivery

Drain: A rubber tube which provides a channel of exit for the discharge from wound

Drip: Intravenous infusion

I.V.'s: Intravenous(lines, fluids or drugs also referred to as drip)

I.V. site: The area where an intravenous cannula is inserted

The lines: Plastic tubing for the administration of intravenous infusion

Epidural pain control: A method of pain control by administering of anaesthetic or analgesic drugs into the epidural space of the spinal cord

Fungated wound : A wound that grows upward from a surface in a fashion resembling a fungus, as do certain tumours.

Hepatomegaly: Enlargement of liver

Hickman (catheter): A catheter inserted into the right atrium of the heart used for blood sampling and delivery of chemotherapy drugs

Hourly urine: Measurement of urine output per hour to monitor kidney function and fluid balance in the body

I/O: Fluid intake and output

Lumbar puncture: A medical procedure performed by putting a hollow needle into the spinal space to collect spinal fluid for investigation

Lymphoma: One of several types of malignant tumour affecting lymphatic structure of the body

Lymphocytic leukemia: A tumour of tissues producing blood cells in bone marrow, spleen and lymph nodes

Mastectomy: Surgical removal of the breast

Multiple myeloma: A tumour of plasma cells

Nephrostomy tube: A tube which drains urine from the pelvis of the kidney to bypass blockage of ureters, bladder, or urethra

N.G.: Nasogastric tube is a plastic tube inserted through a nostril and into the stomach to allow drainage of fluid or provide access for feeding

Obs: Observations, commonly recordings of blood pressure, pulse, temperature and respiration

Osteogenic Sarcoma: A primary tumour involving long bones, and more common in children

Post-op: Post-operative (care, patients, etc)

Prepping: Preparation (usually for an investigative or surgical procedure)

Proctoscopy: Inspection of the anal canal and rectum with a special, instrument called proctoscope

Radiotherapy: Radiation therapy, using ionizing radiation in the treatment of cancer

Redivac: A tube connected to a bottle working under suction to draw blood from a surgical wound

Scan: A diagnostic examination for presence of tumours or other abnormalities. It involves ingestion or injection of radioactive material which spreads through the body. Localized concentrations of radioactivity are picked up by a specialised machine and transformed into visual representations of affected organs or parts of the body.

Shots': Injections

Sinus rhythm: The normal heart rhythm

Sterile: Free from micro-organisms

Syringe pump: Electrically driven machine for regulated delivery of a drug solution intravenously or epidurally

TB: Tuberculosis

Telemetry: Electronic monitoring of the heart and transmission to a distant point where it may be observed or recorded

Temps: Temperature

Tracheostomy: The formation of an opening into the trachea (wind pipe) to bypass a blockage of air passage to and from the lungs

APPENDIX 2

RESEARCH PROTOCOL

MASSEY UNIVERSITY
DEPARTMENT OF NURSING STUDIES

1. TITLE OF THE PROJECT:

Caring in Professional Nursing Practice

2. RESEARCHER:

Payom Euswas, Registered Nurse, PhD Candidate, Department of Nursing Studies, Massey University

3. PURPOSE:

The main aim of this study is to develop a theoretical explanation of caring in nursing practice from the perspective of nurses and patients.

4. DESCRIPTION OF THE STUDY:

The focus of this study is the phenomenon of caring in nursing practice. The aim is to find out what caring in this context means to both patients and nurses. Using participant observation and indepth interviewing the researcher will endeavour to identify occasions and characteristics of nursing care in which the patient feels that he/she is being nursed in a caring way, and in which nurses feel that they are demonstrating caring.

5. SETTING:

Hospital, Hospice, Patient's home

6. PARTICIPANTS:

The study will involve (1) approximately 30 patients who give consent and who meet the criterion of having an actual or possible diagnosis of cancer, and (2) approximately 30 registered nurses who care for cancer patients.

7. ACCESS TO THE SETTINGS AND PARTICIPANTS:

Following approval by Massey University Human Ethics and the Palmerston North Hospital Ethics Committees, and by the Principal Nurse, the researcher will contact Charge Nurses for access to the selected wards. The Charge Nurses will be asked to suggest suitable patients to be approached, and to assist the researcher in making contact with the nursing staff and doctors whose cooperation is required. All participants wiil be volunteers and written consent will be obtained. Before a patient is approached written consent will be obtained from the doctor responsible for his/her care.

