YOUNG PROFESSIONAL NURSES' ATTITUDE TOWARDS CARING FOR THE DYING PATIENTS AND THEIR FAMILIES

by

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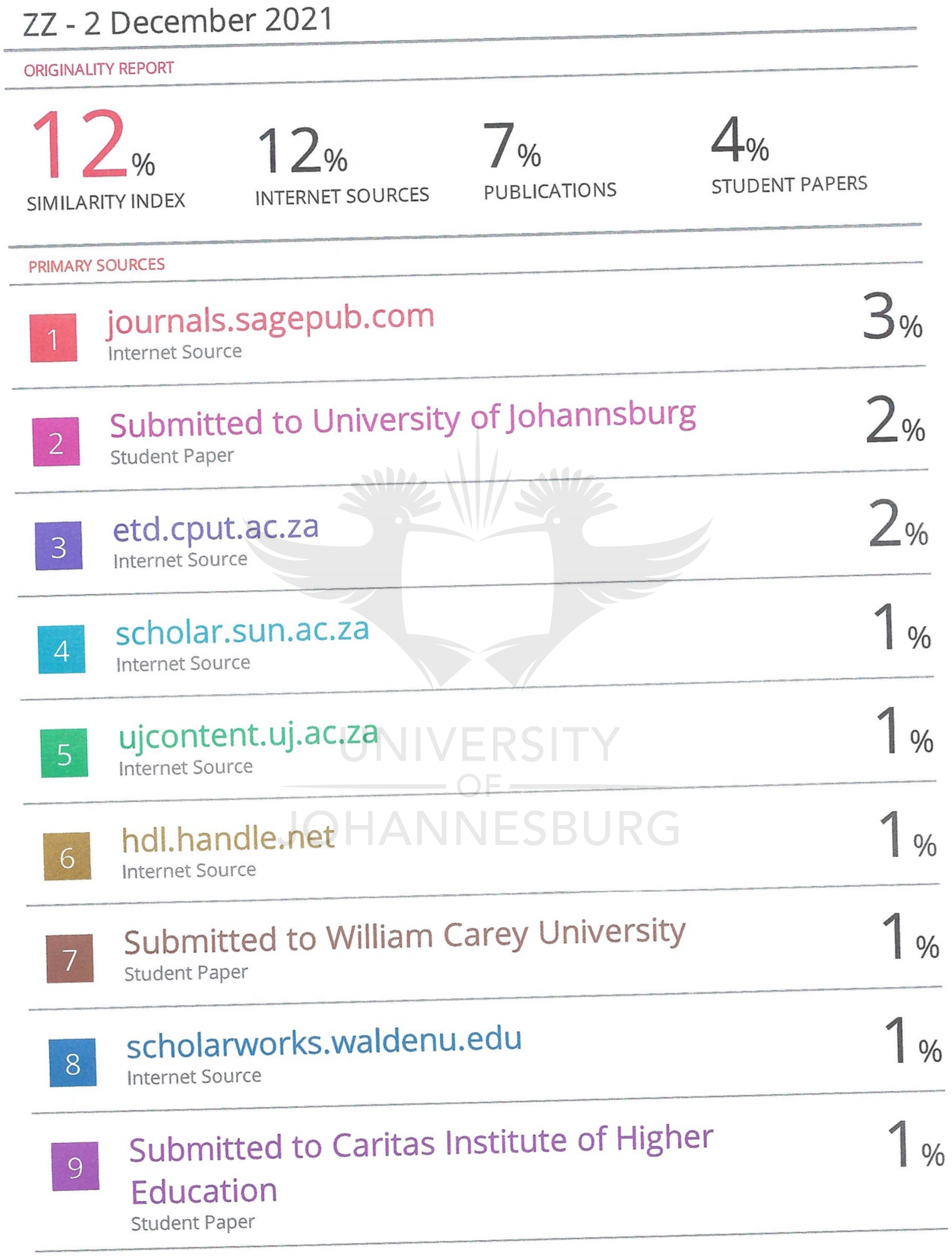

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DEDICATION

I dedicate this work to God; without his grace, power, strength, faithfulness, and leadership, I would not be the nurse or person I am today.

I also dedicate this work to my parents, Philisiwe and Gideon Zulu, without whose faithful support and prayers, I would not have been able to find the courage and confidence to obtain a master's degree in nursing. My parents have taught me the value of hard work, discipline, higher education, and developing an excellent work ethic in my chosen profession.

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ABSTRACT

Background: The evolution of medicine and medical technology in the past centuries has caused a metamorphosis of diseases and increased life expectancy. The change in the disease process has resulted in the advancement of nursing from curative care to end-of-life care. Thus, caring for dying patients in the hospital has become a pronounced trend, and young professional nurses play an important role in managing the patients' quality of life in their final days.

Aim: The purpose of this study was to explore and describe young professional nurses' attitudes towards caring for the dying patient and their family at a secondary academic hospital in Gauteng, to formulate recommendations for professional nurses when caring for the dying patient and their family.

Design: A mixed-method design using an explanatory sequential approach was chosen, which used the quantitative, descriptive, correlation approach followed by the qualitative, phenomenological design.

Findings: Analysis revealed that 74% (n=46) of the respondents had a positive attitude towards caring for the dying patient and their family. When reflecting on experiences caring for the dying patient, the young professional nurse was able to appraise their first experience and how it has impacted their current attitude towards caring for the dying patient. They also highlighted how the workplace influenced how they perceived their experiences caring for the dying patient.

Conclusions: The young professional nurses in this study had positive attitudes towards caring for the dying patient and their family and believed in the importance of extending nursing care to the family.

Keywords: young professional nurse; caring; dying patient; family; end-of-life care

TABLE OF CONTENTS

CHAPTER 1
OVERVIEW OF THE STUDY

CHAPTER 2

LITERATURE REVIEW

CHAPTER 3

RESEARCH DESIGN AND METHODS

CHAPTER 4

PRESENTATION AND DISCUSSION OF RESULTS

CHAPTER 5

EVALUATION OF THE STUDY, LIMITATIONS, RECOMMENDATIONS, CONCLUSIONS AND REFLECTION ON THE JOURNEY

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES

CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

South Africa is a middle-income country with a population currently estimated at 59 million (Stiegler & Bouchard, 2020:695). Before 1994, its health system was divided along racial lines, with one system highly resourced, benefitting the white minority, while the other was systematically under-resourced and for the black majority (Young, 2016:14). Healthcare reform was thus high on the country's development agenda (Burger & Christian, 2018:1). After 1994, there was an explicit focus on equity and redress to benefit those most affected by previous apartheid health policies (Rispel, 2016:18). The government aimed to improve healthcare access for the poorest and most marginalised by expanding the healthcare facility network (Burger & Christian, 2018:2). These health policies assisted in the turnaround and overall improved performance of today's healthcare system (Rispel, 2016:18).

From the early 2010s, people live longer, with the life expectancy of males increasing from 61 to 65 years; and females from 68 to 71 years (Bredenkamp, Burger, Jourdan & Van Doorslaer, 2021:2). This gave rise to new threats to South Africans' health (Ndinda, Ndhlovu, Juma, Asiki & Kyobutungi, 2018:90). As South Africa's population was living longer, it caused a change in the mortality profile, with people dying from non-communicable diseases (NCDs) (Ndinda et al., 2018:90). NCDs account for 41 million deaths each year, equivalent to 71% of all deaths globally. These conditions are often associated with older age groups, but evidence shows that 15 million deaths attributed to NCDs occur between 30 and 69 years (World Health Organization (WHO), 2018).

The disease process of NCDs is marked by a gradual decline, disability and eventual death (Khalaf, Al-Dweik, Abu-Snieneh, Al-Daken, Musallam, BaniYounis, Al-Rimawi, Khatib, Habeeb Allah, Atoum & Masadeh, 2017:229). This change in the disease process has caused a deviation in care, from curative to end-of-life care. End-of-life care is a science achieved when the caregiver views the individual as a holistic being

– embracing the mind, body and soul (Pajnkihar, McKenna, Stiglic & Vrbnjak, 2017:243). The WHO describes end-of-life care as an approach to caring for the dying patient that is achieved through the prevention and relief of suffering. This is done by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems (WHO, 2021). It improves the quality of life of dying patients and their families facing the problems associated with a life-threatening illness. Providing end-of-life care involves meeting both the physical and cognitive needs of the dying patient and their family and being sensitive to daily changes in their condition (Marchesoni, Axelsson, Faltholm & Lindberg, 2015:1).

South Africa has been active in providing end-of-life care since the 1980s and is home to a very strong end-of-life care community (Gwyther, Krause, Cupido, Stanford, Grey, Crede, de Vos, Arendse & Raubenheimer, 2018:86). Though they initially focused on cancer, end-of-life care organisations mobilised responses to the growing HIV pandemic in the 1990s, providing critical services to adults dying of HIV (National Policy Framework and Strategy on Palliative Care, 2017-2022). This resulted in the increased need for end-of-life care (Bajwah, Yi, Grande, Todd, Costantini, Murtagh, Evans & Higginson, 2017:2; O'Neil, Prigerson, Mmoledi, Sobekwa, Ratshikana-Moloko, Tsitsi, Cubasch, Wong, Omoshoro-Jones, Sackstein, Blinderman, Jacobson, Joffe, Ruff, Neugut & Blanchard, 2018:99). However, the availability and access to well-resourced end-of-life care services are limited; according to the Hospice Palliative Care Association of South Africa (2019), there are currently 150 end-of-life facilities in South Africa. This means the vast majority of dying patients experience moderate to severe pain during the course of the disease because they do not have access to affordable and effective pain medication (Drenth, Sithole, Pudule, Wust, Gunnclark & Gwyther, 2017:S171). Drenth et al (2017:S171) found that this was attributed to the South African National Department of Health (NDoH) allocating limited funds towards end-of-life government and non-government organisations (NGOs), resulting in end-of-life facilities closing down or being in dilapidated condition, which are pernicious for quality end-of-life care. As a result, from 2008, 31% of end-of-life care is being provided in hospitals, with the numbers increasing annually due to limited access to out-patient pain medication and limited trained staff to provide professional end-of-life care at the patient's home (Mun, Ceria-Ulep, Umbarger & Nakatsuka, 2016:16; Bajwah et al., 2017:2; Shen et al., 2018:6).

1.1.1 Philosophy of caring in nursing

Caring has proven integral and has been woven through the profession of nursing as the very foundation upon which the fundamentals and principles of nursing practice are grounded (Rosa, Estes & Watson, 2017:58). The American Nurses' Association (2015:11) has described caring as a humane attempt to protect, enhance and preserve humanity and human dignity, integrity and wholeness by assisting a person to find meaning in their illness, pain and existence. Although caring is a common, authentic, human-to-human criterion, its essence was first introduced into the nursing profession by Florence Nightingale. Caring in nursing occurs through two spheres; the first sphere defines caring as an act of helping another person when they are unable to assist themselves. The second sphere in caring is in the context of concern, which is often displayed in actions of compassion and kindness (Adams, 2016:1).

The effectiveness of nursing care requires its grounding in a theoretical nursing framework, which, among other relevant information, guides the embodiment of that caring. In 1979, Watson developed an approach to nursing practice that conceptualised the philosophy and ethics of caring in nursing. Watson's Theory of Human Caring provides an understanding of how nursing is connected to caring by moving away from treatment-centeredness; it focuses on caring and gives a sense of purpose to the concept of caring (Blasdell, 2017:1). The theory focuses on both human and nursing paradigms of care (Ozan & Okumus, 2017:96). The conceptual elements of Watson's Theory of Human Caring include the caritas process, the transpersonal caring relationship, caring moments, and carative factors (Clark, 2016:3).

1.1.1.1 Transpersonal caring

Transpersonal caring is a human-to-human connection that goes beyond the person-body-ego at the moment of care (Kondo, Okanishi, Arai, Morita, Iwamoto & Hosohara, 2020:2). It focuses on consciousness, intentionality, healing, and wholeness rather than disease, illness and pathology (Clark, 2016:3). Transpersonal caring moves beyond the ego-self and radiates to spiritual, even cosmic, concerns and connections that tap into healing possibilities and potentials (Watson, 2014:326). It attends to the human centre of both the one caring and the one being cared for as it embraces a spiritual, metaphysical dimension of the caring process (Watson, 1988:176). According to Watson (1985), transpersonal caring is concerned with preserving human dignity and restoring and conserving humanity in the fragmented, technological, medical cure-dominated systems. It emphasises the phenomenon of human health-illness experience and human-to-human caring and healing experiences (Watson, 2012). Watson (2002:15) proposed that for nurses to demonstrate transpersonal caring, introspection is required because, in the transpersonal relationship, the nurse’s attitude towards caring becomes vital in promoting a connection and understanding of the patient’s perspective (Watson, 1999).

1.1.1.2 Caring moments

Watson (2009:466) regarded caring moments as the foundation of transpersonal caring. She proposed that the essence of the value of human care and caring may be futile unless it contributes to a philosophy of action (Blasdell, 2017:1). According to Watson (2014:328), caring moments become transcendent as it connects personal views and give time to inquire and uncover fear, hopes and wishes related to the process. This assists in promoting a sense of caring and helps patients and nurses find meaning and purpose in their illness (Clark, 2016:5).

Watson (1988:33-34) identifies a dual nature in the relationship during caring moments. It is nurse’s responsibility to create and facilitate encounters of mutual dependency and unspoken understanding that arise during caring moments. The encounters present the nurse and patient with an opportunity to decide how to be in the moment in the relationship – what to do with and in the moment (Watson, 2014:328). Therefore, nurses’ behaviour and attitudes leave an impression on patients, allowing them to assess whether nurses demonstrate a caring stance (Drahošová & Jarošová, 2016:457-458).

1.1.1.3 Carative factors

Watson (1996:143) assumes that caring moments are influenced by carative factors resulting in satisfying certain human needs. Watson (1992:54) wrote that the carative factors in her work are highly consistent with Nightingale's call for a values-based approach to the nursing profession.

Watson (1996:143) believed carative factors are the 'core of nursing'. They are a deeper and larger dimension of nursing that go beyond the changing times, setting, procedures, functional tasks, specialised focus around disease, treatment and technology. According to Wade and Kasper (2006:163), although these carative factors are hierarchical, they are also interrelated, leading to the holistic development of caring. The 10 original carative factors were:

1. The formation of a humanistic altruistic system of values
2. The installation of faith-hope
3. The cultivation of sensitivity to oneself and others
4. The development of a helping trusting relationship
5. The promotion and acceptance of the expression of positive and negative feeling
6. The systematic use of the scientific problem-solving method for decision-making
7. The promotion of interpersonal teaching-learning
8. The provision for a supportive, protective and/or corrective mental, physical, socio-cultural, and spiritual environment
9. Assistance with the gratification of human needs
10. Allowance for existential-phenomenological dimensions

The carative factors pointed to those aspects of nursing that potentiate therapeutic healing processes and relationships, affecting the caregiver and the one being cared for (Watson, 2008:45). These carative factors are redefining contemporary nursing and have become the ethical standards by which treatments and interventions are measured today (Watson, 1988:176).

1.1.2 Nursing in South Africa

In the 21st century, nurses are the glue that holds patients' healthcare journey together and represents nearly one-half of the total number of health workers globally (Motakpalli, Shaheen, Jamadar & Bendigeri, 2018:3866). Nursing is described as both an art and science, with an ethical perspective of human dignity. Nursing understands and applies a moral-ethical praxis that promotes and protects throughout life's continuum (Rosa et al., 2017:58). It is widely recognised as a noble profession that seeks to combine scientific knowledge and specialised skills to provide quality care to patients and others (Al Maqbali, Omari, Slimane & Balushi, 2019:322). The nursing profession is one of the important and integral parts of the healthcare system (Motakpalli et al., 2018:3865).

However, over the past decade, South Africa has seen a shortage of nurses. From 2010, there has also been a 42% decline in student nurses who completed the four-year nursing programme from institutions across all nine provinces of South Africa (Dlamini & Visser, 2017:1). The shortage of new graduate nurses resulted in a change in the retirement age from 60 to 65 years (GEPF, 2020), as a strategy to increase the nursing workforce to meet the global demographic changes and growing ageing population. According to Stevanin, Voutilainen, Bressan, Vehviläinen-Julkunen, Rosolen and Kvist (2020:15), the current nursing workforce is made up of four generational cohorts: the Baby Boomers, Generation X, Generation Y, and Generation Z. The term 'generation' is used both as an approach for grouping age cohorts, as well as for the analysis in tracking people on a range of issues, behaviours and characteristics (Mahmoud, Fuxman, Mohr, Reisel & Grigoriou, 2021:194). Mahmoud et al. (2021:194) highlighted that each generational group has different values and characteristics that directly impact attitudes and behaviours.

1.1.2.1 Baby Boomers

The Baby Boomers are nurses born between 1946 and 1964, constituting 6.7% of the nursing workforce (Şenyuva, 2018:940). This generation grew up in an era focused on protesting for individual rights, questioning and rebelling against the status quo (Miller, 2019:7). Baby Boomers were exposed to the rise of the black resistance movement from 1948 to 1960, the Sharpeville Massacre in 1960, and the Soweto Uprising of 1976 (Potgieter & Doubell, 2018:71).

This is the first generation where women could really acquire an education and work alongside men, bringing many changes to the workforce (Miller, 2019:7). Hence, Baby Boomers are known to be highly motivated by high levels of responsibility and are results-driven. They are willing to sacrifice personally and professionally in order to achieve success (Miller, 2019:7). They are characterised as nurses who equate work with personal fulfilment and self-worth (LeVasseur, Tribble & Desrosiers, 2009:214), yet South Africa is entering a phase during which the Baby Boomers are retiring (Jordaan, 2017:2).

1.1.2.2 Generation X

Generation X refers to nurses born between 1965 and 1979 and they make up 25.6% of the nursing workforce (Şenyuva, 2018:940). This generation is like the Baby Boomers; Generation Xers grew up during the apartheid era in South Africa, so by the time they were entering the nursing workplace, it was in transition. It was a period of economic and social instability, which impacted greatly on their attitudes towards career management (Jordaan, 2017:5).

Generation Xers desire job security and believe their value is created in what they know how to do, so they are always eager to learn (Taylor, 2018:137). This is the first generation exposed to rapid technological change (Stevanin et al., 2020:15). They are self-sufficient, independent, assertive, self-directed and resourceful nurses in the workplace (Taylor, 2018:140). Their formative experiences make Generation Xers more likely to be factual over emotional, and they have an intimate familiarity with ambiguity and flexibility that renders them anxious when faced with fixed, rigidly imposed, or closed-off bottom lines (Stevanin et al., 2020:15).

1.1.2.3 Generation Y

Generation Y is people born between 1980 and 1995, also known as millennials, constitutes about 46.1% of the nursing workforce (Şenyuva, 2018:940). Millennials in South Africans old enough to be part of the old regime, but not old enough to have participated in it. They are the new generation of South Africans born into a new world order, including a new South Africa (Louw & Steyn, 2020:2). This generation is often referred to as the “born free” generation because they grew up in a more liberal era (Miller, 2019:3). Generation Y are young professional nurses, which are the focus of this study.

Generation Y is highly educated and therefore more opinionated, sophisticated and technologically savvy. They can bring valuable knowledge to the table that can be crucial for optimal nursing care (Louw & Steyn, 2020:2). The Baby Boomers and Generation X professional nurses play a significant role in developing the competence of Generation Y professional nurses and serve as a source of support (Tuomikoski, Ruotsalainen, Mikkonen, Miettunen & Kääriäinen, 2018:78). Tuomikoski et al. (2018:78) found that older professional nurses become the mentors responsible for teaching, creating a supportive and caring relationship for the young professional nurses. The attitude of their mentor is important and valued by the young professional nurses, as it can translate later into their professional and personal lives (Garrino, Contratto, Massarrello & Dimmonte, 2017:132).

1.1.2.4 Generation Z

The youngest generation, called Generation Z, was born and raised in completely different circumstances than the other, older generations (Dolot, 2018:44). Generation Z generally refers to those individuals born from 1996; this generation makes up about 21.6% of the nursing workforce (Şenyuva, 2018:940). This generation is known as "digital natives" because they can function in both the virtual and real world by not only using the content of the internet, but also creating and controlling it (Oerther & Oerther, 2021:1).

Generation Z's are known to be pragmatic, in possession of underdeveloped social and relationship skills, are individualistic, exhibit a desire for convenience and immediacy, and are cautious and concerned with emotional, physical, and financial safety (Oerther & Oerther, 2021:1). Plochocki (2019:1) found that the mental health tendencies of Generation Z are more prone to psychological distress than other generations; this corresponded with the National Survey on Drug Use and Health finding that there was a 63% increase in major depressive episodes in young adults, and a 71% increase in psychological distress. Vizcaya-Moreno and Pérez-Cañaveras (2020:1) believe this is due to excessive use of technology and little personal contact, which could affect social relations capacity and lead to isolation.

Although representatives of Generation Z have only just joined the labour market, there are already varying opinions of them (Dolot, 2018:44). According to Szromek, Hysa and Karasek (2019:8), this generation is the most educated and sophisticated generation ever; however, they do not care about stability at work. Instead, they easily change their workplace, look for versatility and to escape from routine. They consider self-employment as a way of professional activity, especially because they consider it better paid and as giving a sense of independence (Dolot, 2018:45). Oerther and Oerther (2021:1) believe this generation is poorly prepared, which could have a negative impact on their caring attitudes and behaviour.

1.1.3 The role of attitudes in caring practices

Nursing practice takes place in a social framework, in which personality traits, environmental elements and interpersonal relations interact (Numminen, Leino-Kilpi, Isoaho & Meretoja, 2015:845). Chen and Hsu (2015:791) claim that becoming aware of one’s personality traits in relation to patient care is a subjective and abstract process that requires honest self-inquiry and introspection. Hawthrone and Gordon (2020:155) regard reflection as an important aspect that helps nurses intentionally connect with themselves and become aware of their attitudes in providing quality end-of-life care.

Nurses’ attitudes can either be uncaring or caring in their practice and relationship with patients and their families (Watson, 1988:33-34). An uncaring nurse-patient relationship is insensitive, apathetic and detached. It means not viewing another person as a unique individual but performing tasks in a mechanical and prescribed manner (Khalaf et al., 2017:229; Kondo & Nagata, 2015:279). As a consequence of an uncaring nurse-patient relationships, the dying patients are left in despair with decreased well-being (Watson, 2012:65).

A caring nurse has been described as someone conscious of patient’s needs (Watson, 2012:66). A caring nurse-patient relationship is kind, compassionate and the dying patient is viewed in a holistic manner. Caring promotes the development of an authentic relationship that assists in the healing process during end-of-life care (Watson, 2008:45).

1.1.4 Death and dying

Death and dying are an inevitable end in human life (Cerit, 2019:336). Death and dying often incite deep and profound questions on the meaning of life, the existence of the soul, and the possibility of an afterlife (Jafari, Rafiei, Nassehi, Soleimani, Arab & Noormohammadi, 2015:192). When people hear about death and dying, they often react negatively and describe it as morbid or depressing, because it addresses a ‘dark subject’ that is often considered taboo (Khalaf et al., 2017:233). In medicine, the subject of death is avoided as it contradicts the values of life preservation; dying is considered a ‘failure’ in care (Khalaf et al., 2017:233). This has hindered open conversations about death and dying despite the importance of effective conversations about this life phase (Islam, Nelson, Longo & Byrne, 2021:2).

In March 2020, the WHO announced the Coronavirus disease 2019 (COVID-19) outbreak as a pandemic. From March to June 2020, the virus claimed 4 517 240 lives globally and 88 429 lives in South Africa. The International Council of Nurses (ICN) reported from early January to February 2020, it had claimed more than 230 000 healthcare workers, and over 600 nurses had died from COVID-19 at the time (Kursumovic, Lennane & Cook, 2020:2). This brought the reality of death and dying to the forefront of public consciousness (Islam et al., 2021:2). People are being forced to have open conversations about death and dying (Graham-Wisener, Nelson, Byrne, Islam, Harrison, Geddis & Berry, 2021:4).

1.2 RESEARCH PROBLEM STATEMENT

In 2020, nursing celebrated the 200th anniversary of Florence Nightingale, titled by the WHO and Pan-American Health Organization (PAHO), as “the International Year of the Nurse and the Midwife” (Stiegler & Bouchard, 2020:695). In a capricious coincidence, the world was confronted with the COVID-19 pandemic the same year, which was associated with a rapid increase in morbidity and mortality rates. It has caused nurses to be confronted with more end-of-life care (Maben & Bridges, 2020:2742). The pandemic placed nurses at the frontline in terms of visibility, dedication and competence, and it is therefore crucial to understand nurses’ attitudes towards caring for dying patients and their families (Padilha, 2020:3).

In the last five years, no mixed-method studies have been conducted in South Africa regarding young professional nurses' attitudes towards caring for dying patients and their families. Moreover, attitudes towards caring for dying patients and their families have not been integrated into the South African nursing context; therefore, this study will add to the body of knowledge in nursing, with specific reference to the South African context and inform current nursing practice. This study has significant value for nursing practice because it highlights young professional nurses' attitudes towards caring for dying patients and their families, and the factors that impacted their experiences.

1.3 RESEARCH PURPOSE

A research purpose is a concise statement of the researcher's aim for the study (Gray, Grove & Sutherland, 2017:78). The purpose of this study was to explore and describe young professional nurses' attitudes towards caring for dying patients and their families at a secondary academic hospital in Gauteng, to formulate recommendations for professional nurses when caring for the dying patient and their families.

1.4 RESEARCH OBJECTIVES

The research objectives were:

- To determine young professional nurses' attitudes towards caring for dying patients and their families.

- To explore and describe the outliers' attitudes towards caring for dying patients and their families.

- To formulate recommendations for professional nurses when caring for dying patients and their families.

1.5 RESEARCH QUESTIONS

The research questions that were answered were:

- What are young professional nurses' attitudes towards caring for dying patients and their families?
- What are the outliers' attitudes towards caring for dying patient and their families?
- What are factors that impact on the outliers' attitude when caring for dying patients and their families?

1.6 RESEARCH HYPOTHESES

Brink (2015:114) defines a research hypothesis as a set of assumptions regarding an observable phenomenon that is expressed coherently. This study had the following research hypotheses:

1) Positive attitudes towards caring for dying patients and their families are prevalent among more experienced young professional nurses.
2) The more frequently young professional nurses are in contact in caring for dying patients and their families, the more positive their attitude.
3) Education on death and dying positively affects the attitudes of young professional nurses towards caring for dying patients.

1.7 NULL HYPOTHESES

The null hypothesis is a statement proclaiming no relationship or difference between variables, and any observed relationship is only a function of chance (Brink, 2015:114). This study had the following research null hypotheses:

1) Positive attitudes towards caring for dying patients and their families are not related to years of experience.

2) There is no relationship between the attitude and the frequency the young professional nurse is in contact with dying patients and their families.

3) There is no relationship between education on death and dying and young professional nurses' attitude towards caring for dying patients and their families.

1.8 PARADIGMATIC PERSPECTIVE OF THE STUDY

The term 'paradigm' originated from the Greek word *paradeigma,* which means pattern. It was first used by Thomas Kuhn (1962) to denote a conceptual framework within the discipline, which provides frames and processes through which investigation is accomplished (Kaushik & Walsh, 2019:1). A research paradigm inherently reflects methodological aspects of research projects used to determine the research methods that will be used and how data will be analysed (Kivunja & Kuyini, 2017:26).

Pragmatism was the paradigmatic perspective used in this study. Pragmatism uses the methodological approach that works best for the research problem being investigated (Kaushik & Walsh, 2019:2). The pragmatic paradigm places the research problem as central, and draws on many ideas using diverse approaches, valuing both objective and subjective knowledge (Creswell, 2007:11). Taking a pragmatic stance in this study allowed the researcher to mix design components as it offered the best chance of answering the research question. This was vital in understanding young professional nurses' attitudes towards caring for dying patients and their families.

1.8.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to philosophical assumptions about the theoretical nature of a phenomenon under study and how it should be thought about and therefore researched (Creswell & Poth, 2018:57). Uher (2013:2) claims meta-theoretical assumptions determine what is considered data in a particular field and how it can be analysed and interpreted. This was valuable for this study, which explored and described young professional nurses' attitudes based on their perceptions and interpretations of their experiences when caring for the dying patient and their families.

1.8.2 Theoretical assumption

Theoretical orientations are based on literature that provides an empirical conceptual or theoretical framework by which the findings of the research study can make sense on a more practical level (Creswell & Poth, 2018:57). They offer an epistemic pronouncement about the research field and shape the study's conceptual framework (Creswell, 2014,13-14). The theories used in this study were Watson's Theory of Human Caring (Watson,1979:243) and Kübler-Ross's Death and Dying Model (Kübler-Ross, 1991:82).

Watson's Theory of Human Caring (Watson, 1979:243-261) was utilised to explore young professional nurses' attitudes towards caring for the dying patient and their family. The goal of Watson's Theory of Human Caring was to apply caring to real clinical settings, which was beneficial for both the dying patient and nurse. The researcher's assumptions about caring for the dying patient and their family were based on the 10 carative factors from Watson's Theory of Human Caring (Watson, 1979:243):

- caring for the dying patient and their family is achieved when there is a helping, trusting relationship between the nurse, dying patient and their family;
- caring for the dying patient and their family is in promotion and acceptance of the expression of positive and negative feelings with regards to the impending death;
- caring is provided by allowing for the existential-phenomenological dimensions of the dying patient and their family;
- caring for the dying patient and their family occurs when support is offered, not only for the dying patient but their family as well;
- caring for the dying patient and their family is seen in assistance with the gratification of human needs;

- caring for the dying patient and their family occurs when there is the systematic use of the scientific problem-solving method for decision-making, which allows for acceptance for end-of-life care;
- caring for the dying patient and their family is realised during the insulation of faith-hope during end-of-life care;
- caring for the dying patient and their family occurs when one is sensitive to oneself and others during end-of-life care; and
- caring for the dying patient and their family takes place when a humanistic altruistic system of values is formed in facilitating quality end-of-life care.

Kübler-Ross's (1999:81) Death and Dying Model was also used in this study to describe the dying patient and their family's experience with death and dying. The researcher based the assumptions of young professional nurses' attitude towards caring fo dying patients and their families on the dying patient and their family's experience of denial, grief, anger, bargaining, depression and acceptance (Kübler-Ross, 1970:105-110)

1.8.3 Methodological assumption

Methodological assumptions relate to the research process and procedures and must be congruent within the research paradigm (Creswell & Poth, 2018:58 & 61). The methodological assumptions direct the accuracy of the information contained in the data. It is incumbent on the researcher to explain the steps taken to justify the applicability of the information obtained from participants (Ndempavali & Justus, 2016:99). Methodological assumptions give form to research objectives and contexts, which, in turn, influence decisions about the research design (Ndempavali & Justus, 2016:9).

The methodological decisions for this study were based on a pragmatic worldview. Creswell (2014:13-14) claim the choice of pragmatism as a paradigm in mixed-methods research mirrors the larger inquiry process by reflecting on the available alternatives and selecting an approach to research that is built around precisely the needs of mixed-methods research as a field. According to Morgan (2017:17), pragmatism, as a paradigm in mixed-method reach designs, argues that all knowledge of the world is based on experience. All knowledge is unique and socially constructed, with versions matching the individual's experiences (Morgan, 2017:17). This was valuable for this study as it aimed to explore and describe young professional nurses' attitudes towards caring for dying patients and their families from the perspective of participants, rather than explain it.

1.9 DEFINITION OF KEY CONCEPTS

The following key concepts are used in this study:

1.9.1 Young professional nurse

Section 30 of the South African Nursing Act (33 of 2005) defines a 'professional nurse' as a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed, and who can assume responsibility and accountability for such practice (SANC, 2013a:4-5). A professional nurse cultivates and harbours traits of a caring person, deployed as a curator and caretaker of the ill (Kaur, Kumar & Kumar, 2016:738). Pool, Poell and ten Cate (2013:36) define 'young nurses' as nurses under the age of 40. In this study, a young professional nurse refers to a professional nurse, registered with the South African Nursing Council (SANC), with one to five years' work experience.

1.9.2 Attitude

Attitude is an automatic emotional response that represents the individual's long-term ideas, feelings and behaviour that cannot be observed directly (Coban, Kiirca & Yurttas, 2015:666). Attitudes can either be positive or negative based on the individual's reaction (Coban et al., 2015:666). In this study, attitude referred to how young professional nurses felt about certain situations in which they were involved when caring for the dying patient and their family.

1.9.3 Caring

Caring is an interpersonal happening between two persons, which Watson (1988:33-34) identifies as a dual nature. The end goal is the protection, enhancement, and preservation of human dignity (Watson, 1999:29). In this study, caring referred to the young professional nurses' attitude towards certain tasks involving dying patients and their families.

1.9.4 Dying patients

A dying patient as a person who is terminally ill, with six months or fewer to live (Frommelt,1991:39). In this study, a dying patient, refers to a person with a gradual decline of health, marked by acute episodes of exacerbation, associated with disability, eventually leading to death.

1.9.5 Families

A family is defined as a group of individuals who support the health and well-being of the critically ill patient. These individuals within a family may be bonded by legal, biological, social, spiritual, or psychological relationships; however, family is defined by its members (McAndrew, Schiffman & Leske, 2020:193). In this study, family referred to individuals with strong ties to the patient, providing emotional, physical, and spiritual support.

1.10 RESEARCH DESIGN AND METHOD

The research design is an outline of the study and dictates the methodology utilised to obtain appropriate and rich data, analyse and interpret the findings in order to answer the research questions, and achieve the aim and objectives of the study (Gray, Grove & Sutherland, 2017:52).

This study used a mixed-method research and employed a sequential explanatory strategy. A mixed-method design is described as a research methodology that employs the strength of both quantitative and qualitative research designs in a single study (Creswell, 2014:13-14). Mixed-method research aids in answering a research question that cannot be answered by quantitative or qualitative methods alone and provide a greater repertoire of tools to meet the aims and objectives of a study (Creswell & Plano Clark, 2007:30). Mixed-method research allows the researcher to explore more divergent viewpoints on the same issue and provide contextual understandings shaped by real-life experiences (Harrison, Reilly & Creswell, 2020:2). This allows researchers to address complex research questions, find answers to both exploratory and confirmatory questions within a single study, and reveal a fuller picture of a problem in practice (Ivankova & Wingo, 2018:979). In this study, the mixed-method research design helped the researcher to explore the young professional nurses' attitudes towards caring for the dying patient and their family and gain a better understanding of young professional nurses' attitudes towards caring for the dying patient and their family.

An explanatory sequential design is one of the most common designs in mixed-methods research. It consists of two distinct interactive phases: the initial quantitative phase, followed by the qualitative phase (QUANT → qual) (Creswell, 2014:13-14). This approach is a mixture of techniques, where statistical information obtained from quantitative measurements is supported and enriched by qualitative information obtained from the explanations provided by the quantitative results (significant, non-significant, outliers or surprising results) (Creswell, Plano Clark, Gutman & Hanson, 2003:215). The explanatory sequential strategy in this mixed-method study was used over three phases; Figure 1.1 is a visual presentation of the explanatory sequential strategy's rigour, as presented by Harrison et al. (2020:5).