8. DATA COLLECTION:

(a) Duration of data collection: Approximately 10 months (September 1989 - June 1990)

(b) Method of data collection: Participant observation will be used in order to build up a picture of the caring components of nursing practice. Concurrently with this and later as follow-up, these data will be extended through indepth interviews (which may be tape recorded) with patients and nurses. Other documentation such as patient records and nursing notes will be referred to, and the researcher will keep detailed field notes.

9. DATA ANALYSIS:

For this qualitative study the processes of data collection and analysis will be concurrent. All observation records, interview transcripts and field notes will be analysed for content. The coded items of data will then be worked by the method of constant comparative analysis to identify categories, themes and patterns which can be integrated into a theoretical description of caring in nursing practice.

APPENDIX 3

INTERVIEW GUIDE FOR NURSES

Each nurse will be asked to supply demographic and biographical data relating to age, gender, educational and occupational background, and work experience in nursing.

The purpose of the interview is to allow the respondent to talk about the topic in her own words and to present events and situations as she sees them.

In the interview situation discussion will be initiated by the researcher posing a broad question.

> "Tell me about your day today" or
> "Can you tell me what has been happening to Mr..... while you have been nursing him?"

The conversation will then be guided by the researcher so that the following topics are covered.

* a typical day/ or atypical day

* the meaning that the term "care/caring" has for the nurse and how this applies in professional nursing practice

* particular incidents that illustrate caring, and why

* ideas about what is caring and what is not caring

APPENDIX 4

INTERVIEW GUIDE FOR PATIENTS

Each patient will be asked to supply demographic and biographical data relating to age, sex, educational and occupational background, and present health problems.

The purpose of the interview is to allow the patient to talk about the topics in his/her own words and present events and situations as he/she sees them.

In the interview situation, discussion will be initiated by the researcher posing a broad question.

> "Can you tell me about yourself. I am particularly interested in how patients experience nursing care. What is it like being in the hospital?"

The conversation will then be guided by the researcher so that the following topics are covered.

* the meaning that the term "care/caring" has for patients

* the situations that the patients perceived being cared for by professional nurses

* patient's perceptions of how caring by professional nurses affects himself/herself

APPENDIX 5

PARTICIPANT OBSERVATION GUIDE

Code number **Nurse.....** **Patient.....**
Date/Time
Place

Theme

* Nursing care events
* Nursing activities
* Nurse-patient encounter
* Nurse behaviours
* Patient behaviours
* Patient response to nursing care

Observation guide

1. Description of events before, during, and after nursing care is being provided.
2. Person's general appearance, person's actions, interactions - verbal and nonverbal.
3. Other significant observations.

APPENDIX 6

NURSE'S CONSENT TO PARTICIPATE IN A RESEARCH STUDY

MASSEY UNIVERSITY
DEPARTMENT OF NURSING STUDIES

1. STUDY TITLE:

Caring in Professional Nursing Practice

2. RESEARCHER:

Payom Euswas, Ph. D Candidate, Department of Nursing Studies, Massey University.

3. VENUE :

Hospital, hospice and patient's home

4. AIM OF STUDY:

The aim of this study is to find out what caring in nursing practice means to patients and to nurses. It is not intended to evaluate nursing care, or the nurses who provide it.

5. YOUR INVOLVEMENT IN THE STUDY :

If you agree to participate in the study you will be asked to take part in one or more interviews; and to grant the researcher permission to observe while you are providing nursing care to patients. The first interview may take 30-45 minutes. Others are likely to be shorter. The interviews will need to take place in your off duty time. With your permission, a tape recorder may be used. The success of this study will depend on your willingness to describe and share your everyday work experience.

6. STATEMENT BY NURSE:

"I have read the above and had all questions answered to my satisfaction. I understand that I may withdraw my agreement at any time. I understand that complete confidentiality and anonymity is guaranteed and any information I

provide or any observations of my behaviour will be used for research purposes only and will not be communicated to anyone in a way that would identify me personally. I further understand that opportunity to discuss the findings of this study will be provided by the researcher. I agree to take part in this study, under the above conditions."

Signature of nurse..... Date.....

Signature of researcher..... Date.....

APPENDIX 7

PATIENT'S CONSENT TO PARTICIPATE IN A RESEARCH STUDY

MASSEY UNIVERSITY
DEPARTMENT OF NURSING STUDIES

1. **STUDY TITLE:**
   Caring in Professional Nursing Practice

2. **RESEARCHER:**
   Payom Euswas, Ph. D Candidate, Department of Nursing Studies, Massey University.