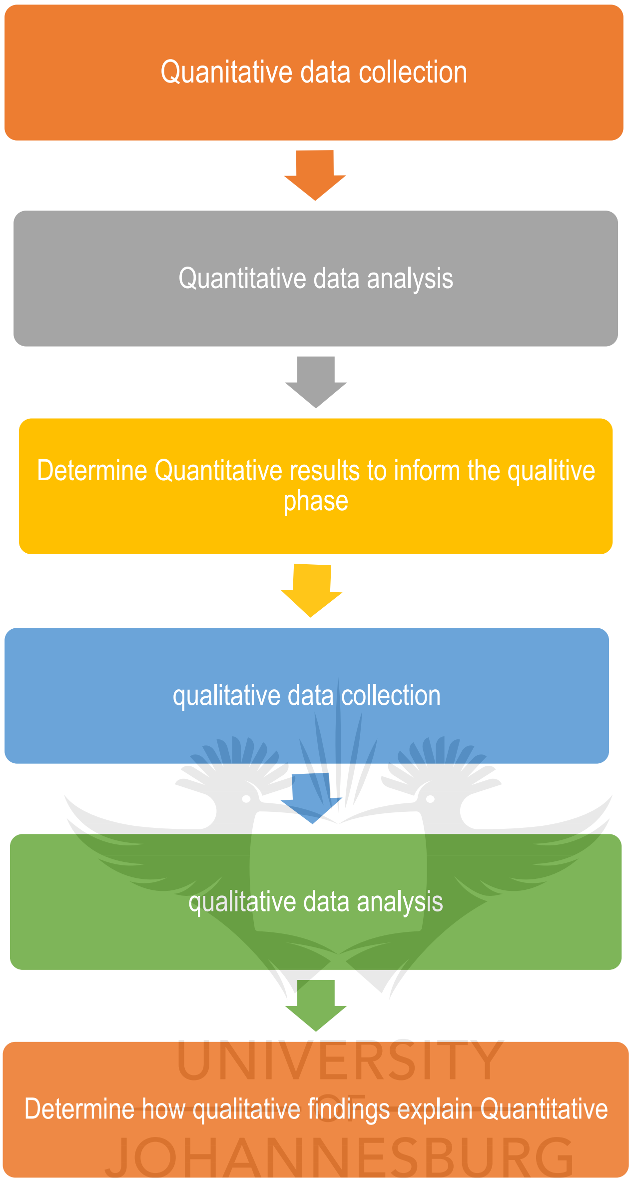


Figure 1.1: Quantitative and qualitative (mixed methods) explanatory sequential strategy

1.10.1 Phase 1

In Phase 1, the researcher applied a quantitative method, which focused on surveying young professional nurses' attitudes towards caring for the dying patient and their family. This was vital in answering the research question. The researcher was able to better understand a diverse aspect of reality, in terms of incidence, connection between two ideas, and cause-and-effect relationships (Gray et al., 2017:37). Numerical values were assigned to qualify attitudes; this assisted the researcher in analysing young professional nurses' attitudes towards caring for dying patients and their families. Participants' age, gender, years of experience, type of ward in which they worked, their previous experience of caring, and previous exposure to end-of-life education were analysed through comparative procedures. These were described in relation to caring and young professional nurses' attitudes towards caring for dying patients and their families.

A descriptive, correlational approach was used to explore and describe ideas as they occurred and examine the relationship among research variables (Gray et al., 2017:39). The numerical data were then analysed using statistical techniques (De Vos, Strydom, Fouché & Delport, 2011:220-221).

1.10.1.1 The setting

Phase 1 took place at a hospital based in Gauteng. The hospital under study was a secondary public hospital that also acts as a teaching hospital for undergraduate and postgraduate training in all health professions. It is affiliated with various universities and nursing colleges and offers a wide range of secondary, tertiary and specialised services. It has two admission wards, nine medical wards, four surgical wards, two orthopaedic wards, a psychiatric unit, an ICU unit, and a high-care unit. It has several specialised clinics on the health campus, such as a Stoma unit, Renal Dialysis Unit, Pain Clinic, Endoscopy Unit, Breast Clinic, and HIV clinic (Hurri, Scribante, Perrie & Chetty, 2020:31).

1.10.1.2 Population, sampling and sample size

A population is a particular group of people that are the focus of the study. The target population is the entire set of individuals meeting the sampling criteria. Gray et al. (2017:330) define an accessible population as a portion of the target population to which the researcher has reasonable access. In this study, the accessible population comprised young professional nurses with one to five years' work experience.

Sampling is defined as a procedure for selecting a group of people who represent the population being studied (Bhardwaj, 2019:157). When the study started, snowball sampling was used. The study was commenced during Level 3 social distancing regulations (attributed to COVID-19), and the hospitals were not allowing visitors or researchers in the hospital in an attempt to curb the infection rate. Snowball sampling was thus deemed useful in this case because the subjects were difficult to access (Anieting & Mosugu, 2017:34-35). Snowball sampling proceeds with the researcher identifying one or more respondents and asking them for further contacts of other respondents that are relevant, available and willing to participate in the study (Barglowski, 2018:161). This was the case in this study; the researcher used Facebook as the platform to contact subjects that met the study's inclusion criteria. The process is described in detail in Chapter 3.

Once the country was placed at Level 2, the social distancing regulations were more flexible. The researcher was able to go into the field and use convenient sampling to recruit respondents. Convenience sampling is defined as a sampling method that uses members of the population that are available at the time the research is conducted until the desired sample size is obtained (Ghaljaie, Naderifar & Goli, 2017:2). Sampling was based on the following criteria: young professional nurses with one to five years' work experience, working at the hospital under study, registered with the SANC, and voluntarily willing to complete a survey questionnaire. The young professional nurses used in the study were in the ward when the researcher conducted the study, as described in detail in Chapter 3. A total of 100 young professional nurses were accessible to the researcher and asked to participate; ultimately, 62 agreed to participate.

1.10.1.3 Data collection

Quantitative research involves collecting data so that information can be quantified and subjected to statistical treatment to support or refute alternative knowledge claims. It employs strategies such as experiments and surveys that yield statistical data (Apuke, 2017:41). In this study, the researcher used a demographic questionnaire (Annexure 1) and Likert scale (Annexure 2) consisting of three sections. A statistician reviewed and ascertained the appropriateness of the demographic questionnaire and Likert scale. Authorisation to use the FATCOD scale (Annexure 3) and Level of Support in the Work Environment Questionnaire was granted by its developers (Annexure 4). Permission to use Templer's Death Anxiety Scale (DAS) could not be obtained from the developer as they had passed away. The researcher obtained advice from another researcher regarding ways to obtain permission and was informed that since the researcher had revised the Templer's Death Anxiety Scale, permission for its use was not necessary (Annexure 5). A detailed description of how Templer's Death Anxiety Scale was revised is given in Chapter 3 of this study.

Section A of the Likert scale comprises the Modified Templer's DAS, Section B is the Frommelt FATCOD scale, and Section C is the Level of Support in the Work Environment Questionnaire. The research instruments are described in detail in Chapter 3 of this study.

a) Demographic questionnaire

A demographic questionnaire is used to capture the attributes of the sample as a whole and their differences that might be associated with the study variables (Gray et al.,2017:499-500). A self-report demographic questionnaire, developed by the researcher, was used in this study.

b) Templers Death Anxiety Scale (DAS)

The Modified Templer's DAS (Annexure 2) forms Section A of the Likert scale. It was developed in 1970 and is still being used to measure death anxiety (Saleem, Gul & Saleem, 2015:724). Templer's DAS was designed to cover a wide variety of feelings related to anxiety regarding death and dying (Saleem et al., 2015:724).

c) Frommelt's Attitude Towards Care of the Dying (FATCOD) scale

The FATCOD (Annexure 2) scale forms Section B of the Likert scale. The FATCOD scale was developed in 1988 and is currently the most widely used instrument for assessing attitudes towards caring for the dying patient and their family in the nursing context (Edo-Gual, Tomás-Sábado, Gómez-Benito, Monforte-Royo & Aradilla-Herrero, 2017:121).

d) The Level of Support in the Work Environment Questionnaire

The Level of Support in the Work Environment Questionnaire (Annexure 2) formed Section C of the Likert scale. This questionnaire was developed by De Kock (2011), and the questions were compiled from the analysis of previous studies by Traynor and Wade (1993) and Cashavelly, Donelan, Binda, Mailhot, Clair-Hayes and Maramaldi (2008).

The demographic questionnaire and Likert scale was pre-tested online for the pilot study. For the main study, the demographic questionnaire and Likert scale were administered in the tearoom of each ward during the young professional nurses' lunchtime. The respondents had to complete the questionnaire individually and place them in a locked letterbox with a slot found in the ward. The researcher collected the box at the end of each week. The data collection procedure is described in detail in Chapter 3.

1.10.1.4 Data analysis

Quantitative research methods deal with quantifying and analysing variables in order to get results (Apuke, 2017:41). Data analysis is a significant methodological component that focuses on the reduction, organisation and statistical testing of information obtained in the data collection phase (Abulela & Harwell, 2019:59). In this study, data were captured by the researcher but were cross-checked for accuracy by the statistician before analysis. The data were ultimately analysed by a statistician consultant from Statkon. The analysis was done by statistical procedures using IBM Statistical Packages for the Social Sciences (SPSS) version 27.0.

The data analysis procedures included descriptive statistics to summarise the data; factor analysis to reduce the data; correlation analysis to identify and explain relationships in the data and significant differences in the data; and path analysis to identify and describe the attitude factors that exerted the greatest influence on caring for the dying patient and their family. These assessment procedures are discussed in detail in Chapter 4.

1.10.1.5 Validity and reliability

The instrument's validity is defined as the extent to which a concept is accurately measured in a quantitative study (Heale & Twycross, 2015:66). The FATCOD scale, Templer's DAS, and Level of Support in the Work Environment Questionnaire were found to be distinct from each other, yet relevant to attitudes and caring for the dying patient (Frommelt, 1991; Pehlivan, Lafc, Vatansever & Yıldız, 2020:130; Watson, 1988:54). The instrument is described in detail in Chapter 4.

The instrument's reliability refers to the consistency of the measures obtained from an attribute in the study (Polit & Beck, 2018:175). Reliability is concerned with the precision, replication and comparability of a measurement method. According to Gray et al. (2017:370), an instrument with strong reliability demonstrates consistency across respondents' scores, which results in fewer measurement errors. Table 1.1 depicts the original Cronbach's alpha coefficient of the research instruments:

Table 1.1: The original Cronbach's alpha coefficient of the research instrument

Scale	Original Cronbach's alpha coefficient
Templer's Death Anxiety Scale (DAS)	0.84
Frommelt Attitude Towards Care of the Dying (FATCOD) scale	0.76
Level of Support in the Work Environment Questionnaire	0.75

The reliability of the instruments used in the study is described in detail in Chapter 4.

1.10.2 Phase 2

Phase 2 was the follow-up phase. It employed a qualitative, phenomenological design (Creswell, 2005:59-60) using a phenomenological approach. The phenomenological approach perceives the participant as a being in constant interaction with the environment, which assists them in attaching meaning to their experience (Gray et al., 2017:65-66). According to Kerwin-Boudreau and Butler-Kisber (2016:956-971), the phenomenological approach involves verbal extraction of important participant statements through the researcher's interpretation, drawing meaning from the statements, organising the meanings into themes, and then clarifying the themes in a rich written description.

The researcher's decision to follow Phase 1 with a qualitative method was fuelled by two motives. Firstly, the objective nature of quantitative inquiry by means of which the initial survey data were collected did not allow for any analysis of the results regarding respondents' subjective experiences. Secondly, following up with a phenomenological qualitative approach provided a detailed description of the young professional nurses' experiences caring for dying patients and their families. This assisted the researcher in deepening and contextualising the overall findings of the core quantitative survey in Phase 1 of the study.

1.10.2.1 Population and sampling

The accessible population comprised outliers in Phase 1 (young professional nurses with low or high scores) who consented to follow-up interviews. Purposive sampling was used at this phase. In purposive sampling, participants are consciously selected by the researcher. According to Gray et al. (2017:345), in purposive sampling, participants are information-rich cases that are important in understanding the purpose of the study. Participants were consciously selected by the researcher (Polit & Beck, 2018:202). The participants SANC numbers were chosen from two hats; one that had the names of participants with low overall scores on the FATCOD scale, and the other with the names of participants with high overall scores on the FATCOD scale. Names were drawn from each hat randomly until the sample size was achieved. The sample size was six young professional nurses: three with low scores on the FATCOD scale, and three with high scores on the FATCOD scale, as guided by the statistician and fitting the study's objectives.

1.10.2.2 Research setting

The focus group was conducted via Zoom call due to social distancing regulations (WHO, 2020). Zoom is a video-conferencing application that allows users to communicate in real time, enabling interactions like those occurring in the traditional face-to-face interplay (Alfadda & Mahdi, 2021:885). Zoom is easily installed on a laptop, computer, or smartphone. A study conducted by Dharma, Asmarani and Dewi (2017:269) established that participants found Zoom an easy application to use as the features are straightforward with a more stable connection compared to other online platforms. A detailed description of the study's context is provided in Chapter 3.

1.10.2.3 Data collection

The researcher conducted a focus group for data collection in Phase 2. Focus groups typically consist of a small number of participants who are guided through a discussion by a moderator using a structured interview protocol (Nyumba, Wilson, Derrick & Mukherjee, 2018:28). Focus groups are useful tools for examining perceptions and feelings about topics (Jones, Newsome, Levin, Wilmot, McNulty & Kline, 2018:99). The focus group discussion in Phase 2 helped clarify and extend the findings from Phase 1. This provided depth and insight into the young professional nurses' attitudes towards caring for dying patients and their families. Details of the focus group are described in Chapter 3.

1.10.2.4 Data analysis

The data were transcribed verbatim. Giorgi's phenomenological method of qualitative data analysis (Giorgi, 2009) was followed. This involved reading the field notes and listening to the audio from the focus group several times to attain a sense of the whole; identifying meaning units or themes from the data; and synthesising a general structure or the central theme from the young professional nurses' experiences caring for dying patients and their families. A more detailed description of the data analysis can be found in Chapter 4.

1.10.2.5 Measurement of trustworthiness

Trustworthiness reflects the rigour in qualitative studies, which simply poses the question “to what degree can the finding in the study be trusted” (Korstjens & Moser, 2018:121). In this study, trustworthiness was pursued to ensure the study’s findings are a true representation of the young professional nurses’ lived experiences of caring for dying patients and their families. Korstjens and Moser (2018:121) urged that the criteria for trustworthiness for all qualitative research be described under the following headings:

- Credibility
- Transferability
- Dependability
- Confirmability

Credibility refers to the confidence placed in the truth of the research findings (Korstjens & Moser, 2018:121). This is established when the research findings represent information drawn from the participants’ original data and views that have been interpreted correctly (Korstjens & Moser, 2018:121). The researcher endeavoured to establish this confidence by attempting to demonstrate a true picture of young professional nurses’ attitudes towards caring for dying patients and their families by engaging the research supervisors during data analysis.

Transferability has been described as the degree to which research findings can be transferred to other contexts or settings with a different population (Korstjens & Moser, 2018:121). To allow this applicability, the researcher tried to provide an exhaustive and rich description of the fieldwork to enable the reader to determine the contextual similarity of the study environment and their environment.

Dependability relates to the stability of the findings over time. This may involve an evaluation of the research findings, interpretation, and recommendations of the study (Korstjens & Moser, 2018:121). All the documents in this study have been kept as an audit trail. By providing enough details of the study, the researcher allowed future researchers an opportunity to repeat the study, and where possible, obtain similar results, thus rendering the study dependable.

Confirmability is the degree to which the findings of the study can be confirmed by other researchers (Korstjens & Moser, 2018:121). Data analysis triangulation and peer expert examination was done to ensure confirmability was maintained. All data for this study will be kept for two years after its publication. A detailed description of the four measures of trustworthiness and the strategies applied in this study is presented in Chapter 3.

1.10.3 Phase 3

In Phase 3, a discussion, interpretation and integration of findings from Phases 1 and 2 were done, considering existing literature, using triangulation methods (Morgan, 2014:28). Based on the study's findings and evidence from literature, recommendations were made to facilitate quality end-of-life care at the hospital under study. This is discussed in detail in Chapter 5.

1.11 ETHICS

Ethical conduct is critical in research, ensuring valid research evidence is developed for practice (Dhai & McQuoid-Mason, 2011:166-179). This study was conducted in accordance with ethical principles required for research practice involving humans, as set out by Dhai and McQuoid-Mason (2011:166-179). The protection of human rights and standards when conducting nursing research is described under the following fundamental ethical principles: respect for autonomy, justice, beneficence and non-maleficence (Dhai & McQuoid-Mason, 2011:14).

1.11.1 Permission and informed consent

Ethical clearance was obtained from the Research Ethics Committee (REC) and the Higher Degrees Committee (HDC) of the Faculty of Health Sciences from the University of Johannesburg (Annexure 6). Permission to conduct the study at the hospital under study was obtained from the Department of Health (Annexure 7).

Further permission to gain access to study sites and participants was granted by gatekeepers (charge nurses in the participating wards). The term ‘gatekeeper’ refers to people controlling access to the field, which influences the potential participants’ willingness to participate in research (Andoh-Arthur, Hjelmeland, Osafo & Knizek, 2018:289). The researcher approached the gatekeepers, namely the nursing hospital manager and operational managers in each ward. The gatekeepers provided access into the field and assisted the researcher in informing the potential participants of the purpose of the study, their rights as participants, the inclusion criteria, and data collection method.

1.11.2 Principle of respect for autonomy

Respect for autonomy underpins the concept of informed consent. This means participants must be allowed the make decisions freely, independently and without any form of coercion (Holloway & Galvin, 2017:53). During the recruitment of participants, it was important to respect the participants as autonomous agents. In order to obtain informed, voluntary consent from participants, the researcher informed participants about the study as well as their right to withdraw from the study at any point by means of an information letter (Annexure 8). A verbal explanation was further extended to each respondent regarding their rights to voluntary participation, withdrawal, privacy, and confidentiality.

Respondents were also informed that although the study had a second phase, they were not obligated to continue to the end of the study if they chose not to; they could withdraw at any time without fear of intimidation, penalty or prejudice. Those who volunteered to participate in the study were asked to sign an informed consent form (Annexure 9), indicating that their participation was entirely voluntary and without any due coercion. Of all subjects invited to participate in the study, 38 declined, but they were not treated with any prejudice.

1.11.3 Principle of justice

Dhai and McQuoid-Mason (2011:15) describe justice as the moral obligation to act based on fairness, a right to privacy and anonymity. Fairness refers to the fair treatment of each participant in the study; from the selection of the subjects to their assignment (Dhai & McQuoid-Mason, 2011:15). The decision to use young professional nurses as the study population was made since they were directly related to the research problem. Their input would lead to the achievement of the study's objectives. When selecting participants, proportionate sampling in Phase 1 ensured that all members of the accessible population had an equal chance of participating in the study in the proportion in which they occurred in the accessible population. Purposive sampling targeted the outliers (respondents with low or high scores on the FATCOD scale) in Phase 2. After the outliers were identified, their names were drawn from a hat so all outliers had an equal chance of being selected.

The right to privacy and anonymity refers to the extent to which personal information can be shared or withheld from others (Dhai & McQuoid-Mason, 2011:14). This ensures that even as the study's findings are published, no information is identifiable to any individual (Gray et al., 2017:170). In this study, the researcher guaranteed that the participants were protected from various physical, psychological, moral and reputational harm that might have resulted from their participation in the study by keeping their participation anonymous.

Gray et al. (2017:170) define the right to confidentiality as the researcher's management of private information shared by the participants with others. To safeguard participants' confidentiality, their anonymity was strictly observed. A master list was compiled to allow data to be linked to the respondents. On the master list (Annexure 14), respondents were asked to write their name, surname, SANC number and telephone number (used to contact them for Phase 2 of the study). The master list and consent form were stored separately from the instruments and transcripts in a safe, only accessible by the researcher. To avoid the breach of justice, each safe had a code only known by the researcher. This provided a guarantee that no study data could be linked to any of the participants.

1.11.4 Principle of beneficence and non-maleficence

Beneficence is the ethical principle that addresses the idea of doing good to others (Dhai & McQuoid-Mason, 2011:14). The researcher promoted and maximised good and minimised harm to the young professional nurses. Even though there were no direct benefits of participating, participants were told that taking part would assist in generating and refining nursing knowledge for evidence-based practice needed to better facilitate quality end-of-life care.

Dhai and McQuoid-Mason (2011:14) describe non-maleficence as doing no physiological, emotional, social or economic harm. The potential for temporary emotional distress from some of the statements on the Likert scale questionnaire was noted. Therefore, participants who experienced emotional distress after filling in the Likert scale and after their participation in the focus group were informed to contact the researcher for referral to the psychology department in the hospital under study for counselling.

1.12 ORGANISATION OF CHAPTERS

This dissertation is composed of five chapters which are organised as follows:

Chapter 1: Overview of the study
This chapter describes the rationale for the research, the aim and objectives of the research. Concepts are clarified, and the research design and methodology are introduced, including sampling methods and data management. The ethical considerations are fully discussed.

Chapter 2: Literature review
In this chapter, the literature review and theoretical framework for the study and their relevance to the research problem are discussed.

Chapter 3: Research design and methods
This chapter focuses on the methodology and research design of this study. It describes the selection of the sample of participants, the data collection methods, and the plan to organise and analyse the data.

Chapter 4: Presentation and discussion of results
This chapter presents the analyses, interpretations and discussions of the findings.

Chapter 5: Evaluation of the study, limitations, recommendations, conclusions and reflection on the journey

The last chapter of this research focuses on conclusions and recommendations.

1.13 SUMMARY

This chapter provided an overview of the study. The background and rationale of the study were discussed, followed by a statement of the research problem. The research questions, research purpose, and research objectives were stated. The key concepts were defined, and the research design and methods were briefly described. The reliability and validity of the questionnaire, as well as the measures of trustworthiness in the qualitative phase, were outlined. Ethical considerations in executing the study were also discussed in detail. In conclusion, the chapter made an introduction to the overall structure of the study. Chapter 2 presents a review of literature relevant to the study.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of the literature review is to identify what is known and what research is available (Gray et al., 2017:120). In this chapter, literature from past studies, published theses and journal articles were reviewed to provide a broader perspective regarding young professional nurses' attitudes towards caring for the dying patient and their families. Relevant sources were included in this review. Various search engines such as EBSCO host, Medline and online journals were consulted. It was established that no studies in the last five years were conducted in South Africa regarding young professional nurses' attitudes towards caring for the dying patient and their family; thus, most of the studies included in this literature review are from other countries.

This chapter commences with Watson's Theory of Human Caring, followed by Kübler-Ross's theory, as these formed the study's theoretical framework. This discussion is followed by the exploration of the caring science of conscious dying and its relation to caring for the dying patient and their family. Literature on the young nurses' attitudes and their effects on caring for the dying patient are also reviewed. The effects of education and clinical exposure on attitudes towards caring for the dying patient are highlighted, followed by a detailed review of end-of-life care and the influence death anxiety has on end-of-life care. A comprehensive description of the family and their role when caring for the dying patient is presented. This chapter concludes with an overview of the current end-of-life practices attributed to the COVID-19 pandemic.

2.2 WATSON'S THEORY OF HUMAN CARING

Watson's Theory of Human Caring has often been referred to as a framework, a theory and conceptual model that brought to light caring science as the essence of nursing and a foundational core of the discipline. Watson's Theory of Human Caring was based on 7 assumptions (Watson, 1979:243-261):

1. Caring can be practiced and effectively demonstrated only through interpersonal relationships
2. Caring can be realised by practicing carative factors which result in satisfying certain human needs
3. There is substantial health promotion and individual or family growth when caring is effective
4. Caring should accept a person not only as they are, but also their ability to become what they can become
5. A caring environment offers the development of potential and upholds the person's best choice of actions
6. Caring integrates biophysical knowledge with knowledge of human behaviour to serve the ill and promote their health
7. The practice of caring is central to nursing.

Watson's Theory of Human Caring is widely used in nursing due to its approach to nursing practice, as it tries to bridge the gap between theory and practice. The theory claims nursing care is developed through a combined study of the sciences and the humanities, culminating in a human care process between nurse and patient that transcends time and space and has spiritual dimensions (Watson, 1988, 1999). It emphasises caring knowledge and actions as a serious ontological, ethical and pragmatic concern for the discipline, as effective caring promotes health for the patient and the nurse. Caring is ultimately related to mental and spiritual growth for oneself and others, and this inner power and control assists in enhancing occurrences of transcendence and self-healing (Blasdell, 2017:2). The central concepts of Watson's theory are the transpersonal caring relationship, caring moments, caring consciousness, and caritas processes. The relationships between these concepts are illustrated in Figure 2.1, as adapted from Pajnkihar et al. (2017:248).

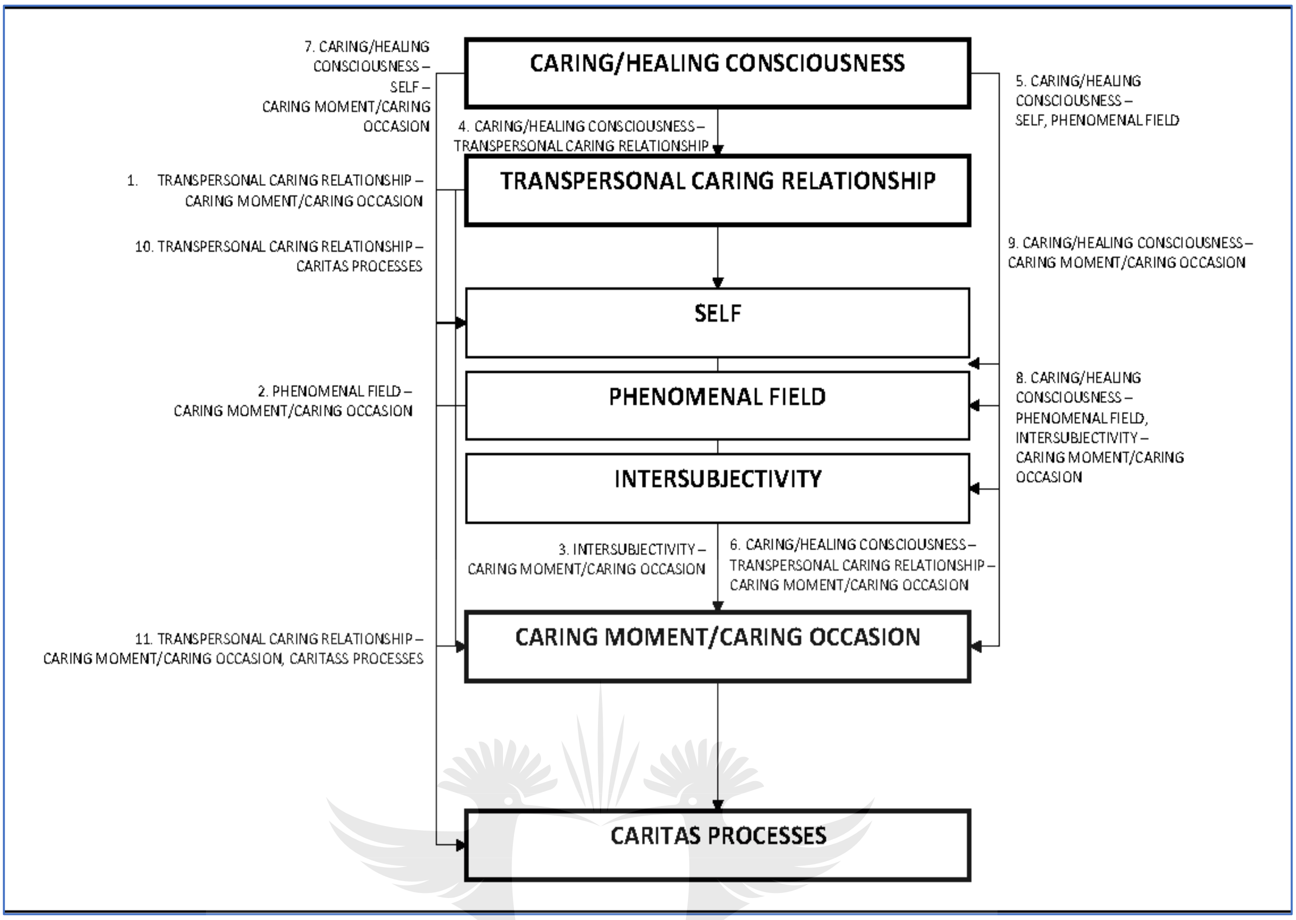


Figure 2.1: Watson's Theory of Human Caring propositions (Adapted from Pajnkihar et al., 2017:248)

2.2.1 Transpersonal caring

The term 'transpersonal' is defined as reaching beyond the personal realm or transcending the singular, personal state of being (Clark, 2016:2). Watson adapted this definition for nursing, referring to transpersonal as an inter-subjective human-to-human relationship in which the nurse affects and is affected by the patient (Watson, 2012:13). This approach was based on holistic principles of caring that involve genuine, relationship-based interactions built on trust, focusing on the patient's well-being (Enzman Hines & Gaughan, 2017:328). Transpersonal caring conveys a concern for the inner life world and subjective meaning of another who is fully embodied and goes beyond the ego-self and the given moment, reaching to the deeper connections to spirit and the broader universe (Watson, 2014:326). Transpersonal caring represents a paradigm shift in thought, science, culture and consciousness, honouring intuition, contemplation, and integrative awareness (Clark, 2016:3). According to Watson (2005:16), the concept of transpersonal caring has three dimensions: the self, the phenomenal field, and intersubjectivity.

2.2.1.1 The self

Transpersonal caring calls for an authenticity of being and becoming, an ability to be present to self and others in a reflective frame (Watson, 2006:299). This principle is founded on the basis that before a nurse can care for another person, they must practice giving kindness, compassion, and equanimity to themselves (Linton & Koonmen, 2020:1697). Self-awareness is unequivocally vital in nursing care; nurses are better equipped to practice sensitivity to others and their needs if they recognise their own feelings and emotions (Watson, 2007:5). According to Watson (2014:327), self-awareness is needed for the nurse to impart genuineness and congruence extending beyond the usual narrow limitations of the professional role of the nurse. This allows the nurse to centre their consciousness and intentionality, which promotes a more authentic holistic experience for patients. It also influences nurses' ability to connect with patients on a transpersonal level in order to create the sort of caring-healing atmosphere where the transpersonal caring experience is actualised (Clark, 2016:4).

2.2.1.2 The phenomenal field

One of the key concepts Watson (2002:13-14) mentioned in transpersonal caring is the notion of intentionality and consciousness. Intentional presence is a conscious and altruistic choice, born of moral virtue and selflessness, to act in a thoughtful, empathetic, and humanistic way that honours and gives meaning to the uniqueness of each nurse-patient interaction (Watson, 2005:16). Intentional presence is guided by trust and a desire to be present in the moment (Watson, 2005:16). Watson (2012:14) defines intentional caring not as being goal-oriented but purpose-driven, which informs one's choices and actions. In this way, it aims to focus more on love and acceptance versus what needs to be done (Clark, 2016:50). It is this conscious commitment that leads to the development of authentic transpersonal caring. Watson (2005:17) believes that through authentic intentionality, the nurse's presence can make a difference in a patient's life. This reinforces Nightingale's metaphysical orientation that nursing is not only a profession but a "calling" (Watson, 1988:57) that makes a difference in a patient's life (Watson, 2005:17).

2.2.1.3 Intersubjectivity

Intersubjectivity is described as the essence of the human-to-human experience that happens in our genuine co-existence with others. Watson (1989:234) believes intersubjectivity in transpersonal caring incorporates the spiritual aspects of humanness and allows nurses to connect with the patient's spirit, which goes beyond the ego (Kaur, Kumar & Kumar, 2016:739). The nurses' moral commitment, intentionality, and consciousness enhance, promote, and potentiate human dignity, wholeness, and healing, sustain caring amid threats and despair, which is vital in transpersonal caring (Watson, 2014:327). According to Watson (2014:327), this allows the nurse to awaken to transpersonal caring enhances caring moments.

2.2.2 Caring moments

Caring is a transitive and intransitive verb that assumes both the doing and being mode. Caring in the doing mode means giving care in the skilled performance of tasks, while in the being mode, it suggests presence and connection (Diener & Hobbs, 2012:35). Caring is conscious and contained in a single caring moment, transcending time, space and physicality (Watson, 2006:51). Caring moments in transpersonal caring transcend time and space, connecting with others on a spiritual level, opening up new possibilities for healing and human connection at a deeper level than that of physical interaction (Watson, 2006:300).

Rosa et al. (2017:60) suggest this caring moment connects people's views and gives them time to inquire and uncover fears, hopes and wishes related to the process. This assists in understanding the individual in their world and allows the nurse and patient to attach meaning to events as they happen (Clark, 2016:5). Caring moments are achieved when nurses and patients have meaningful, authentic and intentional interactions (Pajnkihar et al., 2017:244). Nurses are the ethical instrument of caring moments; therefore, the courage and strength of their personalities and consciousness in caring are vital for ensuring caring occasions are achieved (Watson, 1999:148).

Drahošová and Jarošová (2016:457) found that interpretations of caring moments are often influenced by the contexts in which they take place. Nurses' behaviour and attitudes leave an impression on patients, according to which they assess whether nurses demonstrate a caring stance. The way patients perceive caring contributes to the creation of a relationship of trust. When caring moments occur in the transpersonal space, it increases the range of events that could occur and go above and beyond conventional nursing tasks (Drahošová & Jarošová, 2016:457-458). This is illustrated in Figure 2.2 (Alharbi & Baker, 2020:5):

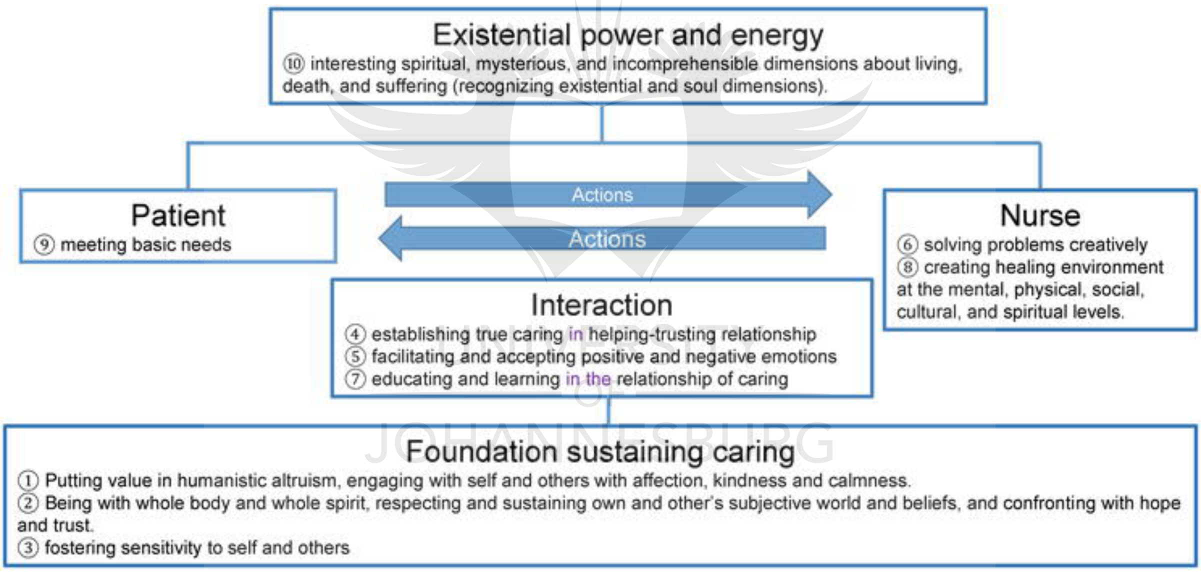


Figure 2.2: Human care transaction through a transpersonal caring moment (Adapted from Alharbi & Baker, 2020:5)

2.2.3 Carative factors

The carative factors in Watson's theory are not linear steps to human caring but represent the core of nursing; they describe those aspects of nursing that potentiate therapeutic interaction and affect the one caring and the one being cared for (Watson, 2000:35). The original 10 carative factors have evolved within an expanding perspective to caritas processes, spiritual dimensions, and an overt evocation of love and caring to merge into a new paradigm (Watson, 1992:148).

2.2.3.1 Caritas process

Caritas processes are an emerging transpersonal caring model that evolved from carative factors (Watson, 2008). Watson adopted the Latin word *caritas,* meaning “to cherish and appreciate, giving special attention to” when describing caring-healing practices (Watson, 2014:323). The caritas processes guide nurses’ knowledge, intentionality, and consciousness toward authentic care and expand the connections between caring and love (Breneol et al., 2019: E13; Watson, 2008:31). According to Watson (2007b:131), these caritas processes are intended to offer more depth and meaning to the carative factors. They capture a deeper dimension of the living processes of human experiences while making a connection between caring and love. The caritas processes are seen as nurse-patient interactions and modalities that can be employed to support and enhance the experience of the actual caring moments (Pajnkihar et al., 2017:245). These processes are the core of caring and represent love-heart-centred caring and compassion (Watson, 2012). Watson (2005:3) outlines each caritas process as follows:

1. Cultivating the practice of loving-kindness and equanimity toward the self and others is foundational to caritas consciousness
2. Being authentically present, enabling, sustaining, and honouring the faith, hope, and the deep belief system and the inner-subjective lifeworld of the self and the other
3. Cultivating one’s own spiritual practices and transpersonal self, going beyond the ego-self
4. Developing and sustaining a helping, trusting caring relationship
5. Being present to and supportive of the expression of positive and negative feelings
6. Creatively using the self and all ways of knowing as part of the caring process, engaging in the artistry of caritas nursing

7. Engaging in genuine teaching-learning experiences that attend to the unity of being and subjective meaning; attempting to stay within the other's frame of reference
8. Creating a healing environment at all levels
9. Administering sacred nursing acts of caring, healing by tending to basic human needs
10. Opening and attending to the spiritual or mysterious and existential unknowns of life and death

These caritas processes are more abstract and focused on spirituality (Pajnkihar et al., 2017:247). According to Watson (2005:300), this shift in the transpersonal dimensions is affected by the nurse's consciousness in the caring moment. This consciousness, in turn, creates new meaning and attention to living and caring-healing practices (Pajnkihar et al., 2017:243).

2.2.3.2 Caritas consciousness

Watson (2006:300) defined consciousness as the ability to react to, attend to, and be aware of self and others. The role of consciousness acknowledges that the caring process transcends time, space, and physicality. The process is intersubjective with transcendent possibilities beyond the given caring moment (Watson, 2006).

Caritas consciousness inverts the relationship between cure and care, and places caring as a moral ideal that becomes dominant over physical illness and the curing ethic (Watson, 1988:175). The caritas consciousness exists through and transcends time and space and can be dominant over physical dimensions. Watson (2008:10) deemed caritas processes and caritas consciousness in caring contributory factors to the satisfaction and well-being of patients, which goes above and beyond healthcare expectations. This is illustrated in Table 2.1.

Table 2.1: Caritas processes and how caritas consciousness integrated

Caritas Processes	Caritas Consciousness
Cultivating the practice of loving-kindness and equanimity toward the self and others as foundational to caritas consciousness	Respecting the patient and family, which allows nurses to be available to themselves
Being authentically present, enabling, sustaining, and honouring the faith, hope, and the deep belief system and the inner-subjective lifeworld of the self and the other	Embracing the patient's beliefs, which allows the patient to make sense of their faith and hope
Cultivating one's own spiritual practices and transpersonal self, going beyond the ego-self	Being more responsive to the patient's needs and feelings, being able to create a more trusting, helping, and caring relationship
Developing and sustaining a helping, trusting, caring relationship	Developing helping, trusting caring relationships with patients, families, and members of the healthcare team
Being present to and supportive of the expression of positive and negative feelings	Co-creating caring relationships in caring environments to promote spiritual growth
Creatively using the self and all ways of knowing as part of the caring process, engaging in the artistry of caritas nursing	Exercising other-centred problem-solving and scholarship in caring for the patient
Engaging in genuine teaching-learning experiences that attending to the unity of being and subjective meaning; attempting to stay within the other's frame of reference	The co-created caring relationship promotes knowledge, growth, empowerment, healing processes, and possibilities for patients and nurses
Creating a healing environment at all levels	By promoting the caring relationship, a space is created for the patient to generate their own wholeness and healing
Administering sacred nursing acts of caring, healing by tending to basic human needs	Being able to help meet the needs of the patient
Opening and attending to the spiritual or mysterious and existential unknowns of life and death	Allowing for miracles to take place with self and others

2.3 KÜBLER-ROSS THEORY

Death and dying are part of the universe's mystery that is unclear to anyone (Jafari, Cheraghi, Pashaeypoo & Hoseini, 2020:170). Kübler-Ross (1969:39) changed the way society approached death and dying by describing the dying patient's experience in approaching death.

The Death and Dying Model was devised by Elizabeth Kübler-Ross almost 50 years ago has been a stimulus toward a better understanding of how people cope with dying (Corr, 2019:405). According to Kübler-Ross (2014:20), dying patients experience these five reactions, denial, anger, bargaining, depression and ultimately end with the acceptance of a loss. Although not necessarily in this order, dying patients go through these stages in a desire to regain control over the dying process.

2.3.1 Denial

Denial is a common defence mechanism used to protect oneself from the hardship of considering an upsetting reality (Tyrrell, Harberger & Siddiqui, 2021:1). Kübler-Ross (2014:38) claims denial is a healthy response, and it acts as a buffer after unexpected news until the dying patient has time to find other, less radical defences. The reaction may be a temporary state of shock from which the patient recuperates gradually (Kübler-Ross, 2014:40).

This phase creates an opportunity for nurses to repeatedly sit, listen, support and comfort the patient while also raising conversations regarding available treatment to keep them comfortable. This repeated encounter with the patient, even when they may not be willing to talk, assists in the development of a transpersonal relationship as the patient feels confident there is someone who cares and is available (Kübler-Ross, 2014:44). According to Kübler-Ross (1970:104), the patients start confiding in someone they trust, who is comfortable with aspects of dying.

2.3.2 Anger

Anger is commonly experienced and expressed by dying patients as they concede the reality of a terminal illness (Tyrrell et al., 2021:1). Kübler-Ross (1970:104) found that once the diagnosis has sunk in, the dying patient becomes angry and resentful, with the logical question being: “Why me?” This is a difficult time for the family and nursing team, because no one at this point can do anything to please the patient. Their anger is displaced in all directions and projected onto the environment, at times almost randomly (Kübler-Ross, 2014:50). The anger may be directed, like blaming medical providers for inadequately preventing the illness, family members for contributing to risks or not being sufficiently supportive, or spiritual providers or higher powers for the diagnosis’ injustice (Tyrrell et al., 2021:1).

Nurses are often the target of this anger. They may thus avoid the patient and shorten their rounds to avoid the patient’s hostile behaviour. Kübler-Ross (2014:51) found that once the nurse places themselves in the patient’s shoes, to try and understand where this anger may be coming from, they do not take this rage personally and treat the patient with respect. According to Kübler-Ross (2014:51), giving the patient attention and time during this period helps the patient express themselves better. The patient will know they are cared for.

2.3.3 Bargaining

Bargaining typically manifests as dying patients seeking some measure of control over their illness (Tyrrel et al., 2021:1). According to Kübler-Ross (1970:105), this stage lasts a short time. The dying patients are seen to rely more on their faith and support from the nurses. They enter into some sort of agreement with a higher power to either postpone the inevitable from happening or wish for a few days without pain or physical discomfort. This bargaining is often kept a secret or sometimes mentioned between the lines for fear of being brushed aside by the medical staff (Kübler-Ross, 2014:81). At this stage, the patient becomes calmer and more receptive to care; depression soon follows.

2.3.4 Depression

The depression stage is parallel to increased weakness and inability to function. According to Kübler-Ross (2014:85), depression is a tool to prepare for the impending loss. Through interviews with dying patients, Kübler-Ross (2014:86) found that depression is necessary and beneficial for the patient to die in a stage of acceptance and peace. Nurses play an important role in helping the patient to accept their imminent death with equanimity and peace. At this stage, the patient draws to the last stage of grief, which is acceptance (Kübler-Ross, 2014:85).

2.3.5 Acceptance

Kübler-Ross (1981:48) described this stage as one of the greatest philosophic calm and spiritual light. The author (Kübler-Ross, 1981:48) defined acceptance as a feeling of victory, peace, serenity and positive submission to things that you cannot change. The patient would have mourned the impending loss of everyone and everything they loved and contemplated the end with a degree of quiet expectation. Patients usually want to be left alone or with their loved ones, with little interference from the medical staff (Kübler-Ross, 2014:130).

Many patients reach the final acceptance without any external help (Kübler-Ross, 1970:105). Kübler-Ross (2014:110) argued that at this stage, the patient is almost void of feelings. It is as if the pain has gone, the struggle is over, and the patient is at peace and accepts the final rest. Kübler-Ross (1970:105) proposed that at this stage, any life-prolonging procedure is often cruel. Nurses need to allow the dying patient to reach the acceptance of their own death with dignity and in peace (Kübler-Ross, 1971:31).

2.4 CONSCIOUS DYING

Conscious dying emerges through the acts of presence, humility, curiosity, willingness and reverence, which aids nurses in broadening their perspectives and embracing a more holistic approach to dying (Rosa et al., 2017:61-62). The conscious dying paradigm is a framework inspired by Kübler-Ross's death and dying model and Watson's human caring ontology. These two paradigms both call for an elevated and evolved human consciousness in the care of self and others, from both personal and global perspectives (Rosa et al., 2017:58). This paradigm creates new possibilities for theoretical-practical applications when caring for the dying patient and their family, as it strives to deepen the nurse's awareness in tending to the dying patient needs, while returning death to its sacred place in the cycle of life (Rosa et al., 2017:58).

The work of the conscious dying model created the opportunity for *healing*, as opposed to *curing* (Rosa et al., 2017:60). Kübler-Ross (1981) saw the dying process as an opportunity for healing, not only for the dying patient and their family but the nurse. According to Kübler-Ross (1970:90), death is a healing event from pain and suffering for the dying patient and their family as it provides a state of peace and new insight into life; for the nurse, the process of death is healing when they face death in a meaningful manner (Clark, 2016:2). Healing care is conscious caring that provides a forum for inquire and uncover fears, hopes, and wishes related to end-of-life care, connect personal views with the care they provide, and explore their relationship to death (Rosa et al., 2017:60).

Healing care empowers the nurse to care for the dying patient with love as they move from form to formlessness; this embodies the sacred tenet of healing that Nightingale identified as ethically core to the profession (Rosa et al., 2017:60). According to Rosa and Estes (2016:334-335), healing care during end-of-life care depends on the nurse-patient relationship, the living-dying experience, and conscious dying principles paired with Watson's 10 carative factors shown in Table 2.2 (Rosa et al., 2017:62).

Table 2.2: Carative factors and conscious dying principles

Carative Factors	Conscious Dying Principles
Embrace altruistic values and practise loving-kindness with self and others	Increase beauty, pleasure, contentment
Instil faith and hope and honour others	Provide emotional and spiritual support
Be sensitive to self and others by nurturing individual beliefs and practices	Initiate conversations about the dying process
Develop helping-caring-trusting relationships	Practice self-care to prevent burnout and emotional fatigue

Carative Factors	Conscious Dying Principles
Promote and accept positive and negative feelings as you authentically listen to another's story	Demystify the stages of the dying process
Use creative scientific problem-solving methods for caring decision-making	Acknowledge mysteries, miracles, and unexplained events
Share teaching and learning that addresses individual needs and comprehension styles	Learn how to *be* with intense emotions
Create a healing environment for the physical and spiritual self that respects human dignity	Attend at bedside – no one dies alone
Assist with basic physical, emotional, and spiritual human needs	Honour others' beliefs without them threatening your own
Be open to the mystery and allow miracles to enter	Be a steward of conscious deaths

2.5 DEVELOPMENT OF ATTITUDES TOWARDS CARING FOR THE DYING PATIENT

South Africa is among the few African countries that promotes notable end-of-life care. It was initially established in communities for patients with cancer, HIV, end-stage organ failure, progressive neurological disorders and tuberculosis (TB) (particularly drug-resistant TB) to receive palliative care. This end-of-life initiative was nurse-led with support from an interdisciplinary team, including social workers, spiritual counsellors and doctors (Gwyther, Krause, Cupido, Stanford, Grey, Credé, de Vos, Arendse & Raubenheimer, 2018:86-87). This integrated approach developed partnerships with the government sector, leading to a greater awareness of the benefits of palliative care by the state sector (Gwyther et al., 2018:87). However, from the mid-1990s onwards, the high demand for end-of-life care in South Africa and the awareness of the benefits of end-of-life care in hospital settings led to the current practice of end-of-life care being provided in the hospital (Faronbi et al., 2021:1).

Nurses have the greatest contact with those at the end of their life, and it is thus necessary to determine nurses' emotions about death to consider the emotional challenges they experience and their thoughts and attitudes about death (Peker, Yıldırım, Arıkan, Kocatepe & Ünver, 2021:693). A'la, Setioputro and Kurniawan (2018:26) believe nurses' attitude towards death affects the quality of care provided to the dying patient and their family at their end of life. Various studies have shown that young professional nurses' attitudes towards caring for the dying patient is affected by factors such as death anxiety, clinical exposure, the nursing work environment and end-of-life exposure (Grubb & Arthur, 2016:84; Khalaf et al., 2017:229; Wittkowsk, 2016:3).

2.5.1 The effects of death anxiety in the development of attitudes towards caring for the dying patient

Nurses encounter death and dying in their work almost daily, and it is assumed they are likely to feel comfortable around this life phase, but this is not always the case (Pehlivan et al., 2020:130). Exposure to death and dying as part of their work routine often makes nurses conscious of their own mortality and may give rise to certain levels of death anxiety (Pehlivan et al., 2019:2). Death anxiety is a distressing, but common human experience evoked by reminders of mortality (Nia, Lehto, Sharif, Mashrouteh, Goudarzian, Rahmatpour, Torkmandi & Yagoobzadeh, 2016:2).

A study by Sahin, Demirkıran and Adana (2016:137) to assess factors influencing nurses' death anxiety while caring for the dying patient (using Thorson-Powell Death Anxiety Scale) found that nurses reported death anxiety increased when they encountered death. According to Draper et al. (2019:267), nurses who feared death often had not accepted death as part of life's journey. Scheinfeld and Lake (2021:611) also determined nurses advocated and encouraged aggressive medical interventions that aim to prolong life even when it is believed the benefits to be gained are insignificant. They often instilled false hope in patients and disenabled early discussions about desired and appropriate end-of-life care (Draper et al., 2019:271). Draper et al. (2019:267) believe this was due to the nurses' recognition that the other person's fate could be their own. These findings concluded that nurses with a significant fear of death and death avoidance had fewer positive attitudes in caring for dying patients (Peker et al., 2021:698). This phenomenon was also found in a study by Pehlivan et al. (2019:8), looking at the relationship between death anxiety and Turkish nurses' attitudes towards caring for the dying patient. They reported that nurses working in internal medicine clinics had higher death anxiety scores than nurses working in emergency units. The nurses who worked in internal medicine clinics also had higher death anxiety levels compared to those nurses who worked in the emergency rooms. Pehlivan et al. (2019:8) believe when the nurse encounters the reality of the death of someone with whom they have a close relationship, their death anxiety increases.

However, Cunningham, Ducar and Keim-Malpass (2019:1482) found that when nurses were able to accept their own death, they could find a sense of meaning in patients' deaths. These nurses had reduced anxiety and more positive attitudes towards caring for the dying and were able to communicate effectively while considering the dying patient's emotions and attitudes concerning life and death (Cerit, 2019:341).

2.5.2 The effects of clinical exposure to the development of attitudes towards caring for the dying patient

Nurses have the greatest contact with those at the end of their life (Grubb & Arthur, 2016:83). They have always had the primary role in the multidisciplinary team, involved with caring for the dying patient and their family (Adams, 2016:2). However, their frequent exposure to death and dying as part of a work routine over a long period may significantly alter nurses' attitude towards caring for the dying patient and their family (Ay & Öz, 2019:2). Smith-Han, Martyn, Barett and Nicholson (2016:1) found that nurses' attitudes towards caring for the dying patient are affected by their clinical exposure in caring for the patient and their family. Watson (1979) believes this introspection is a source of value and strength that further exemplifies the caring experience for the patient and the nurse. It can be exhibited in their level of involvement when caring for the patient and their family (Watson, 1988:33-34).

Nurses' involvement in caring for the dying patient has been described by Watson (2012:6) as either life-giving for the nurse and the patient or leaving the patient in anguish. Kondo and Nagata (2015:282) proposed that nurses' attitudes towards caring for the dying patient can result in the following types of involvement: active involvement, selective involvement, callous involvement, and over-involvement.

2.5.2.1 Active involvement

Active involvement is seen in young professional nurses who attempt to acknowledge the high value of nursing. They regard the categories of suffering as a challenge that can be overcome (Kondo & Nagata, 2015:282). These young professional nurses acquire confidence in caring for the dying patient when they explore the causes of the insolvable problem and learn to face dying and death. Kondo and Nagata (2015:283) argue that these young professional nurses are likely to experience grief yet use their previously acquired skills to continue a peaceful life.

2.5.2.2 Selective involvement

The second style is selective involvement, where young professional nurses are selective in their choices about facing dying and death. They are willing to care for the dying patient only if they have formed a certain attachment to them. This allows the young professional nurse to temporarily escape confronting their feeling about death until they are obliged to do so (Kondo & Nagata, 2015:283).

2.5.2.3 Callous involvement

Callous involvement refers to young professional nurses who treat death as a work routine. They shield themselves from the grief surrounding death and dying (Kondo & Nagata, 2015:283).

2.5.2.4 Over-involvement

The last style of involvement is called over-involvement, which is the opposite of callous involvement. These young nurses respect life and death equally for every patient. They are, at times, easily overwhelmed by uncontrolled grief and suffering, as they have not acquired expertise in caring for the dying patient (Kondo & Nagata, 2015:283-284).

2.5.3 The effects of work environment on young professional nurses' attitude when caring for the dying patient

Caring is a highly complex phenomenon that is affected by the work environment. It can be seen both as an oasis of well-being and social belonging, or as a source of stress and disturbance to nurses' health and performance (Malve-Ahlroth, 2020:12). A working environment that highlights caring values is required, where nurses can express themselves authentically, have reasonable work expectations, and are recognised for significant accomplishments. This assumption was made by Watson (1979:8), who believed a caring work environment emulates caring attitudes and behaviour among its nurses.

Literature shows that nurses' exposure to death and dying in their workplace elicits both negative and positive attitudes towards caring for the dying patient and their family (Sharma, Das, Thakur, Chauhan, Kaur, Kumari and Rahi, 2016:7; Cunningham & Ducar, 2019:429; Fathi & Simamora, 2019:4). According to Paine (2021:9) and Watson (1979:10), the development of attitudes towards caring for the dying patient and their family are affected by the type of nursing leadership and peer support present in the workplace.

2.5.3.1 Nursing leadership

Nursing leadership in end-of-life care is neither defined nor grounded by the level of nursing practice nor education, but rather qualities (Dahlin, 2018:548). Nursing leadership in end-of-life care is about influencing culture and attitudes regarding death and dying; not only for the nurses but for dying patients and their families. This drives change in the work environment and promotes consistent quality end-of-life care (Dahlin, Coyne, Goldberg & Vaughan, 2019:22). Paine (2021:9) found nursing leadership in end-of-life care affects cultural attitudes towards caring for the dying patient and influences behaviour that motivates, engages and empowers nurses to create a caring environment. Various studies found ethical nursing leadership beneficial in a work environment that promotes quality end-of-life care.

Ethical nursing leaders encourage and support open discussions in order to guide nurses to self-reflection, which Owen (2020:323) deems an important aspect, especially when caring for the dying patient and their family. Ethical nursing leaders create a work environment where ethical decisions are made in care, nurses are empowered, and quality patient care is provided by creating a care-oriented ethical climate (Arslan, Özden, Göktuna & Ertuğrul, 2021:2; Pabico, 2015:471; Zhang et al., 2018:36). Ethical nursing leaders are honest, truthful, trustworthy, courageous, fair, just, reliable, responsible, and authentic (Keselman & Saxe-Braithwaite, 2021:155). According to Davies (2016:5), this also enables nurses to express their emotions and grief about a patient's death, influencing how the experience impacts young professional nurses' attitudes towards caring for the dying patient. This creates a work culture that strives to cultivate qualities of virtue, such as integrity, altruism and role modelling, which inspire nurses to perceive their nursing care as meaningful and link it to a larger moral purpose (Mostafa & El-Motalib, 2020:112-113).

Conversely, nurses will find it easier to break the link between moral standards and moral conduct in the presence of a nurse leader who does not embody ethical leadership qualities. Breaking such a link enables them to more easily neglect their patients' needs, especially during end-of-life care (Zhao & Xia, 2017:360). Buch, Martinsen and Kuvaas (2015:125) found this behaviour in working environments with nursing leaders that exhibited in dysfunctional leadership style during end-of-life care. Dysfunctional leaders are often seen as narcissistic, abusive and bullies through their actions (Roter, 2016:58-59). Dysfunctional leaders create negative work environments that foster feelings of being unsupported, incompetent, embarrassed, guilty, and ashamed. These negative feelings often manifest in negative attitudes towards caring for the dying patient and their family (Robert & Vandenberghe, 2020:534-535).

2.5.3.2 Peer support

Wei, Roberts, Stricker and Webb Corbett (2019:687) believes interpersonal relationships in the workplace are fundamental in cultivating a positive culture, which serves as the base for building a resilient nursing workforce. Caring relationships among peers in the workplace promote trust and a sense of warmth, which mitigate the stress of the experience when caring for the dying patient and their family (Meller, Parker, Hatcher & Sheehan, 2019:306-308).

Co-workers play an important role in handling difficult situations with immediate hands-on assistance and in providing emotional support and advice (Paine, 2021:9). Various studies show that high levels of peer support lead to healthier coping behaviours, increased solidarity, and helped individuals perceive situations as less threatening, especially when caring for the dying patient and their family (Paine, 2021:9; Wang et al., 2018:664). A study by Emmamally and Chiyangwa (2020:104) found that student nurses working in supportive wards were able to acknowledge their feelings after a patient had passed away. They were more accepting of death and dying as a normal process when caring for the dying patient. These student nurses developed healthy coping mechanisms and were able to have positive attitudes towards caring for the dying patient and their family. According to Garrino et al. (2017:130-131), these student nurses were warm, felt pleasure and gratification, taking the time to stop, listen and build an authentic relationship with a dying patient.

Conversely, Garrino et al. (2017:130-131) found student nurses who had no support or were uncared for by senior professional nurses often developed maladaptive coping mechanisms after their initial experience caring for the dying patient and their family. This was often portrayed as negative attitudes towards this aspect of care. These young professional nurses were perceived as cold, distant, caring for the dying patient in a prescribed manner as a defence mechanism to avoid having any emotional attachment to the patient that will trigger distress when the patient dies (Tuomikoski et al., 2018:78).

2.5.4 The effects of education on the developments of young professional nurses' attitude towards caring for the dying patient

The topic of death and dying is considered taboo in many cultures, with nurses often describing it as a "dark subject". Loerzel and Conner (2016:8) propose that the topic of caring for the dying patient and their family is an important facet of nursing education. Nursing education has traditionally emphasised the development of cognitive and psychomotor skills in order to produce competent clinical practitioners.

While the acquisition of knowledge and skills is important to professional practice, the developed attitudes, beliefs and values in nursing education are central to the nurturing and caring perspective within the profession (Einhellig, Hummel & Gryskiewicz, 2015:121).

End-of-life education is a prominent strategy that offers support in cases of death and dying experiences. It enhances understanding of personal, professional and interprofessional roles in relation to death and dying. This provides better insight into the various roles each nurse plays in the dying process of patients with whom they work (Ranasinghe, Wathurapatha, Mathangasinghe & Ponnamperuma, 2017:1). According to Astin, Carroll, Ruppar, Uchmanowciz, Hinterbuchner, Kletsiou, Serafin and Ketchell (2015:191), developing skills and understanding through education, combined with reflecting on clinical experiences that occur in the workplace, assists nurses in confronting their personal beliefs about death and dying. Van der Wath and Du Toit (2015:1) claim this confrontation greatly impacts nurses' attitudes towards caring for the dying patient and their family.

End-of-life education programmes are aimed at developing personal coping strategies that emphasise the understanding of death and dying and the nurses' role in promoting the physical, psychological, social and emotional well-being of the patient and their family (Delgado, Upton, Ranse, Furness & Foster, 2016:75). Davis and Batcheller (2020:605) found that these end-of-life educational courses improved not only the care provided for dying patients but also enhanced nurses' attitude towards caring for the dying patient and their family. These findings were consistent with previous research that showed end-of-life education enhanced self-confidence, self-awareness, assertiveness, and self-care among nurses, which in turn, improved their attitudes towards caring for the dying patient and their family (Delgado et al., 2016:77; Low, Kwan, Lui, Jing, Low & Thumboo, 2017:3; Spiva et al., 2020:98).

A lack of knowledge and skills regarding caring for the dying patient has been found to be the basic reason for nurses' negative attitudes towards caring for the dying patient and their families (Cerit, 2019:343). A single-group pre-test-post-test experimental study by Cerit (2019:337-343) considered the influence training had on first-year nursing students' attitudes to death and caring for the dying patient. They found that most students had negative attitudes towards caring for the dying patient before receiving training. This was because most students felt they did not know what approach they should use to address these patients. They felt incompetent in their level of knowledge and skills regarding caring for the patient (Cerit, 2019:343). Professional nurses also expressed a similar sentiment in providing end-of-life care and palliative care for patients with chronic heart failure (Singh, Davidson, Macdonald & Newton, 2019:550). These professional nurses felt that their lack of knowledge made it difficult for them to interact with the dying patient and their family as they were confronted with questions regarding end-of-life care they could not answer.

2.6 END-OF-LIFE CARE

End-of-life care has become an increasingly important topic in modern medical practice, receiving attention locally and internationally (Akdeniz, Yardımcı & Kavukcu, 2021:1). End-of-life care is defined as the provision of supportive and palliative care in response to the assessed needs of the patient and family during the last phase of life (Lewis, 2017:41). End-of-life care entails the management of physical symptoms, such as pain, and the provision of psychological, social, spiritual and practical support, as shown in Figure 2.3 (Adams, 2016:2).

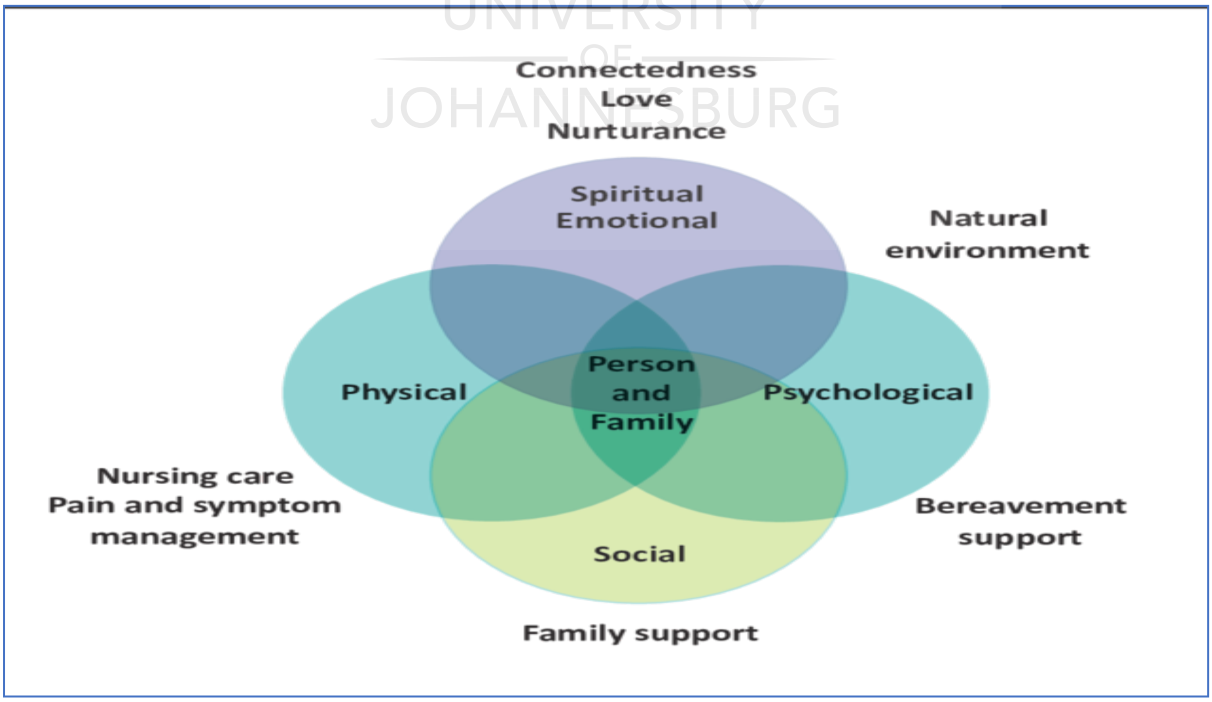


Figure 2.3: Principles of end-of-life care (Adapted from Adams, 2016:2)

2.6.1 Spiritual support during end-of-life care

During end-of-life care, patients' spiritual needs may include, but are not limited to, coping with the loss of roles, purpose and self-identity, feeling safe, building relationships, finishing business, forgiveness and reconciliation, letting go, life reviews, involvement and control. In a study by Ho, Nguyen, Lopes, Ezeji-Okoye and Kuschner (2018:280), 88% of dying patients consider spirituality important in coping with illness, as it helps them overcome their fears, find hope, meaning, and seek closer connection and forgiveness.

Spirituality is a human characteristic that refers to the way individuals seek and express meaning and purpose. It is often tied with the feeling of connectedness to the moment, self, others, nature, the significant, or the sacred (Ho et al., 2018:279). Spiritual care seeks to attend to a dying patient's spiritual or religious needs as they cope with illness, loss, grief, suffering, or pain (Ho et al., 2018:280). Spiritual support during end-of-life care is an important aspect as it promotes meaning and purpose in life and facilitates inner peace that goes beyond religious commitment and divine faith (Küçük Alemdar et al., 2018:998-999).

According to Ho et al. (2018:280), when nurses provide spiritual care, they are attentive, listening to dying patients' feelings, taking appropriate spiritual histories, and supporting spiritual practices. There is a growing body of evidence that suggests dying patients experience significant spiritual stress when confronted with advanced illness (Brelsford, Doheny & Nestler, 2020:38-41). According to Watson's (1979:10) second carative factor, which refers to the installation of faith-hope, the nurse's ability to consciously, spiritually care for the dying patient allows the dying patient to embrace their belief, allowing the patient to make sense of their faith and hope. In a large qualitative study, Roze des Ordons, Stelfox, Grindrod-Millar, Sinuff, Smiechowski and Sinclair (2020:199) found that when nurses met the spiritual needs of dying patients, this aided in their healing and acceptance of their impending death; not only for the dying patient but their family.

2.6.2 Psychological and emotional support during end-of-life care

Death is still a frightening event that may evoke powerful emotions, characterised by loneliness and sadness for the dying patient but their family (Bovero, Gottardo, Botto, Tosi, Selvatico & Torta, 2020:346). These emotions are seen when the dying patient articulates through the five stages of bereavement (Kübler-Ross,1991:17).

2.6.2.1 Denial

Denial is the initial reaction seen after the dying patient is informed about their diagnosis (Kübler-Ross, 2014:38). At this stage, the patient experiences a turmoil of emotions, from being in total shock, to numbness, to being depressed, and wanting to be in total isolation (Kübler-Ross, 2014:44). According to Funk, Peters and Roger (2018:2), the emotional support for the dying patient needed at this point is empathy, as the dying patient may often not be in the mood to talk.

Empathy encompasses a broad range of emotions displayed through therapeutic touch, holding hands and being present (Halli-Tierney, Lippe, Stanley, Ricamato, McKinney, 2019:4). Empathy is defined as the ability to sense the inner world of another, and this also requires that the nurse be aware of their own inner world, creating a common emotional meeting ground (Clark, 2016:4). Watson's third carative factor states that, in order to be authentically sensitive to another person, one has to show a balanced sensitivity to one's own feelings. This sensitivity makes the person who cares feel understood, accepted, and capable of moving towards a more mature level of functioning and growth (Watson, 1979:16-19). Watson (1985:23) suggests even though one cannot completely undertake another person's life experiences, tuning into one's own experience allows the nurse to become sensitive to another's emotional state and needs.

Empathy is essential in caring for the dying patient and their family as it assists the nurses in recognising and resonating the patient's feelings during end-of-life care. Halli-Tierney et al. (2019:4) claim empathy emerges during interactions with the patient. Moreover, Cripe and Frankel (2017:277) described four steps through which empathy can be communicated:

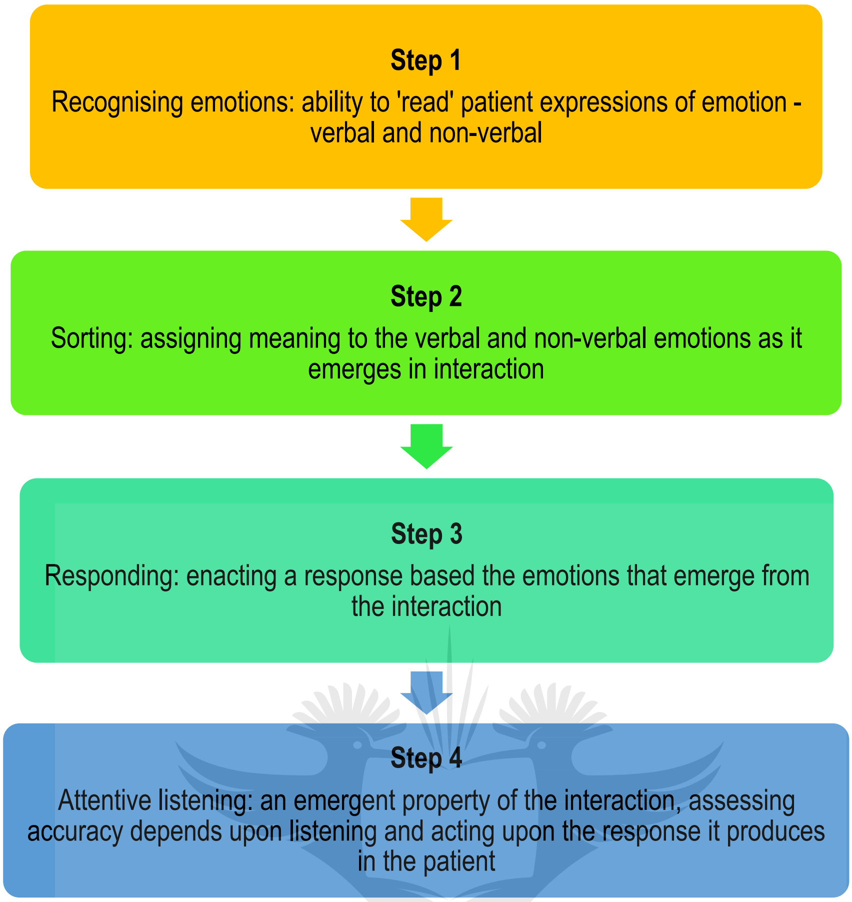


Figure 2.4: Four steps that empathy communicates

2.6.2.2 Anger

Anger is the next emotion that the dying patient often experiences. It is a normal phase of grief and mourning that comes from the loss associated with a loss of control over one’s body and a sense of loss over one’s future (Kübler-Ross, 2014:51). The anger of dying may be a reaction to the experience and process of the illness; including discomfort and receiving negative information (Granek, Ben-David, Bar-Sela, Shapira & Ariad, 2019:1012). The dying patient may have feelings of rage that may be displaced in all directions and projected onto the environment, with the nurses and family at the receiving end of this anger. This anger is often due to the dying patient having no control over the deterioration of their body. Kübler-Ross (2014:51) believes it is at this point nurses need to be compassionate and continue to engage with the dying patient.

Compassionate care is a core value of the nursing profession and is viewed as a guiding foundation for ethical practice (Su, Masika, Paguio & Redding, 2020:481). Compassion is an empathic understanding of emotional resonance with the concerns of pain, distress or suffering of others, coupled with motivation and relational action to help alleviate the suffering. Through compassion, nurses are able to have a sense of calmness, and strength when faced with the angry outburst of the dying patient (Constantinides, 2019:224). This is in accordance with Watson's first carative factor, which is the formation of a humanistic-altruistic value, cultivating the nurse's ability to practice love and kindness towards the dying patient (Watson, 1979:10-11). According to Papadopoulos (2017:290), this gives the dying patient comfort and a sense of being cared for in the moment.