3. **VENUE:**
   Hospital, hospice and patient's home

4. **AIM OF STUDY:**
   The aim of this study is to find out what caring in nursing practice means to patients and to nurses. It is not intended to evaluate nursing care, or the nurses who provide it.

5. **YOUR INVOLVEMENT IN THE STUDY:**
   If you agree to take part in this study you will be asked to participate in one or more interviews: and to grant the researcher permission to observe your nursing care and to consult your nursing and medical notes. The first interview may take 30-45 minutes. Others are likely to be much shorter. With your permission a tape recorder may be used.

   Taking part in the study will not change what would normally happen to you in terms of your care by the hospital staff. Your involvement in the study is based on your willingness to participate, and on protection of your rights as a patient. This means that you are free to ask for further information; and at any time to

decline participation, withdraw from the study or request that the researcher withdraw from observation.

6. STATEMENT BY THE PATIENT:

I have read (or have had read to me) the above information and have had all questions answered to my satisfaction. I understand that all information about me will be treated with strictest confidence; and that taking part in the study will not interfere with my nursing or medical care; and that my doctor and nurses are in agreement with my participation.

I agree to participate in this study with the knowledge that some interviews may be tape recorded and that the researcher may refer to my case notes.

Signature of patient..... Date.....

Signature of researcher..... Date.....

CHARGE NURSE STATEMENT:

Mrs Euswas has approached with my approval and I am satisfied the patient has been adequately informed on all aspects of the study, including the researcher having access to medical records.

Signature of nurse..... Date.....

APPENDIX 8

DOCTOR'S CONSENT FOR PATIENTS TO PARTICIPATE IN A RESEARCH STUDY

MASSEY UNIVERSITY
DEPARTMENT OF NURSING STUDIES

1. STUDY TITLE:

Caring in Professional Nursing Practice

2. RESEARCHER:

Payom Euswas, Registered Nurse, PhD Candidate, Department of Nursing Studies, Massey University

3. VENUE:

Hospital, hospice, Patient's home

4. DESCRIPTION OF THE STUDY:

The focus of this study is the phenomenon of caring in nursing practice. The aim is to find out what caring in this context means to both patients and nurses. Using participant observation and indepth interviewing the researcher will endeavour to identify occasions and characteristics of nursing care in which the patient feels that he/she is being nursed in a caring way, and in which nurses feel that they are demonstrating caring.

5. STATEMENT BY THE DOCTOR:

Having read the description of the research study " Caring in Professional Nursing Practice" I understand that the researcher has discussed this matter with the ward Charge Nurse and I agree to the participation in the study of a patient in my care. I also agree that Mrs Euswas may refer to the patient's medical records for the purpose of the research.

Signature of doctor..... Date.....

Signature of researcher..... Date.....

APPENDIX 9

NURSING ASSESSMENT FORM

Patient A
Date/ Time

Assessment Headings	Patient Comments	Nurse's Assessment
1. Reason for Hospitalization	I'm in for cancer pain control	
2. Home Circumstance	Lives with daughter	Appears to have excellent family support from two daughters
3. Social/ Cultural Circumstance		
4. Activities of Individual's Daily living Pattern	Unable to cope	Needs full nursing care
5. Physical Appearance Head-Foot Assessment	Considerable weight loss loss now 37 kg	A very frail unwell looking lady. Looks uncomfortable. Feels miserable

6.	Mobility		Feeling very weak but stands and walks assisted
7.	Intake and Elimination	Bowels	Not eating Drinking very little
8.	Psychological State	Says she is not anxious or worried	Feeling very tired
9.	Spiritual Needs		Roman Catholic Priest to visit please
10.	Total Communication Ability		Able to communicate Needs to conserve energy
11.	Other Comments		Patient feels miserable to answer. Evaluate further, later date. Pain control has not been effective Needs ongoing assessment

APPENDIX 10

A FIELDNOTE RECORDING OF AN EXAMPLE OF NURSING WORK DURING A MORNING SHIFT

06.50: Participated in patient allocation for nurses. Continued to be responsible for the same patients - Room 1 Mr H, Room 3 Mr He, Room 4 Miss W and Room 2 Mrs B.

07.00: Participated in hand over from night nurses

07.10: Finding more information about patients from a day nurse who read a report giving details of all patients.

07.30: Prepared the morning medication. First went to Mr H (Room 1), a terminal patient with epidural morphine pain control. NP said hello and talked to him. She checked the medication from the Doctor's prescription and recorded medication given in the administration of drug form by putting in the date, time, and dose and signed her name. She put all tablets in a container and asked the patient to have them after breakfast.