2.6.2.3 Bargaining

Kübler-Ross (2014:79-80) found that dying patients, at this point, are calmer as they rely more on their faith. According to Ho et al. (2018:280), at this point, the nurse may need to be attentive, listening to the dying patients' feelings, taking appropriate spiritual histories, and supporting spiritual practices.

Alicea-Planas (2016:162) believes listening gives one a fuller appreciation of the individual and their circumstance. Active listening strengthens the dying patient-nurse relationship and builds a foundation of trust, respect, and honesty, leading to the exchange of critical information (Davis, Asuncion, Rabello, Silangcruz & van Dyk, 2013:13). Kübler-Ross (1981) also believes the simple act of listening makes dying patients feel like they still matter, and their life is still meaningful.

2.6.2.4 Depression

At this stage, the dying patient can no longer deny their illness; they have more symptoms and have become weaker. The patient cannot smile it off anymore, and their rage is replaced with a sense of depression (Kübler-Ross, 1970:105). The dying patient is often seen crying, insisting on being on their own. According to Kübler-Ross (2014:85), the nurse needs to comfort the patient and just be present, allowing the patient to express their sadness and grief of their impending death.

Ranheim, Kärner and Berterö (2012:83) relate the term ‘presence’ to contemplation and completeness, implying that the nurse ‘tunes in’ to the dying patient in the creative use of the self in an open and sensitive state of being present. This is in accordance to Watson’s fifth carative factor suggests that being present to and supportive of the expression of positive and negative feelings creates caring relationships in caring environments, which promote spiritual growth (Watson, 1979:15). Hofmann, Sawyer, Witt and Oh (2010:169) believed that being mindfully present allows for a meaningful self-regulated, non-judgmental awareness of the present moment experience, including one’s sensations, thoughts, bodily states, consciousness, and the environment, while encouraging openness, curiosity, and acceptance. This mindful presence is identified as an important attribute of caring as it often helps the dying patient feel like their grief is real and understood, and they are not alone in their sorrow (Vingerhoet & Bylsma, 2016:212).

2.6.2.5 Acceptance

If the patient has enough time and has been given some help in working through the previously described stages, they reach a stage during which they are neither depressed nor angry about their fate (Kübler-Ross, 2014:109). At this stage, the dying patient has made peace and accepted their fate; they may just need the nurse to hold their hand and sit next to them silently.

Touch is an important caring practice that conveys caring attitudes and regard for dying patients during end-of-life care (Upenieks & Schafer, 2021:1). Kelly, Nixon, McClurg, Scherpbier, King and Dornan (2018:205-206) found that touch reduces worries, anxiety and increases comfort, which counteracts the isolation of illness often felt by the dying patient. Kübler-Ross (2014:110-111) reported nurses’ presence and touch comforted patients, making them feel like they were not alone.

2.6.3 Physical support during end-of-life care

Wilson, Avalos and Dowling (2016:600) describe end-of-life care as the promotion of physical comfort for the dying patient. Schellinger, Anderson, Frazer and Cain (2018:159) also found that when the nurse provides physical support to the dying patient, they are focused on good pain management, which increases the quality of life and may prolong life rather than accelerate death.

Pain control is an important component of high-quality end-of-life care (Khosla, Washington & Regunath, 2016:850). In managing pain during end-of-life care, the complete elimination of symptoms is often an unrealistic goal; thus, the treatment approach should always be to decrease suffering and increase functioning and comfort (Majeed, Ali & Sudak, 2019:141-142). In a systematic review of the prevalence of symptoms at the end of life, the overall prevalence of pain was identified at 52.4% (Coyne, Mulvenon & Paice, 2018:4). A consecutive cohort study by Clark, Connolly, Clapham, Quinsey, Eagar and Currow (2016:1289) described the intensity and prevalence of symptoms in 18,975 patients imminently dying in either a palliative care unit (70%), in an acute hospital with palliative care support (8.7%), or at home (8.7%). They found that although more than half of the dying patients were not experiencing distressing symptoms, of those who did have symptoms, 22.2% identified pain as problematic, and 4.2% reported severe pain. However, in a study by Heckroth, Pludra, Johannssen, Guest, Wiedermann and Bantel (2021:45), employing interviews with a bereaved family member or friend of the decedent, these loved ones reported that the dying patient experienced an unmet need for pain management during the end-of-life period (25.2%). Many other studies reinforce the ongoing problem regarding effective pain management for dying patients during end-of-life care (Ziegler, Mulvey, Blenkinsopp, Petty & Bennett, 2016:2445).

Heckroth et al. (2021:45) found that nurses' decisions regarding the administration of pain medication are typically influenced by their personal values, theoretical knowledge, pattern recognition and intuition. Nurses often found it challenging to administer oral analgesia to dying patients with frequent or excessive drowsiness or who were asleep for extended periods. In other cases, nurses expressed concern regarding the use of needles in dying patients due to beliefs that these routes were painful and distressing for patients, especially for those who were already anxious and agitated (De Witt Jansen, Passmore, Buchanan, Maxwell, McIlfactrick, Morgan, Watson & Parsons, 2017:1240).

However, in most cases, the lack of pain medication administration in end-of-life care was often attributed to nurses' lack of education regarding end-of-life pain management (Jansen, Brazil, Passmore, Buchanan, Maxwell, McIlfatrick, Morgan, Watson & Parsons, 2017:11; Majeed, Ali & Sudak, 2019:141-142; Sand, Harris & Rosland, 2018:85). Witham, Yarwood, Wright and Galvani (2019:1346) claim a lack of education regarding the administration of pain medication during end-of-life care leads to nurses having misconception regarding addiction to pain medication during this time. A study by Heckroth (2021:48) similarly reported that nurses were very cautious in administering analgesia during end-of-life care, which often left dying patients in severe pain. This cautionary approach was based on nurses' concerns about addiction to analgesia (Sand, Harris & Rosland, 2018:82). Willmott, White, Yates, Mitchell, Currow, Gerber and Piper (2020:530) similarly determined that nurses feared losing their jobs; hence, they often under-administered analgesia for symptom relief and over-documented when medication was given.

According to Givler, Bhatt and Maani-Fogelman (2020:1), end-of-life education aided in the appropriate use of pain medicine during end-of-life care. It alleviated nurses' fear and misconceptions regarding pain management and resulted in quality end-of-life physical support.

2.6.4 Person-centred end-of-life care

Person-centred care evolved from patient-centred care, which Balint first introduced to describe the care of patients focused exclusively on biological and physiological markers of disease (Balint, 1969 as cited in Dambha, Griffin & Kinmonth, 2015:45). Patient-centred care focused on the disease rather than the person, while person-centred care focuses on the elements of care, support, and treatment that matter most to the patient and their family (Eklund, Holmström, Kumlin, Kaminsky, Skoglund, Höglander, Sundler, Condén & Meranius, 2019:4).

According to Walji, Karimbux and Spielman (2017:1266), implementing a person-centred care approach when caring for the dying patient is vital as it puts the dying patient and their family at the centre of decision-making. The patient is seen as an expert, working alongside nurses to attain quality end-of-life care. This type of active participation promotes the dying patient’s empowerment and engagement, which gains the trust of the patient and is meaningful to the patient because it respects their values, preferences, needs, and beliefs, and emphasises the patient’s freedom of choice while promoting emotional and physical comfort (Poitras, Maltais, Bestard-Denommé, Stewart & Fortin, 2018:2). Oritz (2018:291) proposed the factors shown in Figure 2.5 are essential components when providing person-centred end-of-life care.

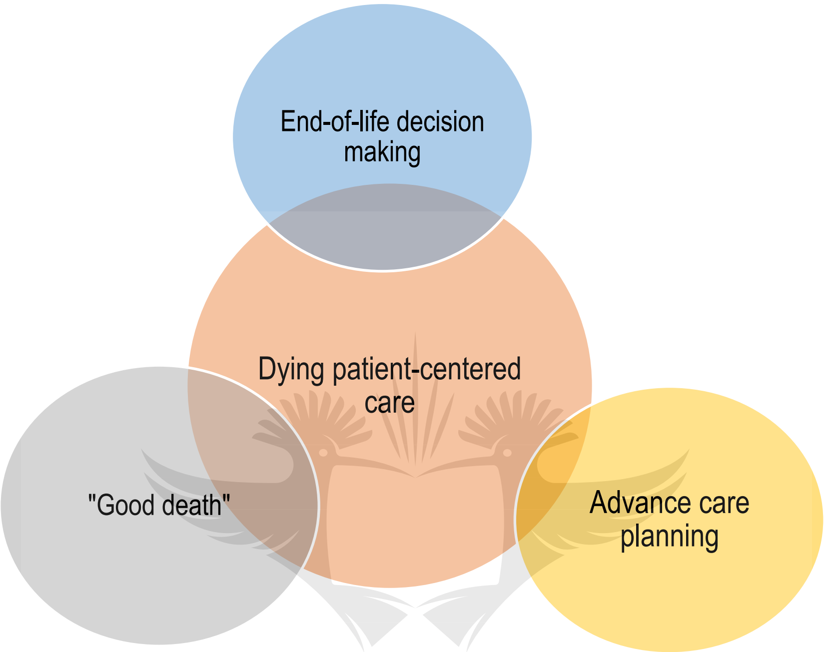


Figure 2.5: Essential components of person-centred end-of-life care

2.6.4.1 End-of-life decision-making

End-of-life care is the lived experience by which individuals or families make decisions about the care they will receive prior to death (Murali, 2020:73). Although end-of-life decision-making is undoubtedly a sensitive subject for dying patients, it is even harder on those in close relation to the dying patient facing the end of their life (Hughes, 2021:20). Murali (2020:73) claim dying patients valued nurses who gave them a chance to make decisions regarding end-of-life care because it made them feel like they still had some control. When nurses include the dying patient during decision-making, they demonstrate effective transpersonal caring as it relates to Watson’s first assumption (Watson, 1979:8) and fourth carative factor. According to Watson (1979:26-32), when there is a transpersonal relationship between the dying patient and the nurse, caring is collaborative, promoting genuine teaching-learning experiences that attend to the unity of being and subjective meaning. It results in empowerment and healing processes for both the nurse and the dying patient.

Kalsi, Ward, Lee, Wee, Fulford and Handa (2020:623) developed a framework (shown in Figure 2.6) that serves as a as a prompt, determining when to start having discussions regarding end-of-life care.

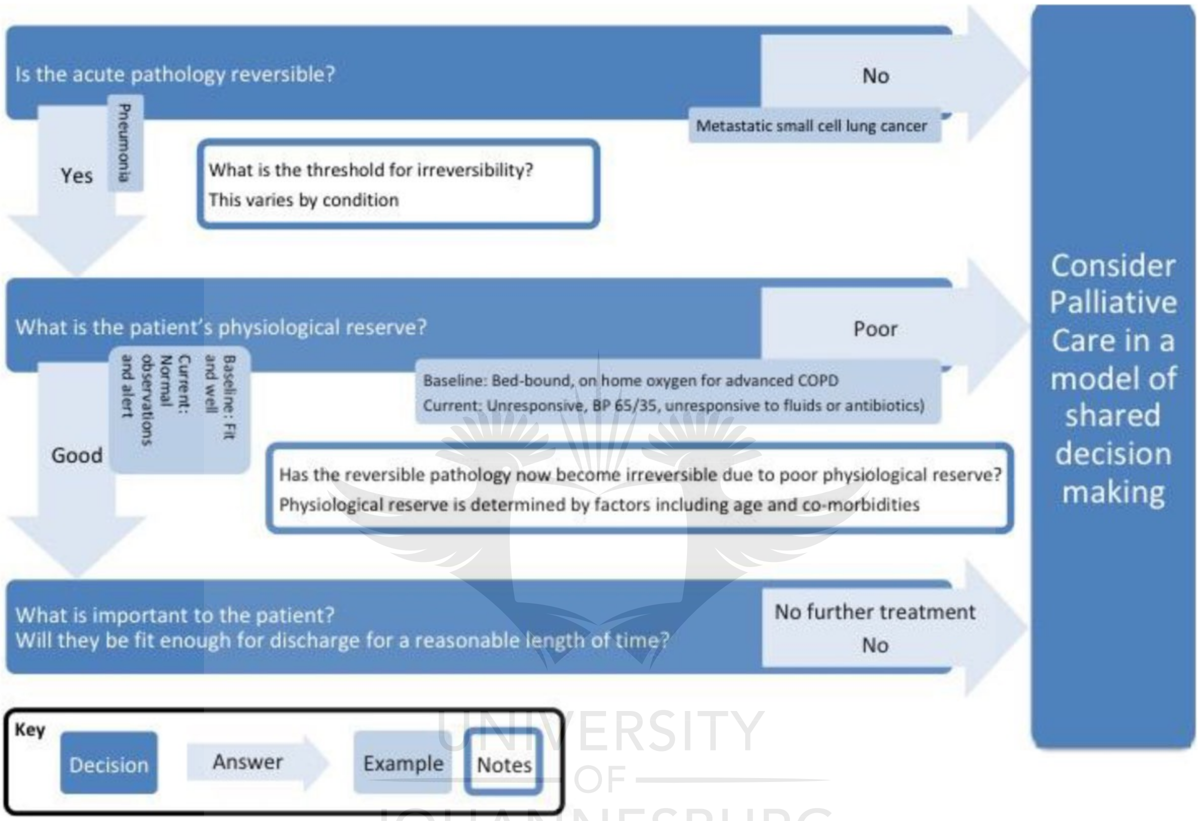


Figure 2.6: A framework that aids in understanding and supporting decision-making (Adapted from Kalsi et al., 2020:623)

Various studies have found that end-of-life decision-making is only possible for the dying patient if the physician initiates the discussion early (Coombs, Parker & Ranse, 2017:50; Kalsi, Ward, Lee, Wee, Fulford & Handa., 2020:623-624: Hughes, 2021:22). According to Seifart, Knorrenschild, Hofmann, Nestoriuc and von Blanckenburg (2020:4), approximately 30–40% of dying patients have discussions regarding their end-of-life decisions with their physicians. This statistic is potentially low due to physicians' fear of hurting the dying patient's feelings or destroying their hopes. Johnstone, Hutchinson, Redley and Rawson (2016:471) thus claim nurses must advocate for end-of-life discussions with the dying patient and their family. When nurses advocate for early end-of-life discussion with the dying patient, they are following Watson's ninth carative factor (assistance with the gratification of human needs). This suggests sacred nursing acts of caring allow the dying patient to generate their own wholeness and healing (Watson, 1979:13-14).

Johnstone et al. (2016:6) explored nurses' roles and strategies in end-of-life decision-making; the authors described the end-of-life strategies used by the nurses shown in Table 2.3 during end-of-life discussions. Moreover, Becker, Beck, Vincent and Hunziker (2020:2) found that these strategies directly affected the dying patient's perceptions, beliefs, and thoughts regarding end-of-life care.

Table 2.3: Strategies used during end-of-life discussions

Nurse's role	Strategies
Doing the groundwork	• gathering information • finding out what the dying patient wants • asking the right questions
Allaying fear	• being readily available • having a discernible presence at the bedside • constantly checking yet at the same time 'giving space' to the dying patient and the family

When the nurse employs these strategies, the dying patient sees the nurse as compassionate, competent, concerned, and respectful; this allows for the development of an authentic, trusting and transpersonal relationships with dying patients (Watson, 1988:175). According to Watson (1979:11-12), this creates new meaning and focuses attention on death and dying, returning death to its sacred place and promoting caring-healing practices during end-of-life care.

2.6.4.2 Advance care planning (ACP)

The principal aim of ACP is to establish the dying patient's wishes about their care towards the end of their life. ACP is only possible with early end-of life discussions and health education regarding the best end-of-life care (Coombs, Parker & Ranse, 2017:50). ACP has become a common practice during end-of-life care, with a recent survey showing that about 28% of the Swiss population above 55 years of age had completed an ACP (Agarwal & Epstein, 2018:316). ACP ensures that dying patients receive end-of-life care consistent with their goals, values and preferences (Sellars, Chung, Nolte, Tong, Pond, Fetherstonhaugh, McInerney, Sinclair & Detering, 2019:275).

It is the nurse's responsibility to provide the dying patient with honest information regarding their prognosis and disease trajectory to aid in the dying patient's end-of-life decision-making (Coombs et al., 2017:50). Watson (1979:9) believes caring interventions for the dying patient do not only include doing and advocating for the dying patients, but also empowering them to make a sound decision regarding their end-of-life care. This confirms Watson's sixth assumption of the science of caring, namely that the practice of caring integrates biophysical knowledge with knowledge of human behaviour in order to generate or promote health and provide ministrations to those who are ill (Watson, 1979:9). According to Becker et al. (2020:3), when dying patients have an opportunity to plan and voice their treatment preferences, there is greater satisfaction and reduced depression and death anxiety. This allows the dying patient to choose the best care for themselves, which is an important part in the notion of the acceptance of their impending death, creating a healing environment at all levels (Kübler-Ross, 1971:31; Watson1979:9).

ACP generally includes discussions about the preferred place of death, resuscitation decisions, and an exploration of patients' views and beliefs about potential treatments during end-of-life care (Xie, Berkley, Kwak, Fleischmann, Champion & Koltai, 2018:7). According to Schellinger et al. (2018:160), nurses need to be conscious of their attitudes towards caring for the dying patient as it plays a critical role in whether ACP promotes the notion of a "good death" for the patient and their family.

2.6.4.3 "Good death"

End-of-life care entails support for patients who are in the last months or year of their life by assisting them in living as well as possible and enabling them to prepare for death, and die with dignity (Buness, Compton, Press & Peternelj-Taylor, 2021:39).

The “good death” concept has acquired great importance in palliative care over the past few decades (Kim & Park, 2021:1).

The concept of a “good death” was first introduced by Weisman in 1972 and was defined as “a transitional stage in which everyone involved knows and accepts the proximity of death and resolves the socio-emotional and material concerns of the dying person” (Weisman, 1988:65). In recent years, a “good death” has been defined as the prevention and relief of suffering through the early identification, assessment, and treatment of physical, psychosocial, spiritual, and existential issues of the dying patient (Bovero, Gottardo, Botto, Tosi, Selvatico & Torta, 2020:344). According to Hilário and Augusto (2020:2), a “good death” is sought to humanise the dying process by recognising suffering is far broader than physical matters of sensation. Becker et al. (2020:3) claim the following attributes make for a “good death”:

- symptoms control
- pain control
- respect for the dying patient’s will with regard to treatments
- presence of loved ones
- good communication with healthcare providers
- a space for sharing emotions
- respect of the dying patient’s will with regard to their death

Borovečki, Nikodem, Ćurković, Braš, Palić-Kramarić, Špoljar, Matulić, Grosek and Tonković (2021:3) determined when nurses understood the importance of providing a “good death”, they were instrumental to the dying patient and their family during end-of-life care. A descriptive and cross-sectional study by Sathiananthan, Manjusha, Crawford and Eliott (2021:4-5) also reported that nurses are vital during end-of-life care as they provide a haven for “good death”. This haven for safe passage was characterised by three processes that nurses identified as important”:

- developing an appropriate care plan for the dying patient that focuses on symptom management and comfort care;
- being there indicates providing support to the dying patients’ family; and

- manipulating the care environment points to making changes in the physical setting to create a peaceful and private atmosphere for the dying patient and their family.

Watson (1999:95) found when nurses were able to provide a “good death” for the dying patient and their family, it gave them a sense of therapeutic healing, knowing that they were able to provide the patient with a dignified death. This helped the nurse self-actualise as they had cared for the patient in a meaningful manner (Watson, 1979:9).

2.7 FAMILY END-OF-LIFE CARE

One cannot care for the dying patient in a meaningful manner without acknowledging the patient’s family (Kübler-Ross, 2014:151). Family members play a critical and positive role during end-of-life care, with some studies demonstrating how the presence and interaction of family members improve dying patients’ emotional and psychological outcomes (McAndrew, Guttormson, Marks, Rhodes, Patel & McCracken, 2021:51-52; Burns, Misak, Herridge, Meade, Oczkowski, 2018:310; Davidson, Accardi, Sanchez & Zisook, 2020:8). Therefore, nursing care should always extend to the family in order to help the dying patient and their family achieve acceptance of this final reality simultaneously (Kübler-Ross, 1969:152). According to Noome, Kolmer, Leeuwen, Dijkstra and Vloet (2016:646), supportive interventions for the dying patient’s family should be emotional, cognitive, and spiritual, as shown in Figure 2.7:

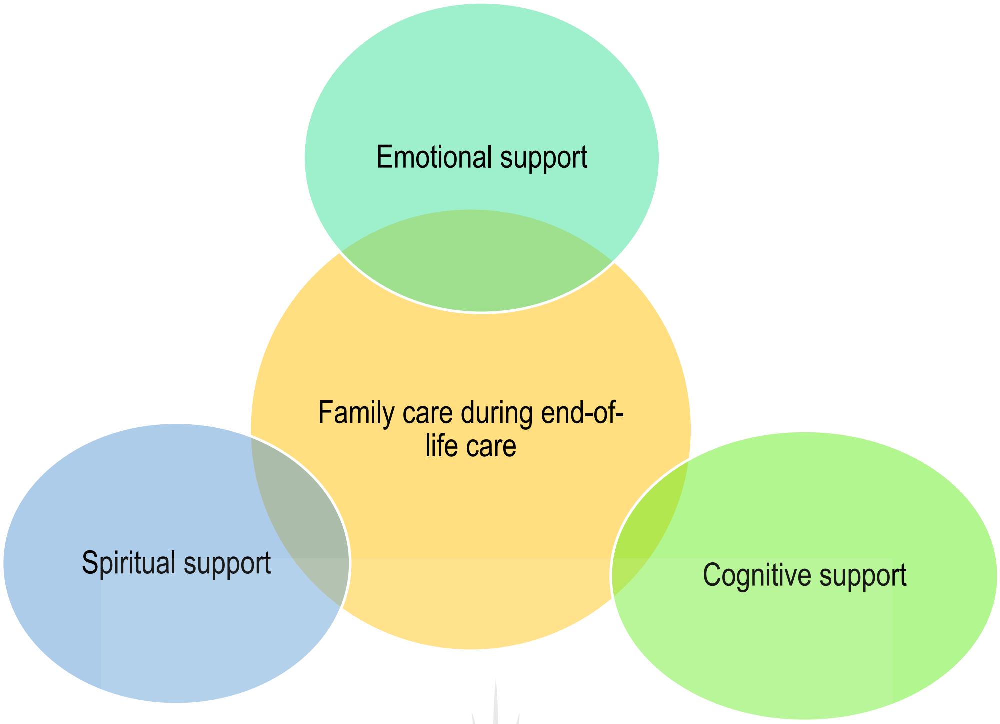


Figure 2.7: Supportive intervention for the family during end-of-life care

2.7.1 Emotional support during end-of-life care

End-of-life care is often traumatic for the family as life is no longer the same (Pelhivan et al., 2020:128). From the time of the diagnosis of a life-threatening disease through the progressive physical and mental deterioration during the patient's advancing illness, relatives are confronted with several losses, including the inevitable death (Coelho, Suttiwan, Arato & Zsido 2020:3109). According to Kübler-Ross (2014:52), the dying patient needs emotional support during end-of-life care, as the family goes through a similar pathway of bereavement as the dying patient, due the anticipatory grief. This begins with a sense of denial, some form of anger, bargaining, depression, and ultimately ends with acceptance of a loss (Kübler-Ross, 1991:103).

2.7.1.1 Denial

This stage manifests initially when the family finds out about the diagnosis of their loved one (Kübler-Ross, 2014:162). Upon learning about the terminality of the disease, the family's confidence is challenged by a sense of 'shock'. This emotional turmoil often results in the family questioning their beliefs (Soroka, Froggat & Morris, 2018:1543). They may deny the fact that there is such an illness in the family and go to different doctors in the hopes of hearing something different (Kübler-Ross, 2014:162).

At this point, nurses need to provide the dying patient's family emotional and cognitive support that will highlight the end-of-life plan for their loved one (Kübler-Ross, 2014:162). According to Watson (1988:175), this allows for the development of an authentic transpersonal relationship with the family, which Kübler-Ross (2014:52) deemed vital when caring for the dying patient.

2.7.1.2 Anger

Just as the patient goes through a stage of anger, the family may also experience the same reaction. The family will be angry at the doctor who examined the patient initially and the doctor who confronted them with the sad reality (Kübler-Ross, 2014:162). Anger also follows moments when family members notice their loved ones do not look 'right' because they are no longer the person they once knew (Chen, Michaels & Meeker, 2020:145). They may project their rage on hospital staff that do not show adequate care, no matter how efficient the care is in reality (Kübler-Ross, 2014:162).

According to Kübler-Ross (2014:162), nurses need to provide compassionate care to the dying patient's family. This compassionate care lies at the intersection of empathy and sympathy (Altimier, 2015:35). Empathy is the ability to acknowledge, understand, and emotionally resonate with a person's feelings and situation, reserving the prosocial desire to help and take actions aimed at alleviating suffering (Guerrero, 2019:279). Sympathy is to show feelings of care and concern for someone accompanied by a wish to see them better off or happier (Guerrero, 2019:279). Nurses' express empathy and sympathy by speaking to the dying patient's family (sharing how sorry they are about the situation), patting a patient's family member on the shoulder during a difficult time, putting a hand on a family member's arm when they hear the bad news, and dropping their tone of voice when speaking when family members are upset or angry (Guerrero, 2019:279).

According to Altimier (2015:35), empathy and sympathy enable the nurse to understand the family's concerns and promote their desire to offer emotional support. Watson (1988:75) believes this cultivates the act of loving-kindness and equanimity, which is the foundation of caritas consciousness.

2.7.1.3 Bargaining

Kübler-Ross (2014:162) believes at this stage the family bargains with a higher power, wishing they could make up for missed opportunities. There is also guilt and resentment at this stage. The nurse, at this point, provides spiritual support to the dying patient's family. Spiritual support gives meaning and purpose to the patient's family and provides them with therapeutic healing during end-of-life care (Johnson, Engelberg, Nielsen, Kross, Smith, Hanada, O'Mahoney & Curtis, 2014:1991).

2.7.1.4 Depression

At this stage, the dying person has separated themselves from the environment and their loved ones; this is the most heart-breaking time for the family (Kübler-Ross, 2014:163). It often results in depression for the dying patient's family, as they may not understand that the dying person does this to prepare themselves for death as they believe that they cannot die peacefully if they are still holding on to meaningful relationships (Kübler-Ross, 2014:163).

According to Kübler-Ross (2014:163-164), it is at this point that nurses need to provide the family with hope. According to Watson's tenth carative factor, the installation of hope allows for existential-phenomenological dimensions that open the mysterious and existential unknowns of life and death (Watson, 1979:20). Szabat and Knox (2021:1) emphasise the notion of hope for the family facilitates an inner power that transcends the present situation and movement toward a new awareness. It provides the family with an overall motivation to carry on (Beng, Xin Ying, Khuen, Yee, Zainuddin, Chin & Loong, 2020:1).

2.7.1.5 Acceptance

Kübler-Ross (1985) believed the resolution of grief occurs during the stage of acceptance when the impending loss is fully comprehended, and the bereaved becomes able to feel a measure of peace and hopefulness again. The family experiences a sense of comfort and confidence that everything else would be manageable, despite the pain of losing a loved one. The family believes that whatever they can do and whatever care they provide is based on their loved ones wishes (Soroka et al., 2018:1543).

The family attempts to adjust to living with a terminal illness; the family also attempts to find meaning in the new existence and live their lives as normally as possible, desiring to return to the normalcy experienced before the terminal diagnosis (Kübler-Ross, 2014:53).

The nurse at this point can involve the family in facilitating a “good death” for the dying patient (Yun, Kim, Sim, Kang, Lee, Choo, Yoo, Kim, Kim, Kang, Shim, Song, Kang, Kwon, Lee, Lee, Maeng, Kang, Do, Choi & Jung, 2018:2). According to Watson (1999:120), this helps the family find healing and closure, even when the patient eventually dies.

2.7.2 Spiritual support during end-of-life care

In modern times, spirituality has become a collective term that refers to religion and all experiences that transcend the ordinariness of this world (Roman, Mthembu & Hoosen, 2020:2). Spirituality is a fundamental element of the human experience that involves finding meaning and purpose in life and creating a sense of peace (Cai, Guo, Luo, Zhou, Abbas, Zhou & Peng, 2020:534). During end-of-life care, Ho et al. (2018:280) found that families need spiritual support because, just like the dying patient, they often need to forgive or reconcile with the patient before their impending death.

Research has shown that spiritual support for families during end-of-life care gives them a sense of belonging, hope, coping, meaning, and purpose toward a new awareness that leaves them with an overall motivation to carry on (Borji, Mousavimoghadam, Salimi, Otaghi & Azizi, 2019:1962).

2.7.3 Cognitive support during end-of-life care

Cognitive support relates to the nurse educating the family when their loved one is ill (Bruce et al., 2016:300). Kübler-Ross's work demonstrated the importance of end-of-life health education in helping the dying patient's family cope with anticipatory grief (Rosa et al., 2017:60). This end-of-life health education is described as honest, timely information about the disease progression and the dying process to prepare the family for life's end (Sawin, Montgomery, Dupree, Haase Phillips & Hendricks-Ferguson, 2019:178). This aids in helping the dying patient's family make appropriate decisions that will not only promote the notion of a good death for the dying patient but also provide them with healing even after their loved one is gone (Coombs et al., 2017:50).

According to Watson (1979:12), when the nurse is providing health education to the dying patient and their family, it is often a genuine teaching-learning experience that mitigates their suffering, promotes knowledge, growth, empowerment and helps the family during the healing process. Scheinfeld and Lake (2019:2) found that cognitive support for the family during end-of-life care aids the family in their acceptance regarding their loved one's impending death.

2.8 END-OF-LIFE CARE DURING THE COVID-19 PANDEMIC

COVID-19 is an unparalleled modern pandemic that has, to date, resulted in over 2.34 million deaths worldwide, leaving an estimated 21 million bereaved (Selman, Sowden & Borgstrom, 2021:1278). COVID-19 is an airborne virus that affects the respiratory system; although other organ systems are also involved, the respiratory symptoms of COVID-19 are extremely heterogeneous, ranging from minimal symptoms to significant hypoxia within nine days after transmission (Ghayvat, Awais, Gope, Pandya & Majumdar, 2021:2). It is very contagious and may be transferred either by direct or indirect connection with an infected person (Yuki, Fujiogi & Koutsogiannaki, 2020:1). Direct connection happens when someone is exposed to an infectious source, such as a handshake, kiss, physical relation, breathing of transmittable viruses' particles released by sneezing or coughing. Indirect connection happens when the virus is competent to resist and survive in the oppressive atmosphere outside the host body area for an extended duration and remain infectious once definite occasion rises (Ghayvat et al., 2021:2). A study conducted with 85 fatal COVID-19 patients with a median age of 65 years in Wuhan, showed that the majority of patients died from multi-organ failure, respiratory failure and shock, as seen in 94%, 81%, and 74% of cases, respectively (Yuki et al., 2020:2). This rapid deterioration due to complications from COVID-19 presented a new challenge to end-of-life care for dying patient and their family because these deaths are often sudden and unexpected (Maben & Bridges, 2020:2743).

Due to COVID-19 being highly infectious, the dying patients was often alone, because the WHO (2020) had recommended social distancing regulations, which caused hospitals worldwide to ban families from visiting their loved ones. The nurses were in personal protective equipment (PPE) when caring for all patients in order to prevent and control the transmission of the virus. This PPE consists of facemasks, goggles or a face shield, gowns, and gloves when handling COVID patients. This left the dying patient with no one to hold their hand and reassure them that ‘everything would be okay’. They had no spiritual support from their loved ones during their last days (Barnet & Grabowski, 2020). A study by Sun, Wei, Shi, Jiao, Song, Ma, Wang, Wang, Wang, You, Liu and Wang (2020:592), to explore nurses’ psychology in caring for COVID-19 patients, found that nurses felt ‘awkward’ caring for dying patients in protective gear in the absence of the dying patient’s family. Video calls were recommended to bridge the gap between dying patients and their families. This initiative allowed family members or friends to say goodbye before withdrawing life-sustaining treatments or imminent death (Galazzi, Brioni, Mistraletti, Roselli & Abbruzzese, 2020:1254). A study by Galazzi, Binda, Gambazza, Lusignani, Grasselli and Laquintana (2021:1-3) reported that this was helpful but insufficient in providing closure and healing for the dying patient and their family.

2.9 SUMMARY

Chapter 2 reviewed Watson’s Theory of Human Caring, and Kübler-Ross’s theory that formed the study’s conceptual framework was also explored. It highlighted the caring science of conscious dying and its relation to caring for the dying patient and their family. Literature reviewed highlighted how death anxiety, end-of-life education, clinical exposure and the work environment affect young professional nurses’ attitudes towards caring for dying patients and their families. A detailed review of end-of-life care was done, and a short comprehensive description of family end-of-life care was presented. This chapter concluded with the current status of end-of-life care due to the COVID-19 pandemic.

Chapter 3 describes the research design and methods used in this study.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter provides a detailed description of the research methodology used in this study. This description is followed by the research design, setting, population, sampling technique, data collection, pilot study, validity, reliability, data collection and data analysis for Phase 1. Thereafter, the description of the research design, research setting, pilot study, data collection, analysis and trustworthiness of this study is presented in Phase 2. The chapter concludes with a description of Phase 3, which focuses on the integration of quantitative and qualitative results.

3.2 RESEARCH DESIGN

The research design chosen for this study was a mixed method. This approach was deemed well-suited due to the complex nature of attitudes that often requires an understanding of behaviours in both breadth and depth; a task for which mixed-methods research is especially applicable (Harrison et al., 2020:2).

3.2.1 Mixed-method research design

As stated, the mixed-method research design was chosen for this study. The term ‘mixed methods’ refers to an emergent methodology of research that advances the systematic integration of quantitative and qualitative data within a single investigation or sustained programme of inquiry (Makrakis & Kostoulas-Makrakis, 2016:144). The basic premise of this methodology is that such integration permits a more complete and synergistic utilisation of data than separate quantitative and qualitative data collection and analysis methods (Creswell, 2005:9). The mixed-methods design gains the strengths of its component parts when it is used in combination with one study. Quantitative and qualitative methods thus complement each other and allow for a complete analysis of the research problem (Harrison et al., 2020:2).

According to Creswell (2003:64), the level of interaction between the quantitative and qualitative strands in a study is an important factor to consider in mixed-method research, as it strengthens the rigour and enriches the analysis and findings. Moreover, the extent of interaction between quantitative and qualitative designs affects the research approach (Creswell, 2003:65). In this study, the interactive level was chosen since the purpose of the study was to explore and describe young professional nurses' attitudes towards caring for the dying patient and their family at a secondary academic hospital in Gauteng. An interactive level of interaction occurs when a direct interaction exists between the quantitative and qualitative strands of the study. Through this direct interaction, the two methods are mixed before final interpretation. This interaction can occur at different points in the research process and in many ways (Creswell, 2003:65) and is called explanatory sequential design.

3.2.2 Explanatory sequential design

An explanatory sequential design is one of the most common designs used in mixed-methods research. It consists of two distinct interactive phases: the initial quantitative phase, followed by the qualitative phase (QUANT→ qual) (Creswell, 2014:13-14). For this study, the quantitative design was therefore the core research method, followed by the supplementary qualitative method. This strategy employed the qualitative data and results to elaborate on or explain the initial quantitative findings (Creswell, 2015:379). In this study, the explanatory sequential strategy was conducted over three phases:

- **Phase 1** focused on surveying young professional nurses' attitudes towards caring for dying patients and their families.
- **Phase 2** focused on examining outliers from Phase 1 and exploring their experiences caring for dying patients and their families through follow-up focus group interviews.
- **Phase 3** focused on the interpretation, integration and discussion, of findings from phases 1 and 2.

A visual presentation of the explanatory sequential strategy for this study is shown in Figure 3.1:

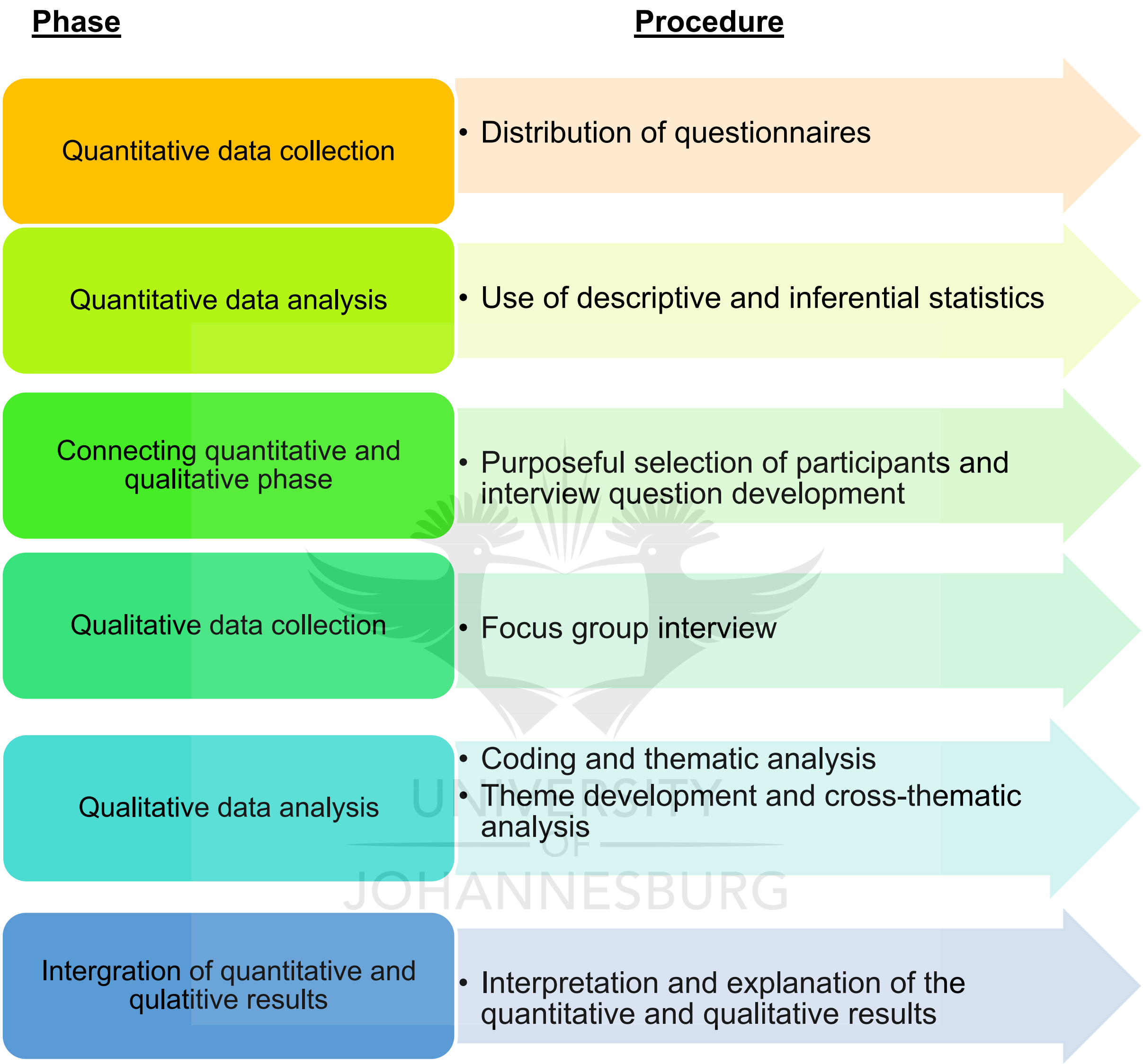


Figure 3.1: A visual presentation of the explanatory sequential strategy rigour

3.3 PHASE 1: QUANTITATIVE RESEARCH

Phase 1 of this study used quantitative research to explore young professional nurses' attitudes towards caring for dying patients and their families. Quantitative research is a strict design that uses rigorous, controlled and precise measurements to examine phenomena (Rahman, 2020:105). Quantitative research focuses on those aspects of social behaviour that can be quantified and patterned rather than just finding them and interpreting the meaning people bring to their own actions (Rahman, 2020:106). It allows the researcher to look at one or more aspects of reality, namely incidence, the connection between two ideas, and cause-and-effect relationships (Gray et al., 2017:37).

Quantitative research follows logical positivism methodological principles that are deductive in nature and attempts to investigate answers to the research questions. This is done by identifying variables before data collection commences (Rahman, 2020:105).

In this study, the quantitative approach was used first, and it allowed the researcher to examine the attitudes of the young professional nurses caring for dying patients and their families. To that end, the researcher employed a descriptive correlation research design.

3.3.1 Descriptive research design

The descriptive design is a quantitative research method that attempts to collect quantifiable information for the statistical analysis of the population sample (Gray et al., 2017:38). A descriptive design is applied when little is known about a particular phenomenon, and the research aims to identify characteristics, frequencies, trends, and categories (Aggarwal & Ranganathan, 2019:35). A descriptive design assists in answering research questions of “what is?” and “to what degree?” Polit and Beck (2018:11) found that descriptive designs observe and describe aspects of a situation as it naturally occurs without manipulating the intervention, which was valuable in this study.

3.3.2 Correlational research design

Correlational designs are systematic investigations of the nature of relationships or associations between and among variables (Gray et al., 2017:39). It is essentially an exploratory technique that seeks to determine whether there is a relationship between two or more variables (Queirós, Faria & Almeida, 2017:381), how one impacts the other, and what changes are eventually observed (Leavy, 2016:101). The relationships are described in terms of the strength, direction, and significance between two or more variables (Pallant, 2016:137-138).

Correlational designs recognise trends and patterns in data but do not analyse them to prove causes for these observed patterns. These patterns, relationships and trends between variables are concluded as they exist in their original set-up (Leavy, 2016:101). The purpose of the correlation techniques used in this study was to examine and describe the observed associations between attitudes towards caring for the dying patient and their family; and describe the relationship between the young professional nurses' years of experience, education in end-of-life care, and the number of dying patients the young professional nurse had cared for. A summary of the techniques is given under data analysis described in detail in Chapter 4.

3.4 POPULATION

The population is defined by Polit and Beck (2017:249) as the complete combination of cases in which the researcher is interested. In this study, the population comprised professional nurses.

3.4.1 Target population for the study

The target population is the entire set of individuals meeting the sampling criteria (Gray et al., 2017:330). According to Gray et al. (2017:330), the target population is identified and described to provide evidence of generalisability of the results. The criteria of the target populations was developed from the research problem, the purpose, conceptual and operational definitions of study variables and the design (Gray et al., 2017:330). The target population in this study was represented by:

- professional nurses in South Africa,
- permanently employed in a government hospital, and
- registered with the SANC.

The researcher used this target population because all respondents in this population would have had sufficient experience caring for the dying patient.

3.4.2 Accessible population

Gray et al. (2017:330) define an accessible population as a portion of the target population to which the researcher has reasonable access. The accessible population for this study was:

- professional nurses in Gauteng,
- working at the hospital under study, and
- registered with the SANC.

3.4.3 Sampling

According to Gray et al. (2017:331), sampling is done from the accessible population within the target population. Sampling refers to the process of selecting a subset of the population to represent the whole population (Polit & Beck, 2017:743). If the researcher considers a part of the population as a representation of the whole, the analysis will be more comprehensive (Ghaljaie et al., 2017:1).

3.4.3.1 Sampling method

A sampling method refers to the process of selecting a group of people who represent the population being studied. The sampling method is similar to the research design as it is very specific to a study (Gray et al., 2017:336). According to Gray et al. (2017:336), the sampling method needs to be described in depth to promote critical appraisal, replication, and future meta-analysis. The sampling inclusion criteria in this study were:

- young professional nurses in Johannesburg,
- with one to five years’ work experience,
- working at the hospital under study,
- registered with the SANC,
- with previous experience in caring for the dying patient in the last six months, and
- willing to participant in both Phase 1 and Phase 2 of the data collection process.

The study initially commenced during Level 3 of the COVID-pandemic, which encouraged social distancing in an attempt to curb the spread of the virus (WHO, 2020). Hospitals were not allowing any researchers on the premises, and the researcher therefore had to employ snowball sampling to select participants. Snowball sampling is defined as a non-probability sampling technique applied when samples with the target characteristics are not easily accessible (Ghaljaie et al., 2017:1). Snowball sampling was useful to initially recruit young professional nurses, since this sampling method allowed the researcher to contact very specific groups of people in a social context through a multi-stage process (Ghaljaie et al., 2017:2).

Snowball sampling starts with the researcher recruiting the first subject, then the first subject recruits the second subject, and so forth. The chain continues to refer linearly up, until the required sample is attained (Anieting & Mosugu, 2017:35). In this study, snowballing sampling was employed using an online platform, Facebook. Stokes, Vandyk, Squires, Jacobs and Gifford (2019:96) claim Facebook is an ideal platform to recruit respondents due to its far reach, rapid pace of data collection, and minimal resources required to collect and manage data. Facebook allowed the researcher to recruit young professional nurses whom the researcher was unable to directly access at the time due to the strict social distancing rules in the hospital.

However, snowball sampling alone was found inadequate in recruiting subjects, leading to a small sample due to limited acquaintances (Polit & Beck, 2017:493). So once the social distancing regulations were relaxed and hospitals were open to researchers, convenience sampling was used to recruit young professional nurses. Convenience sampling is a type of non-probability sampling in which people are sampled simply because they are available at the place and time when the researcher is conducting the study (Bhardwaj, 2019:157). The young professional nurses who participated in this study were in the ward when the researcher was conducting the study.

3.4.4 Sample size

According to Gray et al. (2017:351), the sample size must be large enough to describe variables and identify relationships among variables in quantitative research. The sample size is always determined by the purpose and philosophical basis of the study. Gray et al. (2017:352) believe the sample size varies depending on:

- the depth of information needed to gain insight into the phenomenon, and
- the description and exploration of a concept.

The sample size for this study was determined by the statistician based on the number of professional nurses working at the hospital under study at the time the research was conducted. There were 283 nurses working in the hospital, and the statistician calculated the sample size of approximately 65 professional nurses.

3.5 DATA COLLECTION

Data collection is the precise and systematic gathering of information relevant to the research and the specific objectives, questions, or hypotheses of a study (Gray et al., 2017:675). In Phase1 of this study, the researcher used a questionnaire to collect the data order to answer the research question (Gray et al., 2017:55).

3.5.1 Development of questionnaire

During Phase 1 of the study, data were collected using a demographic questionnaire and Likert scale. Questionnaires are a common measurement tool for data collection in quantitative research; thereby, data are collected in a standardised way, so the data are internally consistent and coherent for analysis (Singh, 2017:791).

Questionnaires are self-report forms designed to elicit information about respondents related to the research objectives (Gray et al., 2017:408). Questionnaires consist of several questions that respondents must answer in a set format (Singh, 2017:792). The hypotheses or research questions are constructed based on the variables intended for measurement (Leavy, 2017:102).

Questionnaires help gather information on knowledge, attitudes, opinions, behaviours, facts, and challenges, among others (Singh, 2017:791). Questionnaires form the backbone of any quantitative study, and their success lies in the questionnaire's design (Roopa & Rani, 2012:273). A well-designed questionnaire requires thought and effort, and needs to be planned and developed in several stages, as illustrated by Roopa and Rani (2012:273) in Figure 3.2:

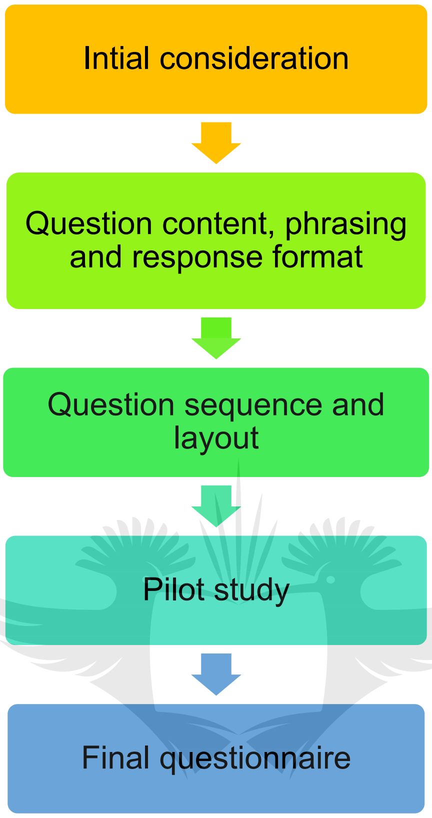


Figure 3.2: Stages of planning a questionnaire

Tsang, Royse and Terkawi (2017:810) propose that the first and most crucial step when developing a questionnaire is to identify the constructs that must be assessed, as the domain of interest will determine what the questionnaire will measure. Theory and literature are vital in guiding the identification of empirical attributes that represent the abstract construct (Carpenter, 2018:31). Theory should pre-specify the structure and meaning of the research constructs. According to Carpenter (2018:32), naming the constructs and each subscale or dimension influences future interpretations of the concept. The questions on a questionnaire are thus designed as precisely as possible to measure the concepts required to answer the research question (Leavy, 2017:102). These questions are designed around each concept in the study and how the researcher operationalises variables not readily observable by direct means (Carpenter, 2018:26). The research questionnaire used in this study was a demographic questionnaire and a Likert scale made up of Templer's DAS, Frommelt

FATCOD scale, and the Level of Support in the Work Environment Questionnaire. The questions on the Likert scale allowed for the researcher to measure all the major elements relevant to the construct being measured. The Likert scale is further discussed in detail in Chapter 4.

The questions in the study's demographic questionnaire comprised open-ended and closed-ended questions. Open-ended questions asked the respondents to formulate their own answers (Singh, 2017:792). The use of open-ended questions for the demographic questionnaire in this study allowed the researcher to accurately describe the sample (Hughes, Camden & Yangchen, 2016:138). Closed-ended questions, where the respondents had to pick an answer from the given number of options (Singh, 2017:792). The use of close-ended questions for the demographic questionnaire in this study helped the researcher tunderstand the outlook of a parameter across the respondents (Hyman & Sierra, 2016:2).

For successful quantitative research, questionnaires' question sequence must be clear and move smoothly. A proper sequence of questions considerably reduces the chances of individual questions being misunderstood (Roopa & Rani, 2012:274). The wording of questions is carefully considered to ensure it does not lead respondents to answer in a particular way and minimise social desirability and acquiescence biases (Leavy, 2017:102).

Questions are crafted to determine respondents' characteristics, attitudes, and behaviours (Leavy, 2017:102). Roopa and Rani (2012:274-275) claim the first few questions are particularly important because they are likely to influence the respondent's attitude and desired cooperation. Thus, question sequences should usually go from the general to the more specific (Roopa & Rani, 2012:274). In this study, the researcher applied those principals by starting with the demographic questionnaire that posed general questions, followed by the Modified Templers DAS, which asked relatively personal questions. The FATCOD scale asked respondents difficult intimate questions, and the Level of Support in the Work Environment Questionnaire was kept for last, as studies have shown that questions relating to the work environment are deemed difficult to answer.

The questions are discussed in detail later in this chapter. A pilot study was also conducted to assess how well the research questionnaires assess young professional nurses' attitudes towards caring for the dying patient and their family. The findings of the pilot study are discussed in detail later in this chapter.

3.5.2 Description of the research questionnaire

3.5.2.1 Demographic questionnaire

The demographic questionnaire used in this study was a self-report survey. It is used to capture the attributes of the sample as a whole, while also highlighting differences that may be associated with the study variables (Gray et al., 2017:499-500). Frommelt (1991:38) believed participants' demographics add more depth to the study. The demographic questionnaire used in this study was ultimately adapted from Frommelt's (1991:38) questionnaire and developed by the researcher.

Frommelt (1991:38) suggested the following variables should be included in the demographic data: gender, age, profession, highest academic qualification, major area of study, previous education on death and dying, previous experience in dealing with a terminal illness, whether the person was anticipating the loss of a significant other in the near future (in six months or less), and the importance of spiritual beliefs or lack of spiritual beliefs. For this study, the following demographic data were included:

- SANC number
- Gender
- Years of experience
- Type of ward
- Previous experience in caring for dying patients and their families in the last six months
- The number of dying patient's respondents have cared for in the last six months
- Previous education on death and dying, and feelings about previous education on the subject of death and dying

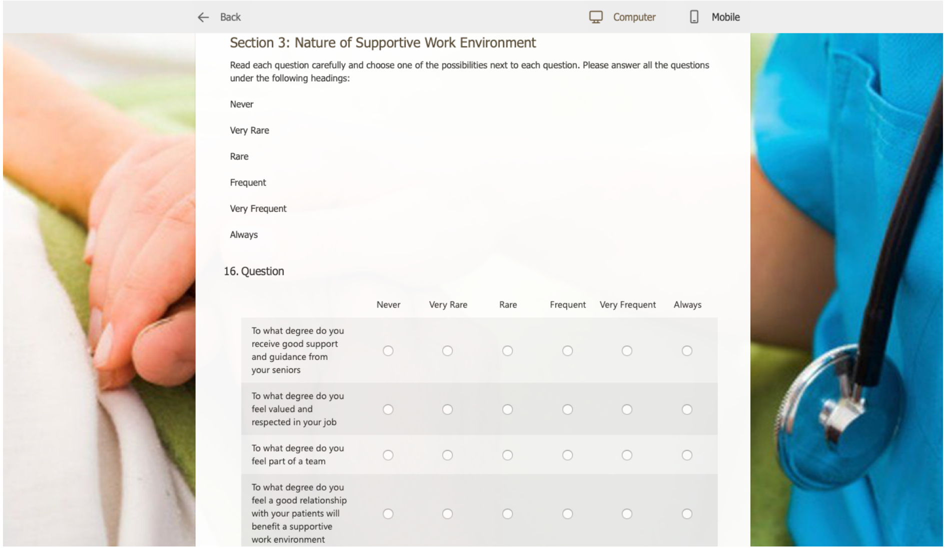
The SANC is entrusted with setting and maintaining nursing education and practice standards in the Republic of South Africa. It is an autonomous, financially independent statutory body, initially established by the Nursing Act, 1944 (Act No. 45 of 1944), and currently operating under the Nursing Act, 2005 (Act No. 33 of 2005). All professional nurses in South Africa are registered under this body in order to practice; therefore, the SANC number acted as an identification number for the respondents. The SANC number was also completed on each page of the three-part Likert scale.

Various studies revealed that age, gender, years of experience, type of ward, previous experience in caring for a dying patient and their family in the last six months, the number of dying patients cared for in the last six months, previous education on death and dying, and feelings about previous education on the subject of death and dying were significantly connected with nurses' attitudes towards caring for the dying patient and their family (Pervaiz & Yousef, 2021:1124; Bizimana & Bimerew, 2021:6). Therefore, these variables were of interest to the researcher to determine their correlation to young professional nurses' attitudes.

3.5.2.2 Description of the Likert scale

The Likert scale is named after Rensis Likert (Likert, 1932), who was the first to use such a scale. This scale allocates a finite number of points based on respondents' responses to an item in a survey (Leavy, 2017:103). Two common applications of the Likert scale are to have respondent use the scale to describe themselves or indicate their level of agreement (Gray et al., 2017:500). For this study, the Likert scale comprised rating scale response sets.

A rating scale response set has been described as a statement provided in response to options on a continuum; respondents are instructed to select a single response (Leavy, 2017:104). Figure 3.3 illustrates this on Templer's DAS:



Section 3: Nature of Supportive Work Environment

Read each question carefully and choose one of the possibilities next to each question. Please answer all the questions under the following headings:

Never

Very Rare

Rare

Frequent

Very Frequent

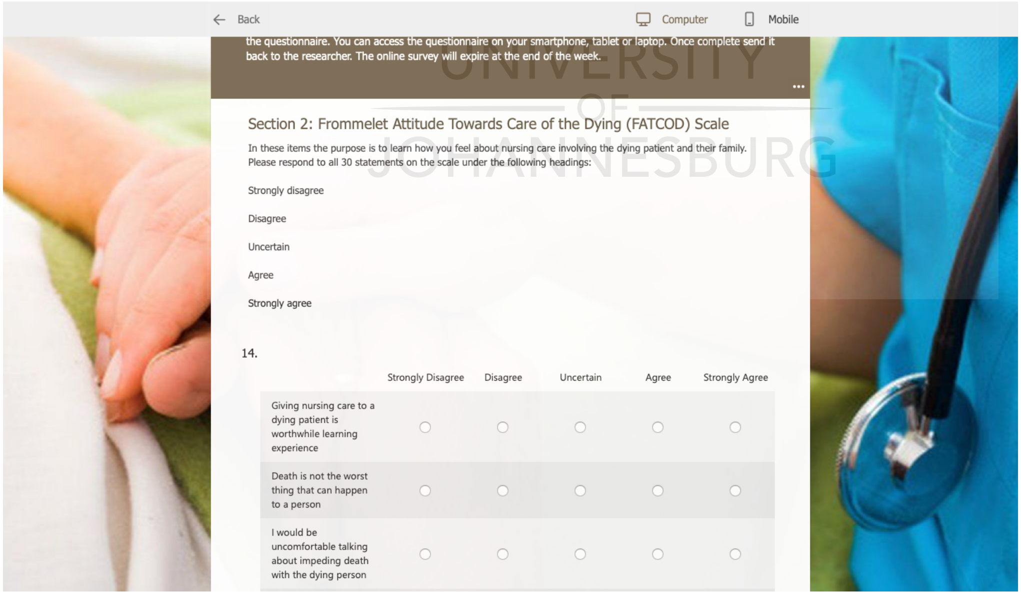
Always

16. Question

	Never	Very Rare	Rare	Frequent	Very Frequent	Always
To what degree do you receive good support and guidance from your seniors	○	○	○	○	○	○
To what degree do you feel valued and respected in your job	○	○	○	○	○	○
To what degree do you feel part of a team	○	○	○	○	○	○
To what degree do you feel a good relationship with your patients will benefit a supportive work environment	○	○	○	○	○	○

Figure 3.3: **The rating scale response set**

A Likert scale response set is described as an item that consists of several declarative statements that express an attitude or belief on a topic (Böckenholt, 2017:5). Respondents are often asked to indicate their degree of agreement or disagreement with each statement that best reflects their feelings. Figure 3.4 illustrates this on the FATCOD scale:



the questionnaire. You can access the questionnaire on your smartphone, tablet or laptop. Once complete send it back to the researcher. The online survey will expire at the end of the week.

Section 2: Frommelet Attitude Towards Care of the Dying (FATCOD) Scale

In these items the purpose is to learn how you feel about nursing care involving the dying patient and their family. Please respond to all 30 statements on the scale under the following headings:

Strongly disagree

Disagree

Uncertain

Agree

Strongly agree

14.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Giving nursing care to a dying patient is worthwhile learning experience	○	○	○	○	○
Death is not the worst thing that can happen to a person	○	○	○	○	○
I would be uncomfortable talking about impeding death with the dying person	○	○	○	○	○

Figure 3.4: **Likert scale response rate**

A Likert questionnaire consisting of three sections was used in this study:

- Section 1: Templer's Death Anxiety Scale (DAS)
- Section 2: Frommelt Attitude Towards Care of the Dying (FATCOD) scale
- Section 3: The Level of Support in the Working Environment Questionnaire

Section 1: The Modified Templer's DAS

Templer's DAS is a self-report, dichotomous questionnaire of 15 questions (Dadfar, Lester & Abdel-Khalek, 2018:3). The questions on Templer's DAS allow respondents to express different degrees of fear of the unknown aspect of death (1, 2, 12, 14, 15); fear of suffering involved in the process of death (3, 4, 5); and fear of loneliness at the time of death (6, 7) (Conte et al., 1982:781-782). Templer's DAS also addresses respondents' fear of extinction (10, 11, 13) (Conte et al., 1982:782). According to Rosa et al. (2017:58-59), when nurses uncover their own fears, hopes and wishes related to death, it affects their attitudes towards caring for the dying patient.

The following Templer's DAS questions were modified from the original Templer DAS by the researcher and reviewed by the statistician for relevance and clarity as suitable for this study. They included all major elements relevant to young professional nurses' attitudes:

Table 3.1: Original Templer's DAS questions versus the modified questions from Templers DAS

Original questions from Templer's DAS	The modified questions from Templer's DAS
Question 1: Do you worry about death?	Statement 1: I worry about dying
Question 3: Do you worry that you may be very ill for a long time before you die?	Statement 3: I worry that I may be very ill for a long time before I die
Question 5: Do you worry that dying may be very painful?	Statement 5: I worry that dying may be painful

Question 4: Does it upset you to think that others may see you suffering when you die?	Statement 4: It upsets me to think that others may see me suffering when I die
Question 7: Do you worry that you may be alone when you are dying?	Statement 7: I worry that I may be alone when I am dying

Templer’s DAS originally required true or false responses (Dadfar et al., 2018:3), but for this study, it was modified to a four-point Likert questionnaire, with the following four response categories: rarely; some of the time (less than 1 day); occasionally (3–4 days); and most of the time (5–7 days). Scoring ranges from 5 to 20, with higher scores reflecting high anxiety regarding death and dying (Saleem et al., 2015:726).

Section 2: Frommelt FATCOD scale

The FATCOD scale is a self-report Likert questionnaire (Frommelt, 1991:39). The statements on the FATCOD scale are relevant in assessing nurses’ attitudes towards caring for the dying patient. Two-thirds of the items relate directly to the nurses’ attitudes toward the patient, and one-third relates directly to the nurses’ attitudes toward the family members of the terminally ill person (Frommelt, 1991:39).

The FATCOD scale contains 30 closed-ended statements. Fifteen of the statements are positively worded (1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27 and 30) and the other 15 are negatively worded (3, 5, 6, 7, 8, 9, 11, 13, 14, 15, 17, 19, 26, 28 and 29) (Edo-Gual et al., 2018:22). Gray et al. (2017:407) claim equal representation of positively and negatively worded statements cause a counterbalance of responses. The statements on the FATCOD scale were not grouped based on a specific topic, and there was no progression of statements from general to very specific, to avoid response-set bias (Gray et al., 2017:407). The FATCOD scale has five response categories: strongly disagree; disagree; uncertain; agree; and strongly agree. Scoring ranges from 30 to 150, with higher scores representing more positive attitudes towards caring for the dying patient (Edo-Gual et al., 2017:123). Scores obtained from the FATCOD scale were used to determine the outliers for the second phase of the study.

Section 3: Level of Support in the Work Environment Questionnaire

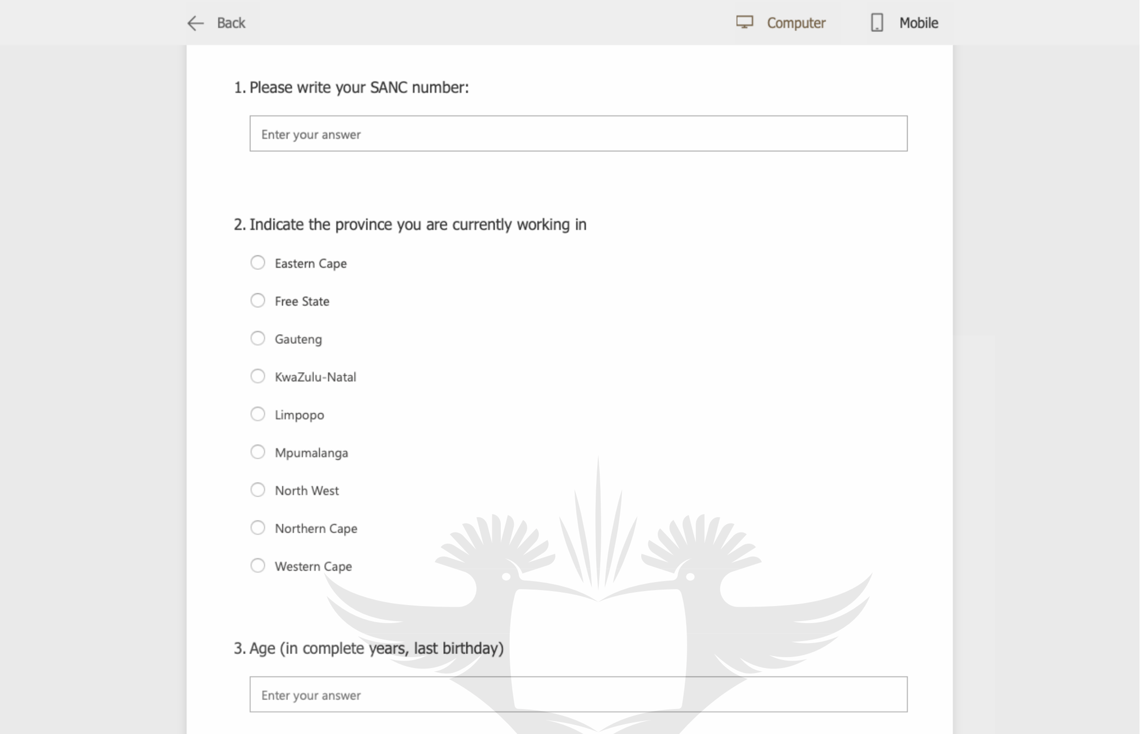
The Level of Support in the Work Environment Questionnaire was used to assess the young professional nurses' perspective on the level of support in their current work environment. This was an important aspect for the researcher to assess as various studies have found nurses' work environment has a direct impact on their attitude towards caring for the dying patient and their families (Ten Hoeve, Brouwer & Kunnen, 2020:836; Downing et al., 2017:4373; Watson,1988:54; Tuomikoski et al., 2018:78 & Oshodi, 2016:4). The Level of Support in the Work Environment Questionnaire is a self-report, dichotomous questionnaire containing eight questions (De Kock, 2011:23). The questions are relevant in assessing the work environment's effect on young professional nurses' attitude when caring for the dying patient. The questionnaire consists of six response categories ranging from 'never' to 'always' (De Kock, 2011:23). Scoring ranges from 8 to 48, with higher scores representing a high level of support in the work environment (de Kock, 2011:97).

Data collection was initially done online, which required the researcher to convert the questionnaire to an online survey. Online surveys are popular due to growing access to the internet globally. A significant proportion of the global population is digitally connected, resulting in the shift from paper to digital (Regmi Waithaka, Paudyal, Simkhada & Teijlingen 2016:640). According to Regmi et al. (2016:642), data collection through an online survey is useful when collecting data from hard-to-reach populations. Online surveys also allow researchers to collect large amounts of data from respondents in a short timeframe (Regmi et al., 2016:640). Regmi et al. (2016:642) further argue online surveys are convenient, as they are easy to access, especially if the survey link is promoted through social media.

3.5.3 Conversion of questionnaire to an online survey

The demographic questionnaire and Likert scale in this study were converted to online survey using Microsoft Forms. Microsoft Forms is a software platform used to create surveys and allows others to respond to it using almost any web browser or mobile device (Tran, 2020:56). Microsoft Forms made it easy to develop point-and-click automated forms that could be distributed electronically. It took the researcher 24 hours to convert the demographic questionnaire and Likert scale to an online survey.

It allowed a full range of scale properties described in nominal, ordinal, interval and ratio scales to be used. It also allowed for open, closed, and written responses (see Figure 3.5).



1. Please write your SANC number:

Enter your answer

2. Indicate the province you are currently working in

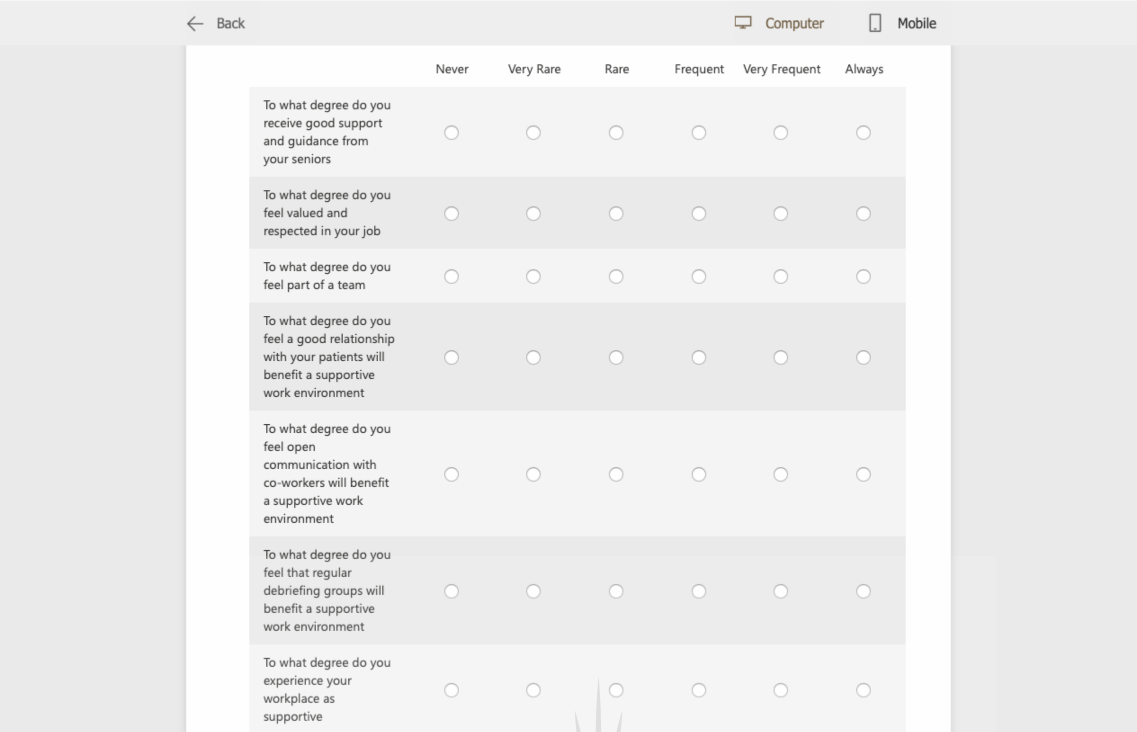
○ Eastern Cape
○ Free State
○ Gauteng
○ KwaZulu-Natal
○ Limpopo
○ Mpumalanga
○ North West
○ Northern Cape
○ Western Cape

3. Age (in complete years, last birthday)

Enter your answer

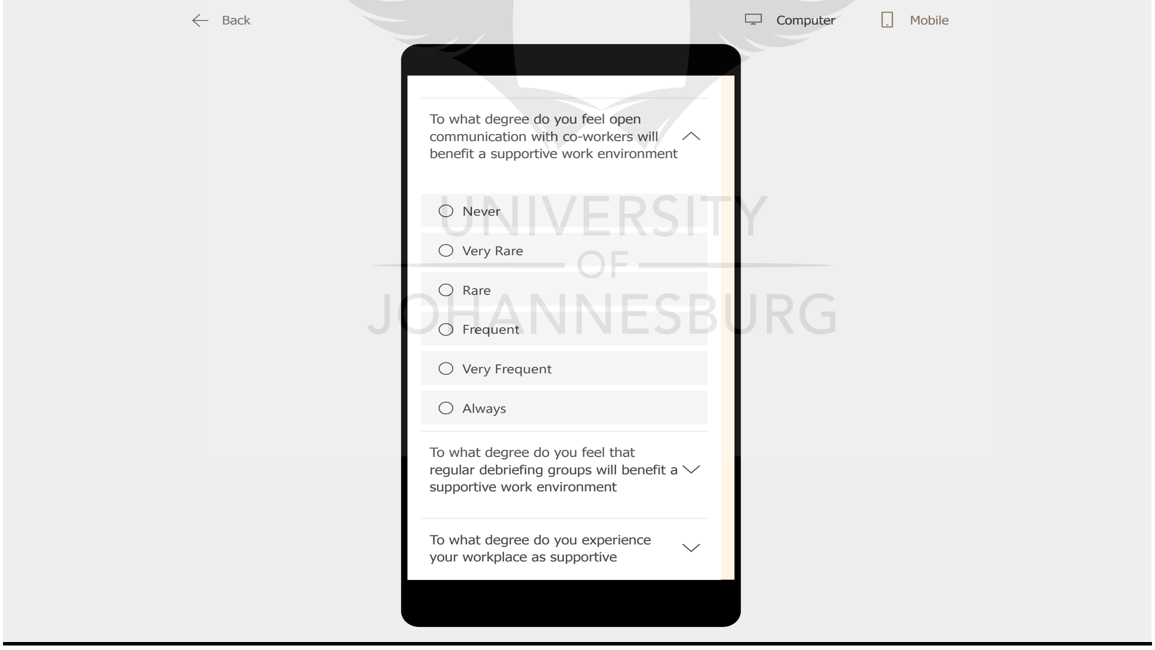
Figure 3.5: Example of the open, closed, and written response from the online survey

There are no restrictions on the number of questions that can be asked and the length of the questionnaire (Microsoft Form, 2020). The questions on the questionnaire remained the same across digital platforms even though they looked different, as illustrated in Figures 3.6 and 3.7:



	Never	Very Rare	Rare	Frequent	Very Frequent	Always
To what degree do you receive good support and guidance from your seniors	○	○	○	○	○	○
To what degree do you feel valued and respected in your job	○	○	○	○	○	○
To what degree do you feel part of a team	○	○	○	○	○	○
To what degree do you feel a good relationship with your patients will benefit a supportive work environment	○	○	○	○	○	○
To what degree do you feel open communication with co-workers will benefit a supportive work environment	○	○	○	○	○	○
To what degree do you feel that regular debriefing groups will benefit a supportive work environment	○	○	○	○	○	○
To what degree do you experience your workplace as supportive	○	○	○	○	○	○

Figure 3.6: Computer version of the scale



To what degree do you feel open communication with co-workers will benefit a supportive work environment

○ Never
○ Very Rare
○ Rare
○ Frequent
○ Very Frequent
○ Always

To what degree do you feel that regular debriefing groups will benefit a supportive work environment

To what degree do you experience your workplace as supportive

Figure 3.7: Phone versions of the scale

Respondents were also able to skip questions and come back to them later before submitting the questionnaire.