07.40: Went to Room 2 where Mrs B, a female patient with cancer of the ovary was vomiting. Mrs B was receiving chemotherapy treatment. NP came close to her and touched her shoulder. Expressed understanding by facial expression, eye contact and talked to her and said "It happens to nearly everyone at the beginning period of having chemo, an anti-emetic drug will help". NP prepared and gave the anti-emetic drug via tablets and intravenous injection. She checked the drug and signed the form. She shared feeling by expressing understanding through her face and eye contact and said "It is an awful feeling". Mrs B stopped vomiting and had eye contact with NP. NP came close to her and touched her shoulder. NP told Mrs B before she left that she would come back to see her later on.

07.45: Went to Room 3 to see Mr He, a terminal brain tumour patient. She checked his medication with the doctor's prescription and prepared his tablets. She then recorded and signed on the nurse's administration of drug

form. She brought the morning tablets to Mr He and said "Hi!" "I'm looking after you today. I'll put your tablets here". She then looked at Mr He's face, touched his cheek and said "I'll come back to help you have your breakfast".

08.00: Came to Mrs B, looked at her and checked her medication prescription. She told Mrs B she was going to give her a Maxolon injection. She then gave the maxalon intravenous injection.

08.10: Checked the intravenous fluid prescription and prepared the bag ready to change when the previous one was finished. She came to Mrs B and asked how she felt and reassured her. She then assessed the vomit and recorded the amount on the intake/output chart and cleaned the vomit bowl.

08.15: Came to Mr He (Room 3) and said "I am going to help you have your breakfast". She positioned Mr He for breakfast and touched Mr He's head. Mr He could not help himself. She started feeding fluid by using a syringe and asked him to open his mouth. She reassured him and said "You're doing well. Good man". Then she fed him porridge. Mr He responded well. Then she fed him prunes with porridge. Mr He finished all his breakfast. NP then asked him to open his mouth for his morning tablets.

08.50: Changed I.V. fluid bag for Mrs B. She was sleeping while NP changed the fluid

08.55: She then came to Mr H (Room 1). She smiled at him, touched his shoulders and had eye contact. She sat near him and offered him a drink. Mr H could drink by himself. She gave him his morning medication and asked whether he would like to have a shower. At first he said, "No". NP talked about his expected visitors. He said, "That's because I am on my way out, P, and he smiled. NP smiled and touched his shoulders, had eye contact. Both were silent for about one minute. NP asked "What do you think about having a shower?" Mr H "Yes, yes, P." NP "I'll get the chair". She brought a chair and put a rubber ring on the chair before Mr H sat on it. (Mr H had painful buttocks). NP took Mr H to the shower, and helped him to take off his clothes. NP asked the researcher to hold his syringe pump

while she gave a shower to Mr H. They had a conversation and laughed. NP allowed Mr H to help himself as much as he could.

09.20: NP helped him to put on his clothes and took him back to his room. She covered the sofa with a sheet and asked Mr H whether he'd like to sit on the sofa for a while. He said, "Yes P, that's good and I'd like something to read." She gave him a magazine. Then she made his bed and gave him elixir morphine which had been prepared by another nurse.

09.30: Walked past Room 2. Mrs B had vomited. NP came close to her and helped her clean her mouth. NP explained about the side effects of chemotherapy to the patient's relatives who had just arrived to see Mrs B. NP was with them for ten minutes.

09.40: A patient in Room 4 has returned from home. She was a young teenage girl with osteosarcoma. NP said "Hello" and smiled, and came close to her and explained to her about the test she was going to have. She then shifted her from Room 4 to Room 10.

09.50: Mr H's wife came to visit him. NP came to say hello to her, talked to her and helped Mr H get into bed. She adjusted the pillows and put a rubber ring under his buttocks. She asked how he felt.

10.00: NP checked and recorded narcotic drugs with one other nurse.

10.20: The Charge nurse asked NP to be with a patient who had had Ceacium (radiotherapy) and was being transferred from the theatre. This patient was under the responsibility of another nurse, but she was not available at that time because she was assisting another patient while a doctor performed a technical procedure. NP greeted the patient, had eye contact and held the patient's hand. She discussed with a theatre nurse about the patient's condition and procedure. She read the doctor's report and checked the patient's perineal area and urinary catheter. She was with the patient during the transfer to the ward. She assisted the patient into bed (Room 5) and covered her with a blanket. She put a lead screen near her at the level of the lower abdomen and buttock. NP explained to the patient about what was

happening to her. The patient was not fully awake. She nodded her head while NP was explaining. NP left the patient and wrote out the patient's progress report.