3.5.4 Pilot study

A pilot study is a small-scale research project conducted before the final full-scale study. A pilot study helps researchers test the feasibility of their study and identify problems that may interfere with the actual study. It is performed with the same research population, setting, plans for data collection, and data analysis (Gray et al., 2017:54). The pilot study is intentional and is planned from the beginning of a proposed project and before the actual investigation. The principal benefit of conducting a pilot study is that it provides researchers with an opportunity to adjust and revise the main study (Ismail, Kinchin & Edwards, 2018:1). Researcher can adjust and refine their research methodology based on this feedback before attempting the final study (Ismail et al., 2018:1). Figure 3.8 illustrates the suggested steps of a pilot study:

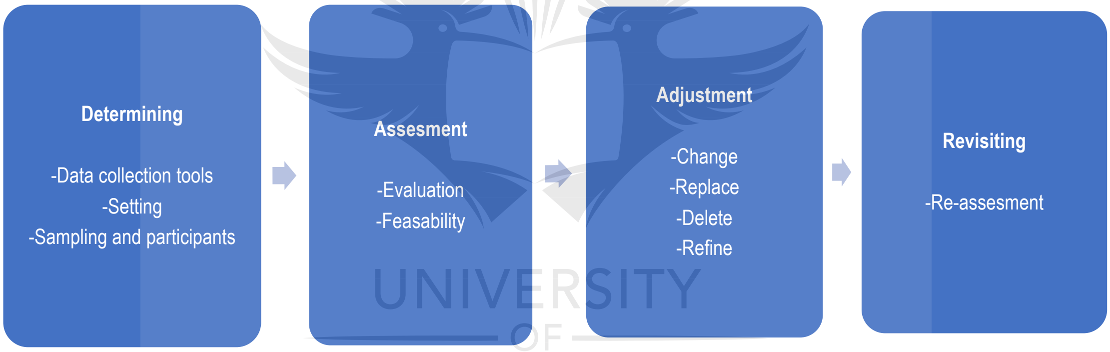


Figure 3.8: Quantitative steps of the pilot study plan

A pilot study was conducted in this study for the following reasons:

- to assess the effectiveness of the sampling method to recruit participants
- to assess how much time is required to gather data from a single subject
- to pre-test the research questionnaire

3.5.4.1 The effectiveness of the sampling method in recruiting respondents

Snowball sampling was used during the pilot study. Parker, Scott and Geddes (2019:3) proposed that when researchers employ snowball sampling, they use networks to establish initial links, with sampling momentum developing from these, capturing an increasing chain of participants (Parker et al., 2019:3). The Facebook social media platform was used to recruit respondents for the pilot study. Adam, Manca and Bell (2016:2) found Facebook to be a popular social media platform, with the greatest portion of users between the age of 18 and 49 years. Therefore, a Facebook page was designed by the researcher, which contained information regarding the study and how to contact the researcher. The page is shown in Figure 3.9:

Young PN's attitudes towards caring for the dying patient

@YoungPNattitudestowardscaring · Not a Business

Figure 3.9: Facebook page

On Facebook, people could ‘share’ the page for the study, which allowed information to be passed along to Facebook friends; this created an organic snowballing effect (Adam et al., 2016:5). Interested subjects could also email the researcher to obtain more information. The purpose of this process was to provide reasonable assurance that the subjects were not deceived or coerced to participate in the study (Parker et al., 2019:1). This strategy was particularly useful as this study was conducted during the COVID-19 pandemic, which encouraged social distancing to curb the spread of the virus (WHO, 2020).

The researcher initially shared the Facebook page with a small number of contacts who fit the research criteria and invited them to become research subjects. Agreeable subjects were then asked to recommend other contacts who fit the research criteria and would potentially be willing participants, who then, in turn, recommended other potential subjects, and so on.

3.5.4.2 The effectiveness in gathering data from a single subject

The researcher scouted young professional nurses who met the inclusion criteria. These young professional nurses were sent the link to the Facebook page for the study, where interested individuals could get more information regarding the study and the researcher's contact details. Interested individuals were able to email the researcher, who sent a detailed description of the study and its purpose, an explanation of the respondent's role, and clarification of the respondent's right to accept or decline participation or withdraw at any stage of the study without any repercussions. The purpose of this process was to provide reasonable assurance that the respondents were not deceived.

Once they had signed the consent form, the researcher sent a link to the respondents containing the demographic and Likert questionnaires. Respondents had one week to complete the questionnaires before the link expired.

3.5.4.3 Pre-test of the research questionnaire

Howard (2018:1) describes pre-testing as a stage in quantitative research when the questions on a questionnaire are tested on members of the target population to evaluate the reliability and validity of survey instruments prior to their final distribution. Pre-testing the research questionnaire is an important aspect to determine whether a questionnaire measures what it is intended to and the respondents' interpretation of items. Hilton (2017:21) recommends while pre-testing an instrument, the researcher needs to evaluate the difficulty of the instrument, the extent of the items and their representation of the focal construct, and their ability to gauge the focal construct. In this study, when pre-testing the Likert scale, respondents were asked:

- to rate the level of difficulty of the questions
- if they understood the questions

- and for them to indicate the questions they found difficult

3.5.4.4 Findings from the pilot study

Gray et al. (2017:55) claim the findings from a pilot study can help researchers modify or refine an instrument, data collection and data analysis procedures. The findings of the pilot study are discussed under the following headings:

- the challenges of the sampling method to recruit respondents
- the challenges in gathering data from a single subject
- the effectiveness of the research questionnaires

3.5.4.5 The challenges of the sampling method in recruiting respondents

In the pilot study, the researcher found some young professional nurses would view the page but not refer friends who met the inclusion criteria to the page. This resulted in the researcher being on Facebook on a daily basis for three months, and only being able to recruit 20 young professional nurses who met the inclusion criteria. The researcher found that not everyone who has Facebook is active on the site. This recruitment method also meant those young professional nurses who did not have Facebook would be excluded from the study.

The researcher ultimately found snowball sampling ineffective in recruiting respondents, as the sample size recruited over three months was too small. Parker et al. (2019:3) found that, with snowball sampling, when the snowball fails to roll, networking does not gain momentum. Therefore, Parker et al. (2019:3) recommend that snowball sampling be used in conjunction with another sampling method, especially if a large sample size is required. The researcher thus decided to use snowball sampling and convenience sampling. The 20 respondents from the pilot study were excluded from the main study as they could affect the internal validity of the main study.

3.5.4.6 The challenges in gathering data from a single subject

In the pilot study, the researcher found respondents were taking longer than a week to complete the online survey, resulting in the link to the demographic questionnaire and Likert scale expiring before they could complete them. By the end of the pilot study, the hospital was allowing researchers in the hospital for data collection; therefore, the researcher decided to distribute physical questionnaires to the young professional nurses in the hospital under study. Once they had completed the questionnaires, the respondents were told to insert them in a letterbox the researcher checked weekly. This allowed the respondents to complete the questionnaire without any pressure or time restraint.

3.5.4.7 The effectiveness of the research questionnaire

The effectiveness of the research questionnaire was measured based on its validity. An instrument's validity indicates the extent to which the constructs being measured can be examined (Gray et al., 2017:375). According to Howard (2018:3), pre-testing an instrument reflects a numerical measure of face validity, which is assumed to contribute to the overall construct validity of the eventual scale.

3.5.4.8 Face validity

Face validity is the extent to which a scale or item is subjectively judged to represent its intended construct (Hilton, 2017:23). Face validity verifies that the instrument appears to be measuring the constructs it is meant to measure (Gray et al., 2017:376). Face validity can also encompass the instrument's readability level, which refers to the level of educational mastery required to understand the questions (Gray et al., 2017:380). Although face validity is considered a weak measure of validity due to its subjectivity and lack of clear guidelines for validation, it is still an important determinant of the usefulness of an instrument because respondents' willingness to complete the instrument relates to their perception of the instrument's relevance (Gray et al., 2017:376).

The questionnaire in this study was neat and attractive, with a pleasing aesthetic. The research questionnaire was well written, easy to read, and concise. Its format was uniform in respect to punctuation, spelling, and adequate spacing between questions. No jargon was used in the questionnaire, just simple English. The instructions on the questionnaires were also clear. During the pre-test, respondents were asked about the online questionnaire's layout and if it stimulated their interest; 75% of the respondents agreed the layout stimulated their interest, with one participant stating that: "*It is well constructed".*

3.5.4.9 Content validity

Content validity examines the extent to which the measurement method includes all major elements relevant to the construct being measured (Gray et al., 2017:376). Two key domains being investigated in this study were young professional nurses' attitude and caring. In the pre-test, it was found the questionnaire measured what it was intended to measure. Based on the feedback received in the pilot study, no modification was made to the research instrument. The Likert scale was efficient in measuring young professional nurses' attitudes towards caring for the dying patient and their family.

3.5.5 The main study: data collection process

As an initial step, an appointment was made to meet the Nursing Deputy Director of the hospital under study to formally discuss the central concept of the study and get permission to conduct the study. This process helped the researcher determine how receptive the institution would be to the researcher conducting the study. During the meeting with the Nursing Deputy Director, the researcher obtained baseline information regarding the type of wards in the hospital and their unit managers, who were the gatekeepers in the units. Gatekeepers are persons who have the authority to allow entry into a research site (Polit & Beck, 2010:1451) and play an important role in recruiting subjects who would be valuable to the study.

Respondents were informed verbally and in writing by the researcher – by means of an information letter – about the purpose of the research, as well as the data collection method. In addition, the respondents were informed about the foreseeable psychological triggers relating to the subject of death and dying pertaining to themselves and caring for dying patients and their families. The potential benefits of the study were explained. Respondents were assured that all information would be kept private and confidential, and that their identities would remain anonymous in all presentations, reports and publications. They were informed that they could withdraw from the study at any time without penalty, and the researcher answered any pertinent questions concerning the research. A completed written consent form was obtained from each respondent before the demographic and Likert scale questionnaire were administered.

The demographic questionnaire and Likert scale questionnaire were distributed in the hospital under study during nurses' tea and lunchtime in the tearoom. Once completed, they were asked to insert the questionnaire in the letterbox kept in the tearoom. The researcher collected data weekly for three months. A further description of the data collection process is provided in Chapter 4.

3.6 PROCESS OF DATA ANALYSIS

Following data collection, the researcher captured the data. Each questionnaire was identified using the respondent's SANC number. The researcher captured the data, but hard copies of the completed questionnaires were submitted to the statistician for an accurate review of the entries. The numerical data were then computed for analysis. The statistician from Statkon analysed the data using IBM Statistical Package for Social Science (SPSS) version 27.0. Both descriptive and inferential analyses were performed.

3.6.1 Descriptive statistics analysis

Descriptive analysis involved the computation of descriptive statistics, which included measures of central tendency (the mean, median, and mode), measures of dispersion (the standard deviation, range), and measures of distribution (percentages and frequencies). Descriptive statistics were computed to describe and summarise the study's findings of respondents' level of death anxiety; attitude towards caring for the dying patient and their family; and the level of support in the workplace. The descriptive statistics were also computed to describe the respondents' demographic characteristics (age, gender, type of ward, estimated number of dying patients cared for, previous education on end-of-life care, and feelings about previous education on the subject of death and dying). The findings of the descriptive statistics are presented in Chapter 4.

3.6.2 Inferential statistics

Inferential statistics are based on the laws of probability provided by data from a sample (Polit & Beck, 2012:405). According to Gray et al. (2017:523), inferential statistics are computed to draw conclusions and make deductions about the population based on the sample data set. This allowed the researcher to determine whether there were differences within the sample and whether these differences were likely to be present in the population of interest (Polit & Beck, 2018:250). Inferential statistics in this study were done under the following headings:

- Factor analysis
- Pearson correlation

3.6.2.1 Factor analysis

Factor analysis is a multivariate statistical technique that uses mathematical procedures to simplify interrelated measures that share a common variance and are unobservable, to discover patterns in a set of variables (Gray et al., 2017:552). These unobservable factors are not directly measured but are essentially hypothetical constructs used to represent variables (Orçan, 2018:415-416). This is achieved by establishing dimensions within the data, and serves as a data reduction technique (Watson, 2017:233). The reduction of data from questionnaires was deemed useful when assembling common variables into descriptive categories in order to get to underlying concepts. This was vital in facilitating interpretations when placing variables into meaningful categories (Orçan, 2018:415).

Factor analysis is used in behavioural and social sciences fields to examine how underlying constructs influence responses on a number of measured variables (Watson, 2017:233-234). In this study, factor analysis was used to:

- assess how young professional nurses' attitudes affect the care provided to the dying patient their family; and
- factors that influence their attitudes towards caring for the dying patient and their family.

The purpose of factor analysis in this study was two-fold: firstly, to use its findings to validate the measuring instrument, and secondly, to use it as a preparatory measure before performing subsequent regression analyses (Pallant, 2016:182). Factor analysis was performed using IBM SPSS version 27.0. The models chosen for the factor analysis were principal component analysis (PCA) and principal axis factoring (PAF). This choice was based on the need for a simple solution with few possible factors that explained as much possible variance in the data (Pallant, 2016:182).

Prior to performing the PCA and the PAF, the data's suitability for factor analysis was assessed. Correlation matrices were inspected for the presence of correlations greater than $r = 0.3$. Pallant (2013:193) suggests that these correlations are reliable indicators of possible underlying correlations among the variables being investigated. Kaiser-Meyer-Olkin's (KMO) index and Bartlett's test of sphericity were also determined. According to Pallant (2013:190), the KMO index ranges from 0 to 1, and a minimum value of 0.6 is recommended to ensure reliable factor analysis. Similarly, Bartlett's test of sphericity needs to be significant ($p < 0.05$) for factor analysis to be considered appropriate (Pallant, 2013:190).

The number of factors to retain was determined using Kaiser Criterion and Catell's scree test. The Kaiser Criterion requires retaining all factors with an Eigenvalue score greater than 1 (Pallant, 2016:185). The Catell's scree test requires plotting all Eigenvalue scores of the factors and inspecting for a point where there is a break in the continuity of the graph. All factors above the observed break are retained, and those below the break are discarded (Pallant, 2016:185). The identified factors were then named and described in view of literature. Factor analysis findings are presented in detail in Chapter 4.

3.6.2.2 Pearson's correlation

Pearson correlation (r) is a statistic that measures linear relationships between two or more variables. It is normally calculated with interval or ratio data, but it is also used with ordinal data on the assumption that they are converted to intervals or measures (Pallant, 2013:129). Correlation output for linear relationships is described in terms of direction, strength, confidence level, and the significance of the correlation. The direction of a relationship is expressed as positive (when one variable increases, the other increases also) or negative (when one variable increases, the other decreases) (Pallant, 2013:138). Moreover, the strength of a relationship is the extent to which scores on one variable are associated with scores on the other (Tokunaga, 2016:577).

The strength of a correlation ranges from -1 to +1. Regardless of the sign, within this range, .1 to .29 indicates a weak correlation, .30 to .49 indicates a moderate correlation, and .5 to 1 indicates a strong correlation (Tokunaga, 2016:579). Confidence level refers to the amount of variance explained by the observed correlation. It is calculated and expressed as a ratio by squaring the correlation coefficient, or as a percentage by multiplying the squared correlation coefficient by 100 (Pallant, 2013:139). Statistical significance indicates how much confidence researchers should have in the observed correlation. In this study, Pearson correlation was computed:

- between age and attitudes towards caring for the dying patient and their family;
- between years of experience and attitude towards caring for the dying patient and their family;
- between the estimated number of dying patients cared for in the last six months and attitude towards caring for the dying patient;
- between death anxiety and attitude towards caring for the dying patient; and
- between the nature of support in the workplace and attitudes towards caring for the dying patient.

Findings on Pearson correlation are presented in detail in Chapter 4.

3.7 PHASE 2: QUALITATIVE RESEARCH

Qualitative research is a systematic, interactive, subjective and holistic inquiry (Gray et al., 2017:63) focused on exploring meanings and insights in a given situation (Mohajan, 2018:1). Anthropologists and sociologists first used qualitative research as a method of inquiry in the early decades of the 20th century. During this period, qualitative data analysis aimed to objectively describe social phenomena in society or other cultures (Mohajan, 2018:3).

Qualitative research follows a constructivist paradigm that reflects the principles of scientific enquiry (Mohajan, 2018:5). Constructivism has been described as an individual's unique experience that emphasises social aspects that shape the way individuals see things from their point of view (Kelly, Dowling & Millar, 2018:9). It offers meaning to subjective emic experiences by focusing on the "how" and "why" aspects of the individual's experience. This offers the researcher the opportunity to acknowledge the social context in conjunction with the individual's meaning of the possible causative mechanisms shaping that experience (Kelly et al., 2017:12).

Qualitative research is inductive in nature and emphasises how people interpret and make sense of their experiences to understand these social realities. It aims to provide a detailed understanding of human behaviour, emotion, attitudes, and experiences (Mohajan, 2018:23). It is focused on describing life experiences, cultures, and social processes from the perspective of the persons involved (Levitt, Bamberg, Creswell, Frost, Josselson & Suárez-Orozco, 2018:27). Qualitative research does not include statistical analysis and empirical calculation but focuses on describing and interpreting issues or phenomena systematically from the point of view of the individual or population being studied, generating new concepts and theories (Mohajan, 2018:2).

Qualitative research is an umbrella term that encompasses a variety of approaches to inquiry, namely phenomenology, ethnography, grounded theory, and exploratory-descriptive approaches (Gray et al., 2017:40). These approaches have distinct philosophical underpinnings, purposes, techniques, methods, and presentations of findings (Patton, 2020:278). For this study, a phenomenological approach was used as a follow-up to quantitative research. This approach assisted the researcher in understanding the young professional nurses' experiences when providing end-of-life care by exploring and describing the outliers' attitudes. This deepened and contextualised the overall findings of the core quantitative survey.

3.7.1 Phenomenological research method

Phenomenology is a movement that explores the lived experience of a given phenomenon. Edmund Husserl and Martin Heidegger, two of the most prominent philosophers who spearheaded this movement, developed their own distinct philosophical approaches and methods of inquiry as a means of exploring and understanding the human experience (Patton, 2020:279). The uniqueness of the phenomenological research method is its view of reality that allows researchers to understand participants' embodied experiences (Tuffour, 2017:2). Phenomenological research encompasses two distinctive inquiry orientations: interpretative oriented and descriptive oriented (Heotis, 2020:2). In this study, a descriptive phenomenology approach was used.

Descriptive phenomenological research is concerned with the "what is it like" of the experience, which is useful in uncovering the meaning of a phenomenon as lived by a person who experienced it (Heotis, 2020:1). In descriptive phenomenology, the aim is to gain insight and describe themes that are common among multiple participants, revealing the essential structure or the essence of their lived experiences (Holloway & Galvin, 2017:227). Descriptive phenomenology looks at participants as beings that are in constant interaction with their surroundings. This shapes how they interpret the world and themselves in the world, providing essence and meaning to their lived experiences (Willis, Sullivan-Bolyai, Knafl & Cohen, 2016:1187).

Phenomenological reduction is an approach used by researchers to set aside their personal attitudes towards the phenomenon, including previous experiences, theories, judgements and explanations (Finlay, 2014:123). This involves dialectical processes, which allow researchers to be genuinely curious while being mindful and reflexive about their own perspective and position (Finlay, 2014:123). This was an important element in understanding the young professional nurses' attitudes towards caring for the dying patient and their family.

3.8 SAMPLING METHOD

The sampling method in qualitative research is determined by the study's purpose (Gray et al., 2017:352). Therefore, purposive sampling was deemed suitable for this phase, as the participants were consciously selected by the researcher based on their characteristics, which were defined for a purpose relevant to the study (Polit & Beck, 2018:202). This deliberate choice of participants was based on their proficiency and being well-informed regarding the phenomenon of interest (Eitkan, Musa & Alkassim, 2016:2).

The participants were identified based on pre-defined criteria (Denieffe, 2020:663). These inclusion criteria were:

- Young professional nurses who participated in the first phase of the study
- Young professional nurses who completed the demographic and Likert scale questionnaire
- Young professional nurses with low scores from the FATCOD scale
- Young professional nurses with high scores from the FATCOD scale
- Young professional nurses who provided consent to participate in the second phase of the study

The exclusion criteria were:

- Young professional nurses unwilling to participant in the second phase of the study
- Young professional nurses who did not complete the demographic and Likert scale questionnaire

3.8.1 Sample size

In qualitative research, the focus is on the quality of information obtained from the participants, rather than the size of the sample (Gray et al., 2017:352). The sample size is determined by the depth of information needed to gain insight into the phenomenon (Gray et al., 2017:352). Samples are also usually small because researchers use qualitative studies to discover the meaning of a phenomenon from multiple realities. The aim is not to generalise the findings in relation to the target population (Polit & Beck, 2018:199). The sample size for this study consisted of three participants with low overall scores on the FATCOD scale, and three participants with high overall scores on the FATCOD scale. The statistician guided this sample size.

3.9 RESEARCH SETTING

Focus groups were conducted via Zoom call due to the social distancing regulations of the COVID-19 pandemic (WHO, 2020). Zoom is a web-based video-conferencing tool (Chawla, 2020:1) that offers the ability to communicate in real time with geographically dispersed individuals via computer, tablet, or mobile device (Archibald, Ambagtsheer, Casey & Lawless, 2019:2). Zoom possesses several additional advantages that enhance its potential research utility. A key advantage of Zoom is its ability to securely record and store sessions without recourse to third-party software. This feature is particularly important in research where the protection of highly sensitive data is required. Other important security features included user-specific authentication, real-time encryption of meetings, and the ability to back-up recordings to online remote server networks referred to as “the cloud”; the researcher found these useful during data collection and analysis (Zoom Video Communications Inc., 2016).

3.10 DATA COLLECTION

Qualitative research aims to generate knowledge. It translates into gathering ‘deep’ information and perceptions regarding a phenomenon from the perspective of the research participant (Gray et al., 2017:256). This data can be collected through inductive, qualitative methods such as interviews, focus groups and participant observation (Gray et al., 2017:256).

3.10.1 The pilot study

A pilot study in qualitative research is a useful tool in assessing the study's feasibility (Schwind, McCay, Beanlands, Martin, Martin & Binder, 2017:93-94). Although they may not be very common practice in qualitative research, William-McBean (2019:1055) explains pilot studies are very beneficial to novice researchers when preparing for data collection, since pilot studies assist researchers in developing and refining the research question and evaluating the feasibility of the recruitment protocols.

Ismail et al. (2017:1) found that pilot studies in qualitative research follow a similar pathway to quantitative studies. However, reflection is an important aspect to consider after the pilot study, as illustrated in Figure 3.10:

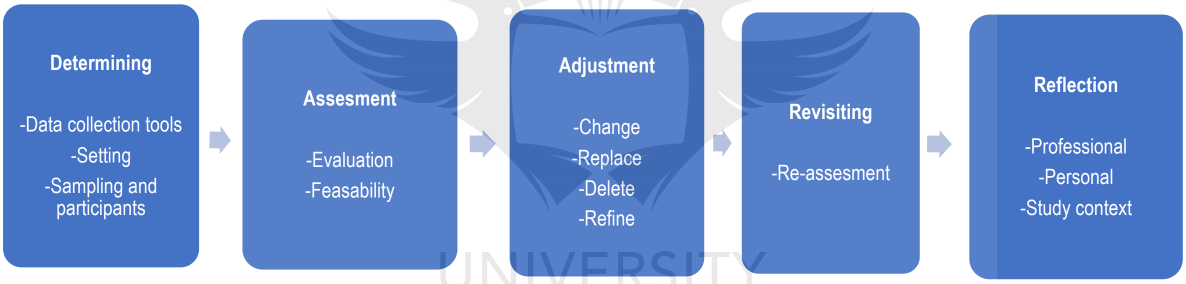


Figure 3.10: Qualitative steps of the pilot study plan

Reflection in qualitative research is used to refine the methodology and increase the novice researcher's confidence in conducting qualitative research, thereby enhancing the creditability of the study (Ismail et al., 2017:7). In this study, the pilot study was conducted:

- to assess the feasibility of the recruitment protocol
- to develop research questions
- to assess the data collection process

3.10.1.1 Feasibility of the recruitment protocol

Recruitment can be defined as a dialogue between the researcher and potential participant before initiating the consent process. The recruitment process involves identifying, targeting, and enlisting potential participants, followed by providing information to potential participants and establishing their interests in the proposed study (Manohar, Steiner, MacMillan & Arora, 2018:2). The successful recruitment and retention of study participants are essential for the overall success of a study (Newington & Metcalfe, 2014:1).

Researchers can use different methods to recruit suitable participants, including telephone calls, door-to-door canvassing or incentives (Nyumba et al., 2018:22). In this pilot study, the participants were recruited based on their scores on the FATCOD scale. Participants with high scores and low scores were contacted telephonically to participate in the focus group. After consenting, the researcher sent the participants 2G data to download Zoom and log in for the focus group and be able to maintain connectivity until the end of the session. This eliminated the cost of data for the participants (Chinembiri, 2021:4).

3.10.1.2 Development of research questions

Qualitative research questions articulate what a researcher wants to know about the intentions and perspectives of those involved in social interactions (Flick, 2018:29). Qualitative research questions seek to uncover the ‘thick description’ of the participants’ experience by asking ‘what’, and even more ‘how’ and ‘why’ relating to the phenomenon under study (Majid et al., 2017:1074). They form the ultimate foundation for the research as they invite the process of exploration and discovery.

The researcher followed Majid, Othman, Mohamad, Lim and Yusof (2017:1075) guide when developing research questions as illustrated in Figure 3.11:

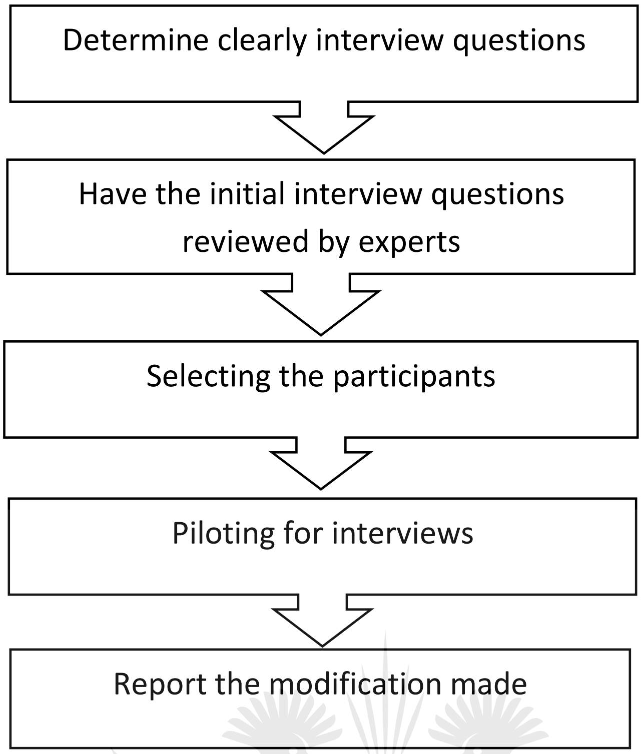


Figure 3.11: Steps in developing research questions

In the pilot study, the researcher developed the following questions based on extensive literature reviews and the trends found in Phase 1's data analysis:

- "Describe your first experience caring for the dying patient in one word."
- "How has your first experience caring for the dying patient impacted your current attitude towards being allocated to caring for the dying patient?"
- "Describe your experience when the dying patient asked you if they were dying?"
- "How important do you think family involvement is when caring for the dying patient?"
- "What would you tell yourself as a nursing student regarding caring for the dying patient?"

3.10.1.3 Data collection process

In the pilot study, the focus group was conducted online using Zoom. Online focus groups are versions of traditional interview methods, using internet venues instead of face-to-face interaction (Lobe, Morgan & Hoffman, 2020:2). Online platforms for focus groups have been used over the last 20 years, with an increasing number of studies making use of these platforms (Kite & Phongsavn, 2017:1). This stems from the introduction of the internet, and the method became very popular during the COVID-19 pandemic, which encouraged social distancing. In this pilot study, the participants were asked to download Zoom, a video-conferencing platform that has already been extensively used for research purposes (Chawla, 2020:4). Participants were emailed an invitation (Annexure 10) leading them to click on the link and enter the focus group; an information leaflet (Annexure 12) and consent form (Annexure 13) to participant in the focus group.

Focus groups are designed to obtain the participants' perceptions of a focused topic (Gray et al., 2017:263) and were used in the pilot study for data collection. The interaction among participants in the focus group helps them express and clarify their views in a way that would be less likely to occur in a one-on-one interview (Polit & Beck, 2018:204). Tausch and Menold (2016:1) claim that focus groups promote synergy and spontaneity by encouraging participants to comment, explain, disagree, and share their views. This generates more ideas and yields deeper insights into the problem under investigation (Tausch & Menold, 2016:1). According to Nyumba et al. (2018:24), online focus groups boast an aura of dynamism, modernity and competitiveness that transcends classic problems with face-to-face focus group discussion.

3.10.2 Findings from the pilot study

3.10.2.1 Assessment in the feasibility of the recruitment protocol

In the pilot study, the participants' SANC numbers were chosen from two hats, one had the names of participants with low overall scores on the FATCOD scale and the other had the names of participants with high overall scores on the FATCOD scale. The names were drawn from each hat randomly until the sample size was achieved. Two pilot studies were conducted due to the failure in the recruitment of participants.

On the first attempt, were approached, but only two were logged in. The other four participants were contacted, but there was no response. Archibald and Munce (2015:34) found that this is quite a common challenge in qualitative research, as researchers often overestimate participants' willingness and guarantee that those recruited will attend the discussion (Nyuma et al., 2018:21). To avoid recruitment failure, Nyuma et al. (2018:21) proposed that researchers need to over-recruit by 10–25%, as far-reaching recruitment helps increase the number of participants in the study. This method was used on the second attempt at the pilot study, which was more successful. The researcher approached eight participants, with only four participants logging in. This was considered an acceptable size for the pilot study (Nyuma et al., 2018:21).

For the actual study, the number of participants in the focus group was increased to six, because the accepted number of participants in a focus group is between six and eight (Nyumba et al., 2018:23). Participants from the pilot study were excluded from the main study to avoid them influencing the dynamics of the focus group in the main study.

3.10.2.2 Development of research questions

In the pilot study, the researcher, under the research supervisors' guidance, found that some of the questions were confusing and unclear. This is quite common among most novice researchers, as they find it challenging to frame a qualitative question that not only enquiries about phenomena, understanding, or perceptions, but also signals the study's relevance (Flick, 2018:30). The reasons for the individual changes, additions and deletions of questions are explained in the table below:

Table 3.2: Individual changes, additions and deletions of questions

Initial questions	Changes	Reasons for the changes
"Describe your first experience caring for the dying patient in one word."	"Describe your first experience caring for the dying patient."	In the pilot study, most participants could not use just one word to describe their first experience caring for the dying patient, as death is a complex topic, which evokes deep emotions (Kübler-Ross,

Initial questions	Changes	Reasons for the changes
		1991:82). Therefore, using one word to describe these emotions may be difficult.
"How has your first experience caring for the dying patient influenced your current attitude towards being allocated to caring for the dying patient?"	No changes were made	In the pilot study, all the participants were able to reflect and compare how their experience had impacted their current attitude. One participant said her first experience was when she was a student and her patient ended up being a failed resuscitation. She shared how that first experience changed her perception of resuscitating patients in the ICU and made her more comfortable caring for the dying patient. One participant expressed how she was emotional and sympathetic when first confronted with caring for a dying patient. The participant was also able to reflect on how, when allocated to caring for the dying patient, she is more empathetic as she understands how one can "do what you can".
"Describe your experience when the dying patient asked you if they were dying?"	"Describe how you would respond if the dying patient asked you if they were dying?"	In the pilot study, most participants described their responses instead of their experiences when the dying

Initial questions	Changes	Reasons for the changes
		patient asked them if they were dying. By rephrasing this question, it allowed the researcher to explore if the young professional nurses would be honest (as per statement 11 on the FATCOD scale: Dying persons should be given honest answers about their condition) or change the subject (as per statement 27 on the FATCOD scale: When a patient asks "Nurse, am I dying?", I think it is best to change the subject to something cheerful). Probing would also be used to ask participants to elaborate on their responses.
"How important do you think family involvement is when caring for the dying patient?"	No changes	This question was clearly understood and answered by all participants. They were all able to answer and describe their perception regarding family involvement in caring for the dying patient.
"What would you tell yourself as a nursing student regarding caring for the dying patient?"	"What advice would you give a student nurse who has never been exposed to	This question was rephrased as the wording was unclear.

Initial questions	Changes	Reasons for the changes
	caring for the dying patient?”	

3.10.2.3 Assessment of the data collection process

The pilot study was conducted using an online focus group in the presence of the researcher’s supervisors. At the end of the pilot study, the researcher received feedback from the supervisors regarding the overall data collection process. The supervisors noted that the way the focus group was conducted, and its duration needed to be changed.

The way the focus group was conducted in the pilot study affected the information obtained from the participants. In the pilot study, the researcher directed the question to a participant instead of posing it to the group for a discussion. This affected the focus group’s interaction and discussion dynamics, which impacted the data collection and subsequent analysis process (Sim & Waterfield, 2019:3004). Polit and Beck (2018:204) propose that in the focus group, the researcher’s role is to facilitate or moderate the group discussion as this interaction assists participants in expressing and clarifying their views in a way that is less likely to occur in a one-on-one interview.

The pilot study also only lasted 50 minutes; according to Nyumba et al. (2018:21), this is too short. Focus group discussions should range between 60 and 240 minutes, with a median of 90 minutes per session. The researcher was advice by the supervisors to use questions to elicit responses, probing and redirecting techniques in order to move the discussion forward, to explore for deeper understanding, and to keep the discussions focused.

3.10.2.4 Reflections on the pilot study

To truly understand participants’ lived experiences, researchers need to reflect on and be aware of their own lived experiences (Van Manen, 2017:812). Patton (2020:278) states this allows the researcher to view the participant holistically and enables the researcher to understand the complex interrelationships among lived experiences and participants' direct interpretation of them. The researcher's reflection from the pilot study had different implications from a professional and a personal perspective. The researcher learnt the importance of employing bracketing in the data collection process.

Bracketing is a method used in qualitative research to mitigate the potentially deleterious effects of preconceptions that may taint the research process (Vasudevan, Antony, Francis, Parayaruthottam, Shaloob & Haris, 2021:4). Therefore, the researcher sets aside all their internal beliefs, ego, experiences, understandings, biases, culture, religion, judgments, and assumptions. This allows the researcher to investigate the phenomenon in its pure and natural state, free of any external interpretation or suppositions (Vasudevan et al., 2021:4).

3.10.3 The main study: data collection

For the main study, three participants with high overall scores from the FATCOD scale and three participants with low overall scores from the FATCOD scale were selected. These participants' SANC numbers were chosen from two hats, one had the names of participants with low overall scores on the FATCOD scale and the other had the names of participants with high overall scores on the FATCOD scale. The names were drawn from each hat randomly until the sample size was achieved. Then the participants were contacted telephonically by the researcher, and verbal consent was obtained. Thereafter, participants were sent 2G data to download Zoom, and emailed the invitation leading them to click on the link and log in to the focus group.

In this phase, a focus group was conducted for data collection. The focus group was conducted on Zoom due to COVID-19 social distancing guidelines (WHO, 2020). Focus groups are a well-established qualitative research methodology that has become increasingly popular among social researchers over the last few decades. Group interactions are used to elicit detailed responses, which have been shaped as much by social cues as by the individual's own beliefs and perceptions (Kite & Phongsavan, 2017:3).

3.10.3.1 Introduction phase

Introductions are important for establishing trust and creating comfort levels among participants (Carey & Asbury, 2016:48). The researcher had their camera on once all the participants had logged on to introduce themselves and state the purpose of the study. The participants were given options to have their cameras on or off, and were asked to introduce themselves and indicate which units they were working in. Figure 3.12 shows the set-up of Zoom used in this study.

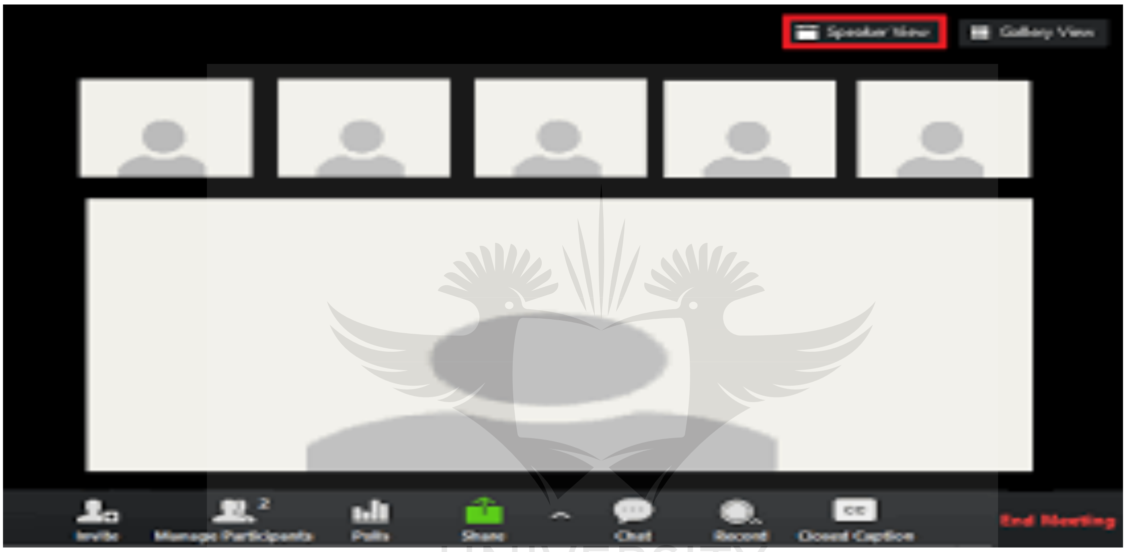


Figure 3.12: Layout of the Zoom focus group

The researcher proceeded to inform the participants about the ground rules of the focus group. These were:

- to make sure that the microphone is off when someone else is talking, to avoid interference from background noise
- to keep cell phones on silent or vibrate mode so that the sound of the phone does cause any interruption during the discussion
- to keep the discussion confidential

The participants were then informed of the researcher’s role as a facilitator responsible for posing questions and probing to elicit more details using questions and taking field notes. Verbal permission to record the session was obtained.

The researcher then proceeded to commence the focus group with a meditation session. Meditation was chosen because various studies had shown it decreases anxiety, which is a feeling most participants expressed when it came to sharing their experiences caring for the dying patient and their family (Romero-Ramos, Romero-Ramos & Suarez, 2021:29). According to Calder Calisi (2017:320), meditation also slows down the mind and aids in reflection; this was helpful in the data collection because the researcher needed the participants to be relaxed in order to reflect in a meaningful manner on their experiences caring for the dying patient and their family. The researcher started the meditation session by playing calming music in the background and then asking the participants to close their eyes. The researcher then asked the participants to take slow deep breaths, in through the mouth and out through the nostrils. According to Saoji, Raghavendra and Manjunath (2019:53), this breathing technique helps in reducing anxiety, which was expressed by the participants before participating in the focus group. The participants were asked to forget about what had happened that day and focus on the present. While their eyes were closed, the researcher then asked the participants a warm-up question, to think of the one word they would use to describe their first experience caring for a dying patient. This prompted them to think about their first experience caring for a dying patient.

3.10.3.2 Working phase

During this phase, the focus group interview questions were posed and discussions commenced. During the focus group interviews, the participants responded to each other and the researcher who posed the following questions:

- “describe your first experience caring for the dying patient.”
- “how has your first experience caring for the dying patient influenced your current attitude towards being allocated to caring for the dying patient?”
- “describe how you would respond if the dying patient asked you if they were dying?”
- “how important do you think family involvement is when caring for the dying patient?”

During the focus group interviews, the researcher maintained phenomenological reduction while recording field notes on a notepad.

3.10.3 Termination phase

During the termination phase, the researcher provided a summary of the discussions and asked the participants for their final thoughts: “what advice would you give a student nurse who has never been exposed to caring for the dying patient?”. They were then thanked for participating and informed that the transcripts from the focus group would be sent through to the supervisors. The participants were also reminded counselling was available if the focus group triggered any uncomfortable feelings and they just needed to notify the researcher privately after the focus group. The focus group lasted for 80 minutes.

3.11 DATA ANALYSIS

Qualitative data analysis refers to the codes and thought processes used in assigning meaning to the data (Gray et al., 2017:269). According to Gray et al. (2017:269), data collection at this phase is creative, challenging and time-consuming, as participants’ words are interpreted into meanings that readers and consumers can understand. The researcher is immersed in the data to reduce volumes of data into codes, which reflect the philosophical base of the study (Gray et al., 2017:270).

In this study, data were analysed by thematic analysis, using Giorgi’s (1985) phenomenological five-stage technique (Giorgi, 2009:243-273). Giorgi (2009:243) designed an eidetic reduction data analysis method to assist researchers in identifying the core components that make up the essence of the phenomenon. This method focused on true facts and reduced irrelevant data in order to identify individual psychological structures that emerged from descriptive data. This approach aims at creating overall statements that mirror the essential structure of the phenomenon (Heotis, 2020:2).

Giorgi’s phenomenological analysis approach was well-suited for this study. The researcher focused on participants’ current attitude towards caring for the dying patient and their family, instead of engaging in past knowledge while determining participants' mode and content of the present experience (Giorgi, 2009:91). Giorgi's (1985) phenomenological five-stage technique entailed:

Stage 1: a phenomenological attitude was assumed by the researcher, which involved recognising and putting aside (bracketing) previous presuppositions, cultural, theoretical or experiential knowledge, and attempting to look at the data with a clear mind.

In this study, the researcher tried to bracket previous theoretical and experiential knowledge on young professional nurses' attitudes in caring for the dying patient and their family. This allowed the two concepts to be viewed and understood from the participants' experiences.

Stage 2 involves reading through the interviews several times to attain a sense of the whole (Giorgi, 1975:85); this is critical in qualitative data analysis. In this stage, bracketing is employed to prevent the researcher from making any judgments or preconceived ideas.

In this study, the researcher conducted the focus groups personally and in reading the transcripts became very familiar with what the participants were saying in the data. The researcher also kept a reflective journal after the pilot study to reflect on their own feelings and experiences with death and dying.

Stage 3 involves determining the natural meaning units as expressed by the participants (Giorgi, 1975).

In this study, the researcher repeatedly read the transcripts and tried to identify the separate meaning entities. The transcript was read several times, highlighting individual meaning units each time. Meaning units that agreed with each other were further clustered together into themes.

Stage 4 involves reviewing the identified meaning units and themes against the purpose of the study. The identified meaning units are reviewed in light of the study's questions (Giorgi, 1975).

In this study, the identified meaning units and themes were reviewed considering what they told the researcher about caring for the dying patient and their family.
Stage 5 involves clumping important non-conflicting themes together in a descriptive statement (Giorgi, 1975:90).

In this study, verbatim transcription of the data was done. As coding began, the researcher sorted through the data to identify similar phrases, emotions, beliefs, experiences, and values frequently stated, leading to the identification of themes and patterns. The coding was done by the researcher with assistance from the supervisors. The identified themes that were finally agreed on are presented in Chapter 4.

The final results obtained from this process were further reviewed in light of literature for integration purposes. This was achieved by presenting literature that supports the findings of this study, providing a broader view of the phenomenon and promoting replication, where necessary (Gray et al., 2016:123).

3.12 MEASURES OF TRUSTWORTHINESS

Trustworthiness is described as the degree of confidence researchers have in their study (Polit & Beck, 2010:1451). Trustworthiness was pursued in this study to ensure the findings were a true representation of the young professional nurses' lived experiences of caring for the dying patient and their family. Korstjens and Moser (2018:121) urge that quality criteria for qualitative research trustworthiness are described under the following headings: credibility, transferability, dependability, and confirmability.

Table 3.2: Measures of trustworthiness

STRATEGY	CRITERIA	APPLICATION IN THE STUDY
Credibility	Triangulation	This was achieved by using multiple data collection methods (focus group, field notes and Zoom recording).
	Prolonged engagement	The researcher conducted the focus group interview. During the focus group, participants were actively engaged. By the researcher conducting the focus group, rapport was established with participants before the discussion commenced, promoting the establishment of trust with participants. It allowed the researcher to be immersed in the data over a prolonged time, thereby getting familiar with the phenomenon. This prolonged contact with the data also happened during data coding and promoted the credibility of the findings.
	Interview technique	Effective communication skills were used to probe for additional explanations during the focus group. This allowed clarification of responses, where necessary. A pilot focus group was conducted with the outliers from the study to pre-test the questions before the actual study was conducted. This enabled the researcher to get familiar with the focus group questions.
	Member checking	Frequent supervision sessions were conducted to discuss the study with the research supervisors and helped identify and rectify flaws as early as possible. The researcher had several supervision meetings where the supervisors offered guidance and direction, thereby improving the quality of the study.

STRATEGY	CRITERIA	APPLICATION IN THE STUDY
		The findings were discussed in light of literature that both supported the findings and were against the findings.
Confirmability	Audit trail	All documents of the study, including data transcripts, study permission, supervisors' recommendations and corrections, were kept throughout the study and will be kept for another two years after the study's publication.
	Triangulation	Discussed under 'credibility'.
Transferability	Thick description of the study results	The study's findings were described, with participants' direct quotes included.
	Sample description	Participants' demographic characteristics were described in detail.
Dependability	Audit trail	Discussed under 'confirmability'.
	Code-recoding	The researcher, with the assistance of the supervisors, coded the data obtained from the focus group.
	Thick description of the research methods	This involved describing the study participants in terms of inclusion criteria, the number of participants, data collection methods, the duration for each session of data collection, and the overall length of the data collection period.
	Frequent supervision	As discussed under 'member checking'.
	Triangulation	As discussed under 'credibility'.

3.13 PHASE 3: RESEARCH INTEGRATION

3.13.1 Integration of the quantitative and qualitative results

Mixed-method research has at least one point of integration; the point at which the qualitative and quantitative components are brought together (Schoonenboom & Johnson, 2017:115). Schoonenboom and Johnson (2017:115) claim it is at this point that the components are ‘mixed’. The mixing strategy directly relates to the following points of integration: merging the two data sets; connecting the analysis of one set of data to the collection of a second set of data; embedding one form of data within a larger design or procedure; and using a framework (theoretical or program) to bind together the data sets (Creswell, 2003:66). According to Creswell (2003:66), the point of integration is to address the purpose of the study and answer the research questions using both phases of the study (Creswell, 2013:13). In this study, the integration of quantitative and qualitative results is discussed in detail in Chapter 4.

3.14 SUMMARY

A mixed-method design was used in this study, which included both quantitative and qualitative research designs. An explanatory, sequential approach was adopted, which used the quantitative, descriptive, correlation approach, followed by the qualitative, phenomenological design. The target population of this study comprised young professional nurses. Snowball sampling, using Facebook as a platform, and purposive sampling methods were used in Phase 1 and Phase 2, respectively, to recruit participants. A demographic and Likert scale questionnaire consisting of three sections was used to collect data. The measures to enhance the validity and reliability of the study’s findings were also described. The results of the study are presented in Chapter 4.

CHAPTER 4

PRESENTATION AND DISCUSSION OF RESULTS

4.1 INTRODUCTION

In this chapter, the analysis and interpretation of the data that were collected, using a demographic questionnaire and Likert scale, are presented. The data were captured and analysed in consultation with a statistical consultant at Statkon, using IBM SPSS version 27.0. The data were presented using tables, charts and narratives. The study's findings are first presented, followed by a discussion of the results.

4.2 PHASE 1: QUANTITATIVE PHASE

4.2.1 Overview of the study

During the quantitative phase, the researcher distributed the research questionnaire to the respondents at the hospital under study in person during their tea or lunch break. This distribution of questionnaires happened from September 2020 until the end of April 2021. The accessible population size was N=120 young professional nurses. The acceptance rate for the total sample was n=62 (52%) young professional nurses. A brief overview of the data analysis process is illustrated in Figure 4.1:

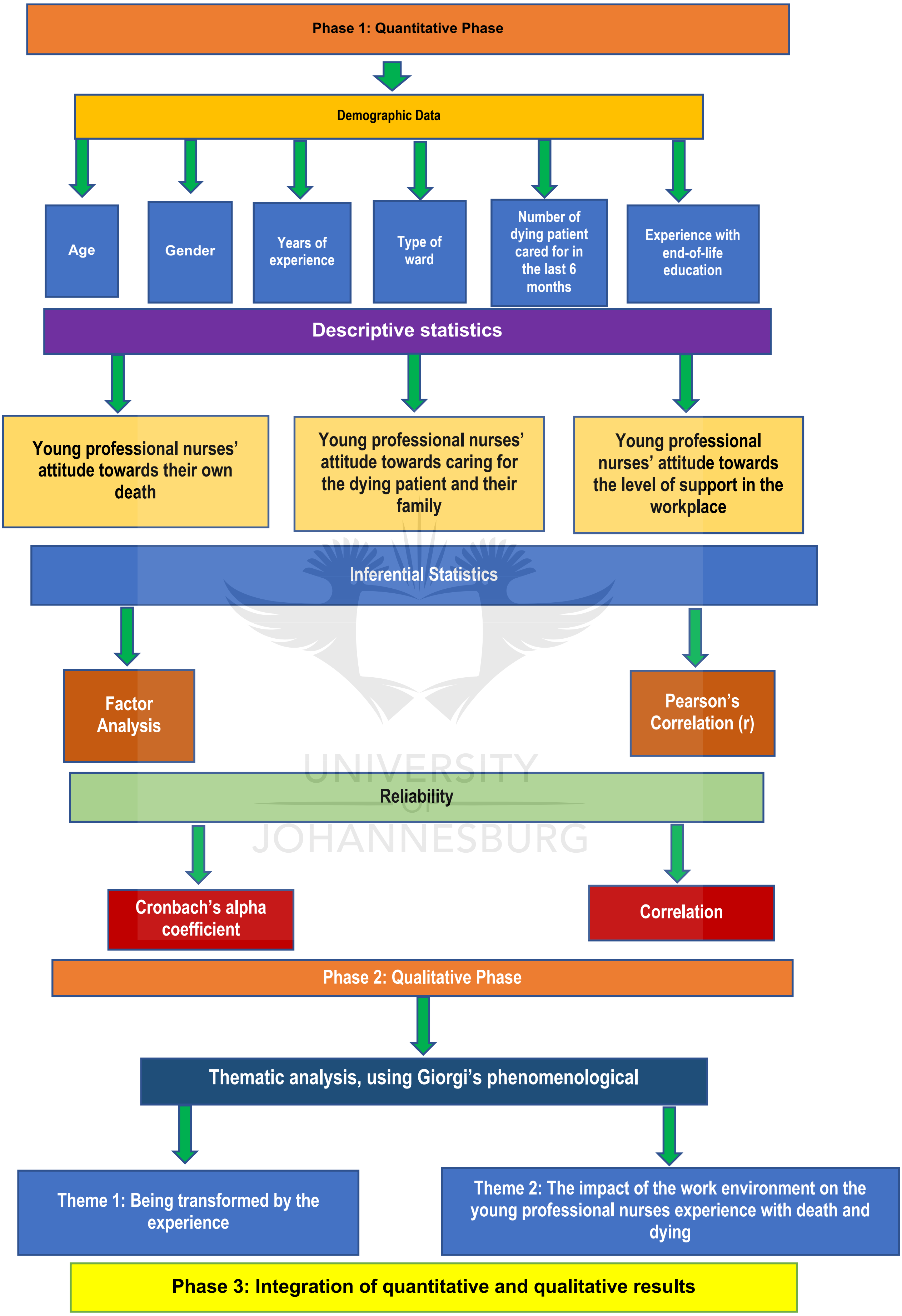


Figure 4.1: **Summary of data analysis process**

4.2.2 Analysis of the demographic data

The first section of the questionnaire asked respondents to indicate their:

- Age
- Gender
- Years of work experience
- Type of ward the respondent was currently working in
- Number of dying patients the respondent had cared for in the previous six months
- Their experience with end-of-life education

Data analysis and an interpretation of these demographics are described in this section. Descriptive statistics (percentage, mean, standard deviation, and range) are used to present the findings in a summarised way.

4.2.2.1 Age distribution

The respondents' age distribution ranged from 21 to 54 years. For statistical analysis, respondents were categorised by generations as Generation X (42–56 years), Generation Y (26–41 years), and Generation Z (younger than 24 years). Their average age was 31.85, which is in line with Pool et al.'s (2013:36) definition of a "young nurse" being under the age of 40 years. Table 4.1 shows that 93,54% (n=58) of respondents were Generation Y, while 1,61% (n=1) were Generation Z.

Table 4.1: Age distribution

GENERATION	NUMBER OF RESPONDENTS	PERCENTAGE (%)
Generation X	3	4,83
Generation Y	58	93,54
Generation Z	1	1,61
Total	**62**	**100**

The age range from the sample of young professional nurses implied the inclusion of Generation X, Generation Y and Generation Z individuals. This age distribution is fitting to the global patterns reporting the current nursing workforce is made up of four-generation cohorts: the Baby Boomers, Generation X, Generation Y and Generation Z, just entering the workplace (Stevanin et al., 2020:15). The current age distribution from the SANC reflects that 45% of professional nurses are Generation X; 45% are Baby Boomers; 7.6% are Generation Y; and 2.4% Generation Z make up the current nursing workforce (Mthathi, Dikolomela-Lengene & Rispel, 2020:19). The differences in generations are important to consider, especially in South Africa, which has faced unique challenges because of its politically and socially divided past, to which some generations may not be able to relate (Heyns & Kerr, 2018:2). These experiences shape how each generation perceives death and dying, influencing their attitude towards caring for the dying patient and their family (Mahmoud et al., 2021:194).

4.2.2.2 Gender distribution

From the 62 respondents, with 1,6% (n=1) respondent not specifying their gender, 80,6% (n=50) were female and 17,7% (n=11) were male. This is demonstrated in Figure 4.2:

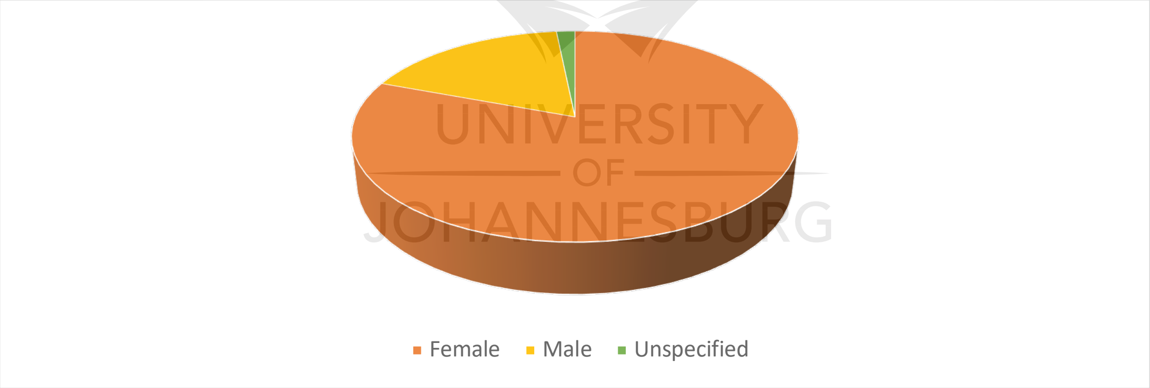


Figure 4.2: Gender distribution

This gender distribution is consistent with global trends and recent statistics from SANC that illustrate the disproportionate representation between men and women in nursing (Noordien et al., 2020:220). Historically, men in nursing pre-date Florence Nightingale. Military orders of male nurses included the Order of St. John of Jerusalem, founded in the 11th and 12th centuries. In addition to protecting pilgrims, they built hospitals throughout Europe to lodge and care for the sick. Male nurses were also represented by groups such as the Brothers of St. Anthony, established in 1605

(Kronsberg et al., 2018:47). Until the 16th century, the provision of health services was the responsibility of male nurses until this field found Florence Nightingale (Arif & Khokhar, 2017:1890). Nightingale considered nursing a suitable job for women because it was an extension of their domestic roles. She firmly established nursing as a female occupation and diminished men's role in the profession; this brought men's participation in nursing to an abrupt end (Kronsberg et al., 2018:47).

This gender stereotype has not changed decades later, as society still views nursing as a female-dominated profession. Men are still discouraged from entering nursing for several reasons, all of which have been explored in the literature, such as public perception, images of nursing, value of nursing in society, gender stereotype, and patient preferences (Arif & Khokhar, 2017:1890). Although there has been a shift, with more men entering the profession in the last 10 years, it has been a small, slow increase. Men in nursing still constitute a minority, accounting for only approximately 11% of the nursing population globally, and 9.1% in South Africa (Noordien et al., 2020:220).

4.2.2.3 Years of work experience distribution

In this study, respondents were asked to indicate their work experience, ranging from 1 to 5 years' work experience. Of the respondents, 33,9% (n=21) had 5 years' work experience, which was above the mean of 3,42; 21,0% (n=13) had 2 to 3 years' work experience; 14,5% (n=9) had 4 years' work experience, and 9,7% (n=6) had 1 year of work experience. Table 4.2 illustrates this distribution:

Table 4.2: Years of work experience distribution

YEARS OF EXPERIENCE	NUMBER OF RESPONDENTS	PERCENTAGE (%)
1 year of work experience	6	9,7
2 years' work experience	13	21,0
3 years' work experience	13	21,0
4 years' work experience	9	14,5
5 years' work experience	21	33,9

These findings correlated with the current status of the nursing workplace, which has found more experienced young professional nurses at the bedside caring for the dying patent. According to Husley (2021:5), the decision for professional nurses to stay at patients' bedsides caring for dying patients, is often motivated by personal and professional values such as honesty, responsibility, justice, and altruism (Schmidt & McArthur, 2018:70). Professional values are vital in a profession with integrity that aims to uphold human dignity (Husley, 2021:20). These characteristics are often found in professional nurses who find value and meaning in their work, which deepens their understanding that empathy is beneficial when providing quality end-of-life care (Galemore et al., 2019:329; Şenyuva, 2018:940). Literature reports that experienced professional nurses possess knowledge that includes values, contextual information, and vital insights when providing quality end-of-life care (Husley, 2021:20). This knowledge includes subjective understanding and intuition (Gaffney, 2021:8), allowing them to consciously care for the dying patient (Rosa et al., 2017:58).

4.2.2.4 Distribution of the type of ward respondents were currently working in

This study was conducted in a tertiary government hospital based in Johannesburg. This hospital acts as a teaching hospital offering undergraduate and postgraduate training in all areas of health professions, including a wide range of secondary, tertiary, and specialised services (Hurri et al., 2020:31).

The wards chosen for this study were ward A, ward B, ward C, ward D, and ward E. Research has found these wards have high capacities of patients near death (Long & Mathews, 2018:2130). In this study, 43,5% (n=27) of respondents were working in ward A; 21% (n=13) were working in ward B; 16,1% (n=10) in ward C; 11,3% (n=7) in ward D; 1,6% (n=1) were working in ward E; and 6,5% (n=4) were working in other wards (ward F). Table 4.3 shows this distribution.

Table 4.3: Distribution of the type of ward respondents were currently working in

TYPE OF WARD	NUMBER OF RESPONDENTS	PERCENTAGE (%)
Ward A	27	43,5
Ward B	13	21,0
Ward C	10	16,1
Ward D	7	11,3
Ward E	1	1,6
Ward F	4	6,5
Total	**62**	**100**

4.2.2.5 Estimated number of dying patients the respondents had cared for in the last six months

Caring for a dying patient in the hospital has become a pronounced trend, with approximately 50% of all deaths occurring in the hospital (Van der Venter, 2021:1). Therefore, nurses play an important role in managing patients' quality of life in this final phase (Kondo & Nagata, 2015:278). All the respondents in this study (100%; n=62) indicated that they had cared for a dying patient and their family in the last six months. Moreover, 12,9% (n=8) of respondents gave an estimate of caring for 20 dying patients in the last six months, which was above the mean of 18,52.

This number of dying patients was a reflection of the current global situation, as the study was conducted when the country faced the COVID-19 pandemic, which caused a rise in morbidity and mortality rates across the world (WHO, 2021:1). By January 2021, there were 3,392,117 COVID-19 cases in Africa, with 83,787 deaths reported (Nachega, Kapata, Sam-Aguu, Decloedt, Katoto, Nagu, Mwaba, Yeoah-Manu, Chanda-Kapata, Ntoumi, Geng & Zumla, 2021:2). The influx of requests for admission due to COVID-19 also created an extreme scarcity of ICU beds, which saw dying patients being admitted into normal wards. Consequently, this led to an increase in the number of dying patients young professional nurses were caring for (Robert, Kentish-Barnes, Boyer, Laurent, Azoulay & Reignier, 2020:1).

4.2.2.6 Experience regarding end-of-life education

Nurses develop skills through education combined with reflection on clinical experiences that occur in the workplace (Astin et al. 2015:191). Respondents in this study were asked to indicate if they had any end-of-life training. Figure 4.3 shows the respondents' experiences with end-of-life education.

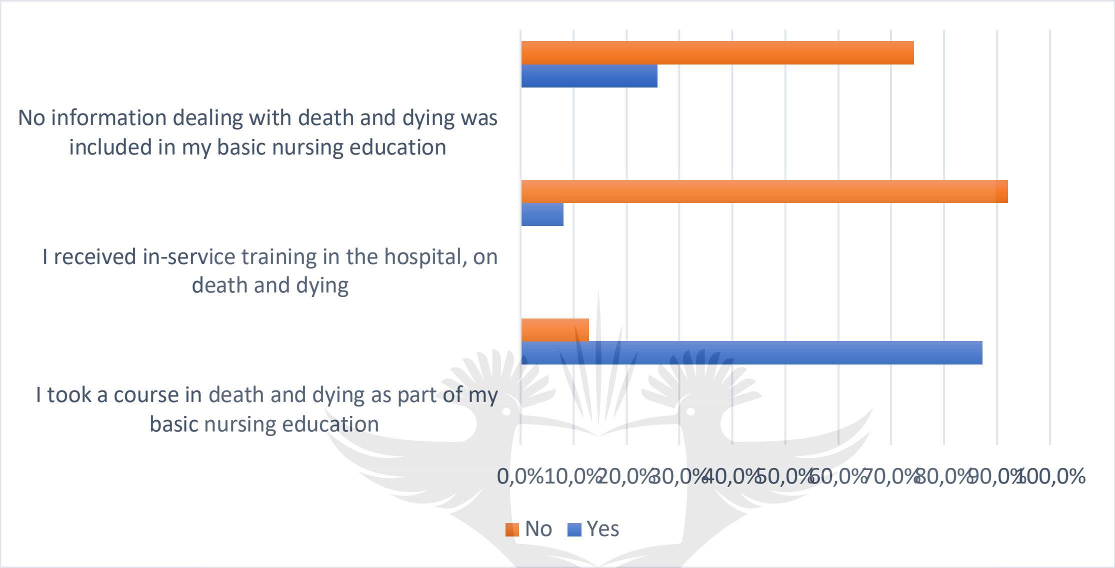


Figure 4.3: Experience regarding end-of-life care

These results reflect the current status of nurses' exposure to end-of-life education (D'Antonio, 2017:34). It has been reported that only 1,1% of nursing schools include end-of-life care in their curriculum, because death has often been considered a taboo topic that is either neglected or examined cursorily, as it disputes the values of preserving life (Wallace, Cohen & Jenkins, 2019:53). However, there has been a change in mindset in recent years due to the change in global disease profile (WHO, 2018:1). End-of-life education is now considered a vital facet as literature shows its importance in preparing young professional nurses in caring for the dying patient and their family (Wallace et al., 2019:53).

In this study, respondents felt that the end-of-life education they had received, whether formal or informal, was inadequate in preparing them when caring for the dying patient and their family (see Figure 4.4).

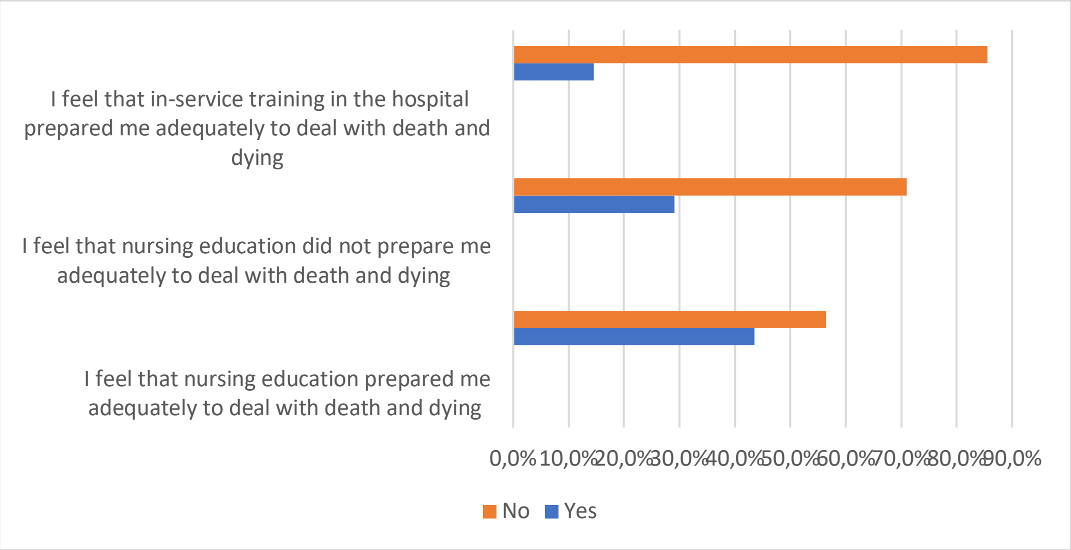


Figure 4.4: Effectiveness of end-of-life education

These results concur with literature claiming young professional nurses often felt end-of-life education was inadequate in preparing them to care for the dying patient and their family (Tamaki, Inumaru, Yokoi, Fujii, Tomita, Inoue, Kido, Ohno & Tsujikawa, 2019:2; Cox Brighton & Russell, 2018:21). According to Dimoula, Kotronoulas, Katsaragakis, Christou, Sgourou and Patiraki (2019:8), such feelings can contribute to the development and exacerbation of negative attitudes towards death and caring for the dying that may impact quality end-of-life care.

End-of-life education for nurses is an important consideration to properly prepare nurses for their likely encounter with dying patients across the practice spectrum (Wallace et al., 2019:54). The outcomes of death education include changing beliefs about death and dying; increasing knowledge about ethical dilemmas in caring for dying patient and their family and increasing competence and confidence in interdisciplinary practice during end-of-life care (Wallace et al., 2019:55). However, once-off end-of-life education was found to have short-lived success, as the skills learnt faded over time (Cox et al., 2018:21). Therefore, various studies proposed frequent end-of-life education, whether formal or informal, as they found this ensures a consistent development in skills, improving attitudes regarding end-of-life care (Cox et al., 2018:21; Dimoula, Kotronoulas, Katsaragakis, Christou, Sgourou & Patiraki, 2019:7).

4.3 ANALYSIS OF TEMPLER'S DAS

This study's objective was to determine young professional nurses' attitudes towards caring for the dying patient and their family. To meet this objective, death anxiety was assessed. Death anxiety is a notion utilised to theorise the apprehension caused by death consciousness when caring for the dying patient and their family (Saleem et al., 2015:724). Templer's DAS was thus used to assess respondents' anxiety regarding death and dying (Saleem et al., 2015:724), which studies have shown affect their attitude in caring for the dying patient and their family (Draper, Hillen, Moors, Ket, Laarhoven & Henselmans, 2019:267). Templer's DAS is a self-report, four-point Likert questionnaire containing five statements that measure different aspects associated with death anxiety. This questionnaire has four response categories with anchors 1 (rarely or never) to 4 (most of the time). The mean, median, mode, standard deviation, and percentiles of the respondents' scores for each item on Templer's DAS are discussed.

4.3.1 Descriptive statistics

The following descriptive statistics discussion will elaborate on the results of the response rate for Templer's DAS.

4.3.1.1 Statement 1: *I worry about dying*

Statement 1 reflects a fear of the unknown aspects of death (Wong, Reker & Gesse, 1994:100). Death is a source of great sadness, despair, worry, and fear for nursing students who encounter this reality for the first time during their clinical practice. Knowing how nurses perceive death will affect the quality of care they provide for the terminally ill (Bilgiç, 2021:3).

In this study, 38,7% (n=24) of the respondents indicated that they rarely or never worry about dying. Moreover, 35,5% (n=22) of the respondent indicated that they worried some of the time (in less than 1 day), 11,3% (n=7) indicated occasionally (3-4 days), and 14,5% (n=9) indicated they worry most of the time (5-7 days). This shows that most young professional nurses in the study were not worried about their own death, coinciding with literature regarding death anxiety among young professional nurses. Young people often do not think about death; they pride themselves on embracing life because they feel they are still far from it (Çakar, 2020:101).

4.3.1.2 Statement 2: *I worry that I may be very ill for a long time before I die*

According to Wong et al. (1994:100), Statement 2 reflects the fear of suffering involved in the process of dying. Although death is a natural and inevitable part of the life cycle, the manner and methods of dying often impose anxiety (Bruce & Beuthin, 2020:268).