10.35: Break for morning tea.

10.45: Came to see Mr H. He was with his wife. Room 2, Mrs B was sleeping. She stopped and looked at her and the I.V. Room 3, Mr He was sleeping on the sofa. NP stopped and looked at him. Room 4, Miss W had gone to have a scan.

10.50 Admitting a new patient, Mrs E, who had a recurrent cancer of the oesophagus. Talking to the patient and relatives.

10.55: Helped to transfer a patient to bed (Room 4). Discussed with ward clerk about arranging admission record.

11.05: Discussed with a doctor about Mrs E 's narcotic drug at the counter for pain control. Enrolled nurse gave her information about Mrs E's previous narcotic drug prescription.

11.10: Discussed the patient's pain control drug used with the doctor, relatives and the patient. NP filled out the admission form.

11.20: Checking, preparing and giving Morphine elixir to the patient at 11.25 A.M. Explained how the patient would have Morphine.

11.30: Came to Room 2, Mrs B, and checked I.V. Talked to her and reassured her. The patient was feeling better.

12.00: Lunch time.

12.30: Came to Room 2 Mrs B. Checked intravenous drips, prepared Maxolon (a drug used as an anti-emetic) and administered it intravenously, then filled in the Intake/Output form. Asked how the patient was feeling.

12.35: Checked medication for a nurse student. Stopped at Miss T and talked to her.

12.37: Stopped at Room 1, talked with Mr H 's relatives. His wife showed NP a sheepskin that she had put in Mr H's bed to support him. NP expressed appreciation.

12.40: Prepared I.V. for Mrs Th. Took place of other nurse who had gone for lunch. Checked I.V. fluid and antibiotic with a nurse colleague for confirmation. NP discussed putting antibiotic in I.V. fluid and drug interaction. That nurse suggested not putting it in I.V. fluid containing potassium. She commented, "It is alright to put it in normal saline". NP looked up the information about this kind of antibiotic in the drug manual.

12.50: Came to Mrs Th (Room 11). Put antibiotic in a connected bottle. Changed the I.V. bag connected to the bottle and clamped. Regulated antibiotic drip. Talked to Mrs Th while she was changing the bag.

12.53: Cleaned C.V. (Central venous) set (Helping other nurse who was busy).

12.55: Prepared and gave medication to Mr H, Room 1, and talked to relatives. Helped him to sit up and go to have a smoke.

1.10: Took responsibility in caring for Mrs Th whose nurse was away for lunch. Checked Mrs Th's I.V. Talked to her and her relatives.

1.20: Checked medication for Mr He Room 3, also checked her note book, marked list of things which she had done.

1.22: Mr H's wife called NP to come. NP talked to her about Mr H's condition that day. She was surprised that he was getting better.

1.28: Came back to give medication to Mr He

1.32: Discussed with the Charge Nurse about Miss T going home. The Charge Nurse agreed but needed to confirm with the doctor. NP came to Miss T and explained it to her.

1.40: Read patient's report and discussed with Doctor K about a new admission. Prepared assessment form and progress notes and other forms; identification band; patient's name card.

1.44: Discussed with Doctor H about allowing Miss T to go home.

1.46: Came to Mrs E. Put on identification name band and put up name card. Checked Morphine prescription. Prepared Morphine elixir for her. Checked it with other nurse. Gave Mrs E Morphine elixir. Asked her about feeling sick and whether she had had Maxolon. The patient said that she needed to have some. NP gave her one and recorded it. NP took Mrs E's temperature, pulse, respiration, asked about bowel movement. Made note in her own note book.

2.15: Helped her to get out of bed to pass urine, then weighed Mrs E and helped her to get back into bed. NP was in quite a hurry. She went out of the room with the bed pan and the scales. Then she did urine analysis which was a routine for newly admitted patients.

2.20: Wrote report and progress notes.

2.30: Checked Mrs B's I.V. Filled in Intake and Output form. Reassessed her condition.

2.32: Prepared and gave attention to Room 1, Mr H.

2.38: Took history of Mrs E and recorded it in nurses assessment form.

2.40: Interrupted by another nurse asking her to give her report. Gave report to afternoon staff.

2.55: Continued taking history of Mrs E.

3.05: Took off Mrs B's I.V. and injected heparinised saline.

3.10: Wrote progress report for five patients under her care until 3.30.

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