In this study, 50% (n=31) of respondents indicated that they rarely or never worry that they may be very ill for a long time before they die; 25,8% (n=16) indicated this is a concern some of the time (in less than 1 day), 12,9% (n=8) indicated occasionally (3-4 days), and 11,3% (n=7) indicated most of the time (5-7 days). These findings reflect that most young professional nurses do not worry about being ill for a long time before dying. Literature supports this claim, as it is reported that nurses who viewed death as a means-to-an-end to long-term suffering from illness considered death as a healing process (Rosa et al., 2017:59).

4.3.1.3 Statement 3: *It upsets me to think that others may see me suffering when I die*

According to Wong et al. (1994:100), Statement 3 reflects the aspects of the dying process. Dying and death are an inescapable part of life and are beyond human beings' complete control (Barry & Yuill, 2016:263–264).

In this study, 35,5% (n=22) of respondents indicated that they rarely or never get upset thinking that others would see them suffering when they die. Moreover, 33,9% (n=21) of respondents indicated this concerned them some of the time (in less than 1 day), 11,3% (n=7) indicated occasionally (3-4 days), and 19,4% (n=12) indicated most of the time (5-7 days). These results reflect what is found in literature regarding young professional nurses' understanding of death as part of life's journey (Draper et al., 2019:272). Barry and Yuill (2016:264) found that when young professional nurses view death as life's journey, they are able to cope with the psychological emotions often triggered when caring for the dying patient and their family. According to Kuber-Ross (2014:110), this comes with peace and acceptance of death as the final rest.

4.3.1.4 Statement 4: *I worry that dying may be painful*

Statement 4 reflects the aspects of dying associated with suffering (Wong et al., 1994:100). Dying is an event beyond our comprehension and an experience that can only be imagined, fuelling individuals' fear of death and the dying process (Hofer, Busch, Šolcová & Tavel, 2017:344).

In this study, 41,9% (n=26) of respondents indicated that they rarely or never worry about death being painful; 25,8% (n=16) of respondents indicated they worried some of the time (in less than 1 day), 11,3% (n=7) indicated occasionally (3-4 days), and 21% (n=13) indicated most of the time (5-7 days). These results are consistent with literature claiming young professional nurses often do not worry about aspects relating to death and dying (Bass, 2021:5).

4.3.1.5 Statement 5: *I worry I may be alone when I am dying*

According to Wong et al. (1994:100), Statement 5 reflects a fear of loneliness at the time of death. The term 'dying alone' describes dying in a place where significant others are unable to be near (Corpuz, 2021:1).

In this study, 58,1% (n=36) of respondents indicated that they rarely or never worry about dying alone; 25,7% (n=16) of respondents indicated they worry some of the time (in less than 1 day); 8,1% (n=5) indicated occasionally (3-4 days), and 8,1% (n=5) indicated most of the time (5-7 days). These results illustrate that most young professional nurses were not scared of dying alone, contradicting the universal fear of dying alone (Wakam, Montgomery, Biesterveld & Brown, 2020:e88). However, these results may be attributed to the COVID-19 pandemic, which has distorted the primary principles when caring for the dying patient in ways previously thought unimaginable (Chochinov, Bolton & Sareen, 2020:1294). Patients are now dying alone, as families have been barred from visiting their loved ones due to the strict safety policies enforced during the pandemic (Chochinov et al., 2020:1294). This may have influenced the young professional nurses' views on dying alone.

4.3.6 Summary of findings of the descriptive statistics from Templer's DAS

Death is a source of great sadness, despair, worry, and fear for nursing students who encounter the reality of death for the first time during their clinical practice (Bilgiç, 2021:3). Death anxiety is a term used to conceptualise the apprehension generated by death awareness (Abdel-Khalek & Neimeyer, 2017:2). This awareness often creates feelings of fear, worry, insecurity and tensions related to aspects of death and dying (Abdel-Khalek & Neimeyer, 2017:2). According to Dadfar et al. (2018:2), young professional nurses' personal anxieties about death and dying often affect their attitude towards caring for the dying patient and their family since they become conscious of their own finiteness. The findings from this study supported this notion, showing that death anxiety and death acceptance are inversely correlated but not mutually exclusive. Table 4.4 shows the means and standard deviations from Templer's DAS.

Table 4.4: The means and standard deviations from Templer's DAS

STATEMENT	MEAN	STANDARD DEVIATION
I worry about dying	2,02	1,048
I worry that I may be very ill for a long time before I die	1,85	1,038
It upsets me to think that others may see me suffering when I die	2,15	1,114
I worry that dying may be painful	2,11	1,175
I worry I may be alone when I am dying	1,66	0,940

4.4 INFERENTIAL STATISTICS

Templer’s DAS was subjected to PCA and principal factoring analysis (PAF) using SPSS version 27.0. Prior to performing PCA and PAF, the data’s suitability for the factor analysis was assessed. On inspection of the correlation matrices, several correlations were greater than r = 0.3. The KMO value was found to be 0.78 for Templer’s DAS. The *p* score for Bartlett’s test was 0.00, as shown in Table 4.5. These findings from the visual inspection of the correlation matrices, the KMO test and Bartlett’s test of sphericity strongly confirmed the data’s appropriateness for factor analysis.

Table 4.5: Kaiser-Meyer-Olkin and Bartlett’s test

TEST	STATISTIC	SCORE
		Templer’s DAS
Kaiser-Meyer-Olkin (KMO)	KMO	0.78
Bartlett’s test of sphericity	Approx. Chi-Square	85,754
	df	10
	p	0.000

Using PCA, a total of five factors in Templer’s DAS were identified. Of these, only one had Eigenvalue scores greater than 1. The one retained factor in Templer’s DAS explained a total variance of 54,638%. Using PAF, one factor had an Eigenvalue of 1 and higher. The total variance explained by this factor in Templer’s DAS was 54,638%. Guided by the need for a simple solution with as few factors as possible, and the need to explain as much variance as possible in the data (Pallant, 2013:191), the choice of model was PAF for Templer’s DAS. Tables 4.6 present the extracted factor.

Table 4.6: Death anxiety factor extracted by Kaiser’s criterion (PAF)

FACTOR	EIGENVALUE		
	TOTAL	% OF VARIANCE	% OF CUMULATIVE VARIANCE
1	2.732	54.638	54.638

The Kaiser's criterion was complimented with Catell's scree test. Using this test, Eigenvalues were plotted and inspected for a point where the shape of the curve changed direction and became horizontal. It is recommended to retain all factors above the break in the plot as these explain most of the variance in the data set (Pallant, 2013:191). A vertical-horizontal break was visible at component 2 in the PAF (for death anxiety). This suggested the possibility of having a one-factor solution that cannot be rotated. Figure 4.5 illustrates these observations.

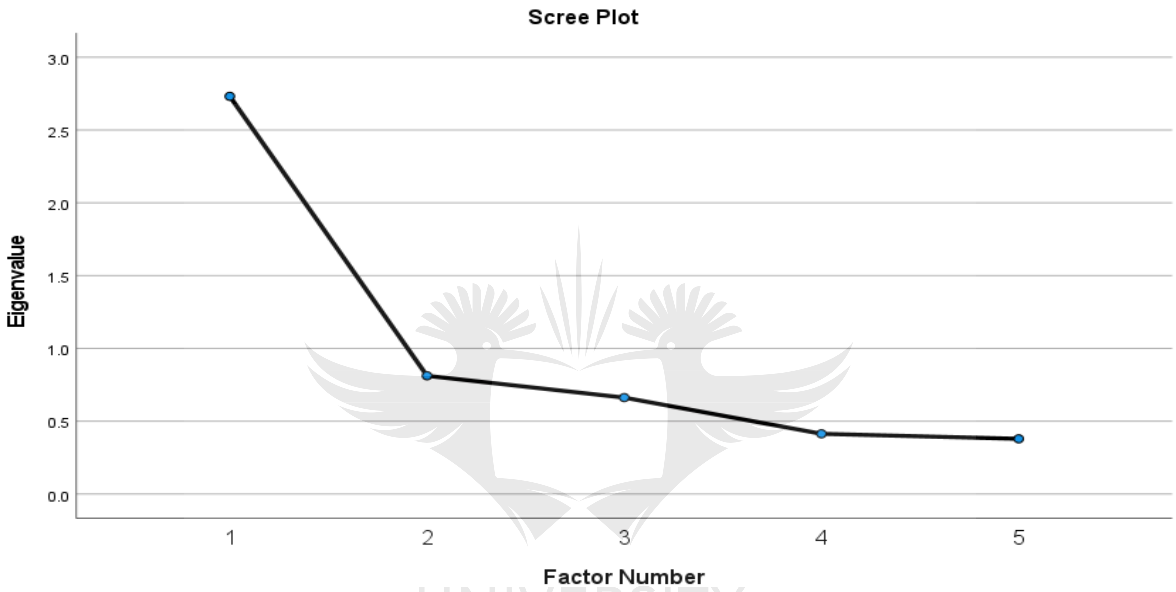


Figure 4.5: The scree plot for death anxiety

4.4.1 Death anxiety: Factor 1- Fear of death and dying

Factor 1 comprised five statements. All items loaded positively well above 0.788. According to Pallant (2013:206), loadings of 0.3 and higher indicate that the items fit well with each other. The lowest loading item was statement 5 *(I worry I may be alone when I am dying),* with a loading coefficient of 0.430. Statement 2 (*I worry that I may be very ill for a long time before I die*) loaded the highest with a coefficient of 0.673. Table 4.7 shows these results.

Table 4.7: **Factor 1: Fear of death and dying**

ITEM NUMBER	ITEM DESCRIPTION	ITEM LOADING
1	I worry about dying	0.537
2	I worry that I may be very ill for a long time before I die	0.673
3	It upsets me to think that others may see me suffering when I die	0.552
4	I worry that dying may be painful	0.659
5	I worry I may be alone when I am dying	0.430

The five items on Templer's DAS were divided into two concepts: fear of the unknown aspects of death, and fear of the dying process. These concepts are presented in Figure 4.6.

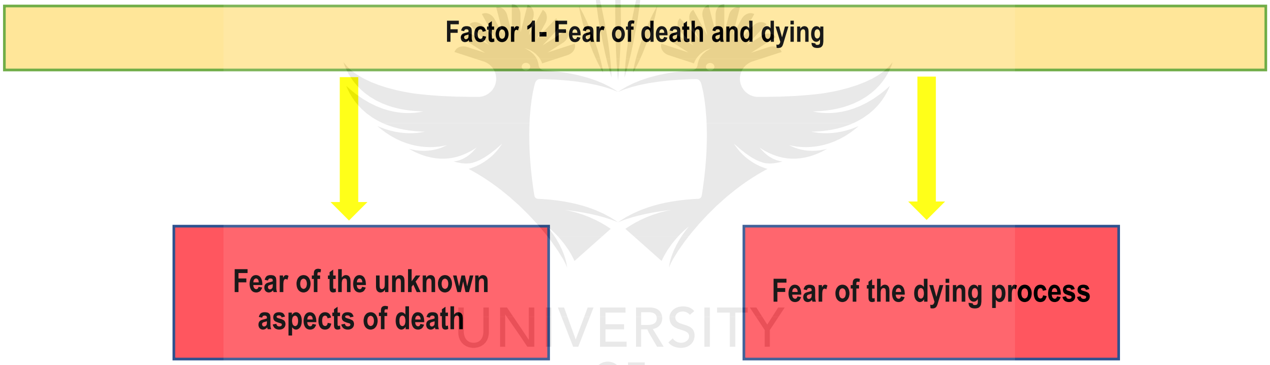


Figure 4.6: Factor 1: Fear of death and dying

4.4.1.1 Fear of the unknown aspects of death

Death is the only certainty in life. However, human beings alone are burdened with the cognitive capacity to be aware of their own inevitable mortality (Penberthy, Russell, Phillips, Banaji, Mann & Dameron, 2020:2). The fear of death is a fundamental source of death anxiety (Penberthy et al., 2020:2), which was first conceptualised by Hoelter and Hoelter (1978). Pehlivan et al. (2019:2) proposed that death anxiety is experienced by all nurses providing care for the dying patient, as the death of a patient often makes nurses conscious of their own death.

Death anxiety is described as fear and anxiety about death, triggered by thoughts of dying (Karabağ, Aydın & Fidan, 2021:1). Ramvi and Gripsrud (2017:2) believe this poses the most significant challenges for young professional nurses because they are young and often have little to no personal experience with death and dying, even though they encounter the phenomenon daily in their profession (Martí-García, Ruiz-Martín, Fernández-Alcántara, Montoya-Juárez, Hueso-Montoro & García-Caro, 2020:2). This lack of personal experience often causes death anxiety, influencing their attitude towards caring for the dying patient and their family (Menzies, Sharpe & Dar-Nimrod, 2019:452). Death anxiety can cause nurses to develop negative attitudes towards caring for the dying patient, prompting them to apply defence mechanisms by distancing themselves or practicing death avoidance behaviours (Nobahar, Talebi, Amaniyan & Tarahomy, 2021:4). These young professional nurses refrain from communicating with or establishing emotional relationships with dying patients and their families. When they must provide care, they exhibit behaviours such as treating the patient as an object, wearing a dull facial expression, sharing very little information about the patient’s condition, and creating a feeling that they do not have time for the patient and their family (Lee & Hong, 2021:1568).

However, when the unknown aspects of death are not feared but accepted, death anxiety is mediated and young professional nurses are able to find meaning in death and dying (Wallace et al., 2019:65). These young professional nurses have positive attitudes towards caring for the dying patient and their family (Nia, Lehto, Ebadi & Peyrovi, 2016:2). They honour the unknown aspects of the process by consciously making an effort to be benevolent, responsive, fostering compassion and caring that is meaningful to the patient and their family (Schellinger et al., 2018:160). These young professional nurses believe in preserving the dying patient’s personality, dignity, autonomy, and privacy. They aim to reduce the symptoms and invasive procedures in the process of care and ensure that the patient maintains meaningful communication with their family and receives a peaceful and respectable death (Cerit, Çoşkun, Çalışkan & Temelli, 2021:171).

4.4.1.2 Fear of the dying process

The 'dying process' refers to the ultimate and progressive loss of body functioning (Sadock, Sadock & Ruiz, 2017:1). It is often associated with suffering and pain; hence, it evokes immense fear among all humans, including young professional nurses (Greene, 2017:289). Studies have found that the fear is often not of death but the process of dying, which remains a mystery (Ozawa-de Silva & Parsons, 2020:613). Although Kübler-Ross (1969) compared the dying process to moving from one house to another, the process remains an enigma. According to Fernández-Martínez, Martín-Pérez, Liébana-Presa, Martínez-Fernández and López-Alonso (2021:2), an awareness of the processes of dying and coping with death are important for young professional nurses caring for the dying patient and their family, since accompanying the dying and coping with death are part of their daily work. Çakar (2020:102) also emphasises how young professional nurses cope with their fear of the dying process impacts the quality of end-of-life care provided to the patient and their family.

Being present to witness the dying patient take their last breath is a significant and emotional experience for most young professional nurses (Garrino et al., 2017:132). This experience can evoke emotions of wonder, terror, and anxiety at the time of death and could be attributed to the transfer from this world to another unknown world (Shamloo, Elahi & Zarea, 2021:3550). According to Ådland, Gripsrud, Lavik and Ramvi (2021:2), if young professional nurses cannot cope with these emotions, it can lead to the development of maladaptive coping strategies, creating negative attitudes towards caring for the dying patient at their final moment. Young professional nurses with negative attitudes in caring for the dying patient are often seen as distant and disengaged, leaving the dying patient isolated in their attempts to avoid the grief and distress triggered by the event (Ozawa-de Silva & Parsons, 2020:614).

However, when young professional nurses perceive the dying process as liberating, they find gratification in being present for the patient in their final moments (Heidari, 2021:233-234). Young professional nurses with positive attitudes in caring for the dying patient in their last moment embrace caring behaviour like touch; they also offer quiet and private space for the patient and their family to be in the moment (Puspitawati & Yuliawan, 2019:19).

4.5 ANALYSIS OF THE FATCOD SCALE

Nurses are the largest and most essential healthcare workforce across the globe. They use their expertise and skillsets every day in clinical practice to protect, promote, and advocate on behalf of the patients and families under their care (Ulrich et al., 2020:838). According to Pehlivan et al. (2020:129), caring for dying people is often considered to be one of the most stressful responsibilities of nurses, and as the level of exposure to death increases, the professional life quality decreases. Therefore, it is crucial for nurses to be aware of their attitudes towards caring for the dying patient and their family as it affects the quality of care they provide (Akbolat, Ünal & Karakaya, 2020:4).

This study’s main objective was to determine young professional nurses’ attitudes towards caring for the dying patient and their family. Nurses’ attitudes toward caring are defined as feelings, thoughts and comfort level while caring for the dying patient and their family (Kim, Kim & Gelegjamts, 2020:3). To meet this objective, the FATCOD scale was used. Frommelt (1991) developed the original FATCOD scale to assess individuals’ attitudes toward caring for dying patients. The FATCOD scale is currently the most widely used instrument for assessing attitudes towards caring for the dying patient and their family in the nursing context (Edo-Gual et al., 2018:121).

The FATCOD scale is a self-report, five-point Likert questionnaire comprising 30 closed-ended statements (Frommelt, 1991:39). FATCOD scale has five response categories with anchors 1 (strongly disagree) to 5 (strongly agree). The mean, median, mode, standard deviation, and percentiles of the respondents’ scores to statements in the FATCOD scale are discussed next.

4.5.1 Descriptive statistics

The descriptive statistics are presented below and the discussion elaborates on the results of the highest agree response rate for the FATCOD scale.

4.5.1.1 Statement 1: *Giving nursing care to a dying patient is a worthwhile learning experience*

Death and the dying experience are integral and inevitable aspects of human existence (Faronbi, Akinyoola, Faronbi, Bello, Kuteyi & Olabisi, 2021:1). However, the experience remains an enigma that evokes a series of emotional triggers, such as uncertainty, fear, anguish and sometimes anger and depression (Faronbi et al., 2021:1).

In this study, 42,5% (n=28) of respondents agreed with this statement, supporting literature that has found young professional nurses often feel caring for the dying patient is a privilege as it brings new insight into their own lives (Lui & Chiang, 2017:34). Astin et al. (2015:191) found this in young professional nurses who reflected on their experiences with death and dying and used it as an opportunity to develop their skills and understanding of aspects related to caring for the dying patient.

4.5.1.2 Statement 2: *Death is not the worst thing that can happen to a person*

Death is an inevitable part of human life. However, biomedical advances are enabling people to live longer, and it appears by doing so, people have become detached from the reality of death being a normal human phenomenon (A'la, Setioputro & Kurniawan, 2018:25).

In this study, respondents were ambiguous about their feelings regarding death being the worse thing to happen to a person. Of the respondents, 24,2% (n=15) agreed or disagreed with this statement. These findings were consistent with literature claiming that although young professionals understand death as a normal part of the cycle of life (Beaty, 2015:304), they often consider death as a 'failure' in care as it contradicts the values of life preservation (Khalaf et al., 2017:229).

According to Ranse, Ranse and Pelkowitz (2018:2), these attitudes may be attributed to how their first exposure in caring for the dying patient was handled. The authors proposed that the first encounter with death and dying can influence a nurse's future responses to end-of-life care. Garrino et al. (2017:130-131) agree, as student nurses who were not adequately supported after their first encounter caring for a dying patient had more negative overtones to death than students who were supported and allowed to grieve their first encounter with death. These students were found to process the death of a patient easier as they viewed death as a healing process for the patient (Khalaf et al., 2017:233).

4.5.1.3 Statement 3: *I would be uncomfortable talking about impending death with the dying person*

Communication is a vital component when caring for dying patients, and the topic surrounding their impending death is often deemed the most challenging aspect in nursing (Río, Marván & Gómez Avalos, 2020:349). Sawin et al. (2019:178) describe effective end-of-life communication as providing honest, timely and sensitive information in preparing the patient for life's end.

In this study, 40,3% (n=25) of respondents were uncertain how they would feel discussing a patient's impending death. These results were consistent with literature that reported young professional nurses were filled with uncertainty despite knowing the importance of conversing with the dying patient about their condition (Dong et al., 2016:189). Sawin et al. (2019:178) claim dying patients appreciated honesty regarding their condition as they often felt it allowed them to make decisions in facilitating a good death. During conversations, nurses gain a better sense of patients' preferences for care in terms of withdrawing or withholding life-sustaining therapies (Murali, 2010:74). This includes not being placed on life support when there is little hope for recovery, having an opportunity to nominate their preferred decision-maker, and starting funeral planning. These aspects are often considered difficult and stressful and impose significant burdens and distress on the family (Scheinfeld & Lake, 2021:612).

4.5.1.4 Statement 4: *Nursing care for the patient's family should continue throughout the period of grief and bereavement*

The family unit forms a crucible source of physical, emotional and spiritual support for the dying patient (Kaakinen et al., 2018:5). Thus, Kübler-Ross (1974:160) claims the family's problems start once the patient dies, as their lives are no longer the same.

In this study, 43,5% (n=27) of respondents agreed that nursing care for the patient's family should continue throughout the grieving and bereavement period. Nurses' involvement during end-of-life care naturally cultivates a relationship between the nurse and the family (Vierhout, Varenbut, Amos, Buchman, Husain, Meuser & Bernstein, 2019:1). Therefore, when the patient dies, there is a sudden termination of this contact and an end of routine, imposing intense emotional reactions among those left behind (Coelho, Suttiwan, Arato & Zsido, 2020:76). These emotions may inflict new demands and transitions on grieving family members who are already at risk of adverse mental and physical health outcomes (Breen, Szylit, Gilbert, Macpherson Murphy, Nadeau, Reis e Silva & Wiegand, 2019:173). Therefore, when nursing care continues during the time of families' grief and bereavement, the family feels a sense of support. It results in lowered adverse grief reactions, higher relationship satisfaction, and increased meaning-making and reorganisation of roles within families (Breen et al., 2019:173-174).

4.5.1.5 Statement 5: *I would not want to be assigned to care for the dying person*

Nurses command the rare privilege of witnessing both the beginning and end of life. However, evidence suggests that caring for dying patients is the most stressful facet of nursing (Faronbi et al., 2021:1).

In this study, 40,3% (n=25) of respondents disagreed with this statement, indicating their willingness to care for the dying patient. This reflects their positive awareness in the context of end-of-life care, which Matsui, Yanagihara, Satou, Notohara, Shimo, Tsukamoto, Nakamura, Nishino, Higashi, Hyouda, Murata, Motohashi, Morita and Yonezawa (2017:125) described as "the attitude of not running away from death". Laporte, Juvet, Desbiens, Tapp, Pasquier and Bornet (2020:5) proposed that this may be attributed to nurses' understanding of caring for vulnerable patients as a core value of the nursing profession. The awareness makes young nurses feel obliged to be attentive and present when caring for the dying patient (Ricot, 2016:50).

4.5.1.6 Statement 6: *The nurse should not be the one to talk about death with the dying person*

A growing body of evidence has demonstrated most patients want to be informed about their illness, treatment and prognosis, whether this information is good or bad (Griffiths, Ewing, Wilson, Connolly & Grande, 2015:139). Providing patients with accurate information about their health can help them make informed decisions about their treatment as there is an increase in their understanding of their condition (Griffiths et al., 2015:139).

In this study, 22,6% (n=14) of respondents disagreed with this statement; they believed nurses should be the ones to talk about death with the dying patient. The nurse's role is understood as a supportive one after the doctor initially discloses the patient's prognosis (Bumb, Keefe, Miller & Overcash, 2017:574). However, in recent years, discussions about death have fallen on nurses' shoulders (Moghaddam, Manzari, Heydari, Mohammadi & Khaleghi, 2018:116). This has become particularly apparent during the COVID-19 pandemic, which forced nurses to have these conversations with dying patients (Caulkin & Robinson, 2021:26). Studies have shown that having conversations about death with patients were seen to play an important role in ensuring the patient is able to have a 'good death', which was discussed in detail in Chapter 2 (Vanderveken, Schoenmakers & Lepeleire, 2019:1).

4.5.1.7 Statement 7: *The length of time required to give nursing care to a dying person would frustrate me*

Patients in the last days of their lives have needs that may not be fully fulfilled. This may be a difficult time for the nurses, as these patients often display depressed moods or even chaotic tempers towards the nurses (Kübler-Ross, 2014:50). This may be challenging for nurses as they are coming to grips with their own feelings while trying to provide care for the dying patient (Berndtsson, Karlsson & Rejnö., 2019:1).

In this study, 35,5% (n=22) of respondents disagreed with this statement. This was consistent with literature claiming once young professional nurses were able to identify with the dying patient, it assisted them in being sensitive to the patient's needs and emotions (Watson, 1985:11). According to Halli-Tierney et al. (2019:4), this was only possible during caring moments in the presence of an authentic transpersonal relationship.

4.5.1.8 Statement 8: *I would be upset when the dying person I was caring for gave up hope of getting better*

Nurses spend significant time with dying patients learning more about them, their family, plans, hopes and dreams for the future (Wang, 2019:262). Thus, when caring for the dying patient, young professional nurses may be confronted with the patient's rollercoaster of emotions as they process the inevitable (Kübler-Ross, 2014:20).

In this study, 35,5% (n=22) of respondents indicated that they would be upset if the dying patient gave up hope of getting better. Literature similarly recognised the importance of appropriately handling the loss of hope among dying patients (Stuart, Danaher, Awdish & Berry, 2019:682). According to Coulehan (2018:739), young professional nurses need to make it their duty to assure that patients remain hopeful, even in the face of an incurable disease. Ultimately, hope reduces the incurable disease's impact on the person's quality of life as it helps them accept their imminent death with equanimity and peace (Kübler-Ross, 2014:110).

4.5.1.9 Statement 9: *It is difficult to form a close relationship with the family of the dying person*

Assisting the dying patient and their family is a key component of nursing practice. Nurses' attitudes about including the family in care define the type and quality of relationship that will be developed between professionals and the family (Rodrigues, Badagnan, Nobokuni, Fendrich, Zanetti, Giacon & Galera, 2021:212).

In this study, 30,6% (n=19) of respondents disagreed with this statement; they did not have difficulty forming a close relationship with the dying patient's family. This correlates with what was found in literature regarding holistic caring. It involves relationship-based interactions built on trust and focuses on the well-being of the dying person and their family (Enzman Hines & Gaughan, 2017:328).

According to Azevêdo, Júnior and Crepaldi (2017:3654), having a relationship with the family of the dying patient is the first step in establishing an authentic transpersonal relationship with patients (Enzman Hines & Gaughan, 2017:328). The family is able to provide insight into the patient, which allows the young professional nurse to provide quality end-of-life care (Mastroiann, Piredda, Taboga, Mirabella, Marfoli Casale, Matarese, Murray Frommelt & Marinis, 2015:228).

4.5.1.10 Statement 10: *There are times when death is welcomed by the dying person*

There is a high expectation of medicine to perform miracles, saving lives against all odds. However, death is an evitable part of human life (Khalaf et al., 2017:3).

In this study, 43,5% (n=27) of respondents agreed with this statement. Literature agrees, especially in this climate where nurses are confronted with COVID-19 and its associated high mortality rates (Maben & Bridges, 2020:2742). According to Yi (2021:56), death acceptance is the opposite of negative death anxiety. When nurses adopt an existential perspective on death, they assert a positive attitude towards death; patients' death is viewed as a passageway to an eternal existence, as an escape from suffering, or as an inevitable reality. Nurses' acceptance of patient deaths enables them to practice holistic and meaningful end-of-life care (Bellali, Giannopoulou, Tsourti, Malliarou, Sarafis, Minasidou & Papadatou, 2018:265).

4.5.1.11 Statement 11: *When a patient asks, "Nurse, am I dying?", I think it is best to change the subject to something cheerful*

In many cultures, death and dying are stigmatised, taboo, or fear-inducing topics. This makes communicating about death challenging (Lambert South & Elton, 2017:2).

In this study, 43,5% (n=27) of respondents agreed with this statement. This was consistent with literature that found young professional nurses use this tactic to deflect from their own anxieties surrounding death and dying. Although patients appreciate humour, young professional nurses need to understand when it is appropriate (Costello, 2017:64). In a study by Lambert South and Elton (2017:6), humour was used in two ways; firstly, it was used as a release valve for a difficult part in the conversation to diffuse tension. Secondly, it was used to deflect the discomfort of thinking about death.

4.5.1.12 Statement 12: *The family should be involved in the physical care of the dying person*

The family plays a significant role in providing patients physical, mental, emotional, and spiritual support during the time of diagnosis of the illness, and their reactions contribute to how the patient experiences their illness (Kübler-Ross, 2014:152). Families are seen as valued members of the interdisciplinary team and the 'experts' when caring for the dying patient (Howitt, 2011:109).

In this study, 41,9% (n=26) of respondents agreed with this statement. Nurses' beliefs in family involvement in the physical care of the dying patient are also reflected in literature (Wang, Sun, Lui, Kong & De Fries, 2021:3). Clark (2016:3) determined that involving the family in physically caring for the dying patient made them feel as if they had provided the best possible care. Physically caring for the dying patient becomes a sacred moment for the patient as it is often the family's way of finding closure and healing before the patient dies (Kübler-Ross, 2014:170).

4.5.1.13 Statement 13: *I would hope the person I am caring for dies when I am not present*

Death and dying is a common phenomenon in all clinical settings (Faronbi et al., 2021:1). According to Bilgiç (2021:2), death is described as an important but difficult part of life's cycle.

In this study, respondents were ambiguous as 24,2% (n=15) agreed and 24,2% (n=15) disagreed with this statement. Research has found that, for the past 30 years, nurses' feelings regarding being present during a patient's death is still not fully understood. Their decision to be present was often influenced by the age of the patient and the presence or absence of an authentic nurse-patient relationship (Hall-Lord, Petzäll & Hedelin, 2018:18). Hall-Lord et al. (2018:23) claim that if the dying patient was old and had a long life, nurses described dying as natural and peaceful and were touched by the situation. However, when the dying patient was young, encounters with the dying patient was deemed emotionally demanding, unreal and unfair. According to Pehlivan et al. (2019:2), this was due to the young professional nurses' ability to relate to the dying patient, which often made them conscious of their own anxieties about death.

4.5.1.14 Statement 14: *I am afraid to become friends with a dying person*

The nurse-patient relationship is viewed as the foundation of caring built on trust and focusing on the well-being of the person as a whole (Enzman Hines & Gaughan, 2017:328). Watson (1999:118) believes for the nurse-patient relationship to develop, the nurse must be perceived as genuine, thoughtful and empathetic.

In this study, 33,9% (n=21) of respondents disagreed with this statement; these young professional nurses were not afraid of being friends with a dying patient. These findings were consistent with what was found in literature. According to Garrino et al. (2017:130-131), young professional nurses who place importance in the 'here and now' when caring for the dying patient understand the importance of a nurse-patient relationship. These young professional nurses found pleasure and gratification in taking the time to stop, listen and build an authentic nurse-patient relationship. Donkor and Dorsey (2019:26) concur that for the dying patients, it gave them the incentive to continue to live as it helped them find a sense of peace and security, which eased their perception of the dying process.

4.5.1.15 Statement 15: *I would feel like running away when the person actually died*

Death and dying are becoming more controlled, scientific phenomena instead of normal social occurrences. This brings about the notion that death and dying are more secularised, rationalised, individualised and medicalised in the society in which we find ourselves (Van der Venter, 2021:50).

In this study, 50% (n=31) of respondents strongly disagreed with this statement; these results did not correlate with those found in literature. Most studies reported that 80%

of young professional nurses do not want to be present when their patient dies, because the moment of gasping and the spirit's exit is traumatic. It makes them feel sad, angry, powerless, unable to preserve the patient's life (Khalaf et al., 2017:229; Garrino et al., 2017:130-131; Linge-Dahl, Heintz, Ruch & Radbruch, 2018:890). This avoidance was also described by Hernández and Negredo (2020:38) as a maladaptive defence mechanism used by young professional nurses to protect themselves from the realities of death.

4.5.1.16 Statement 16: *Families need emotional support to accept the behaviour changes from the dying person*

When patients are told about the change in their prognosis, they may experience a shift in their personality and behaviour. The dying patient might become insulting or hurtful, then depressive, and finally find peace (Kübler-Ross, 2014:10). Kübler-Ross (2014:38) describes these changes after her observations from working with dying patients. Accordingly, each dying patient does not necessarily experience all these stages, nor do they progress smoothly in a sequence from one stage to another (Kübler-Ross, 1985). This may result in feelings of guilt and hopelessness for the family (Akdeniz et al., 2021:1).

In this study, 61,3% (n=38) of respondents strongly agreed with this statement, reflecting their positive attitudes towards providing emotional support to the family in order to accept the dying patient's behavioural changes. This was consistent with literature regarding nurses' understanding of extending nursing care to the dying patient's family (Kübler-Ross, 2014:170). Studies have shown that when young professional nurses emotionally support the family during the dying patient's behavioural changes, the family is assisted in their resolution of grief (Soroka et al., 2018:1543).

4.5.1.17 Statement 17: *As a patient nears death, the nurse should withdraw from his/her involvement with the patient*

Nurses are responsible for creating a haven for safe passage for the dying patient. Their involvement can either be comforting or leave the patient and their family in anguish. Nurses' presence can provide guidance and emotional support or leave the patient and their family feeling abandoned (Watson, 2012:6).

In this study, 54,8% (n=34) of respondents strongly disagreed with this statement, which meant they understood how their involvement allows the patient to reach acceptance of their own death with dignity and in peace (Kübler-Ross, 1971:31). These findings coincide with what was found in literature. According to Kondo and Nagata (2015:283), when the dying patient is nearing the end, young professional nurses need to be actively involved in providing psychological, spiritual and emotional care to the patient and their family while respecting their preferred end-of-life care that allows for the facilitation of a "good death".

4.5.1.18 Statement 18: *Families should be concerned about helping their dying member make the best of his/her remaining life*

Upon learning about the terminality of a disease or a change of status from serious to terminal, the family of the dying patient experiences a sense of emotional turmoil that Kübler-Ross (2014:152) described as similar to those of the dying patient. Kübler-Ross also believed the family's reaction contributes to the dying patient's experience.

In this study, 53,2% (n=33) of respondents strongly agreed with this statement, which meant young professional nurses believed families should focus on helping the dying patient make the best of their remaining time. These results were consistent with literature. According to Kübler-Ross (2014:162), when the family initially hears of their loved one's prognosis, some bargain with a higher power wishing they could make up for missed opportunities. Others seek counsel from different doctors, even resorting to aggressive treatments in the hopes of a different outcome. The family's inability to come to terms with the dying patient's reality prevents them from finding meaningful ways of spending time with their loved one (Soroka et al., 2018:1543).

4.5.1.19 Statement 19: *The dying person should not be allowed to make decisions about his/her physical care*

End-of-life decision-making is the lived experience where dying patients make decisions about the end-of-life care they will receive (Murali, 2020:73). End-of-life decision-making provides paradigms that promote discussions of how to address the unique needs of dying patients (Tyrrell et al., 2021).

In this study, 56,5% (n=35) of respondents strongly disagreed with this statement; they believed dying patients should be allowed to make decisions regarding their physical care. These findings were supported by emphasising young professional nurses' belief in allowing dying patients to take charge of their care (Houska & Loučka, 2019:835; Murali, 2020:73). This act of respect and compassion by young professional nurses made dying patients feel valued and restored their inherent worth as human beings (Hunt, Nouvet, Chénier, Krishnaraj, Bernard, Bezanson, de Laat & Schwartz, 2020:10). This experience of coming together in a caring situation provides young professional nurses with the opportunity to develop an authentic transpersonal relationship with the dying patient (Blasdell, 2017:2).

4.5.1.20 Statement 20: *Families should maintain as normal an environment as possible for their dying member*

A normal environment for the dying patient has been described as either deciding to live in the present or making plans for their remaining time (Houska & Loučka, 2018:836). Maintaining a normal environment in either situation may often be difficult for dying patients' families, as they may be processing their own emotions regarding the impending death of their loved one (Coombs, Parker, Ranse, Endacott & Bloomer, 2017:39).

In this study, 45,2% (n=28) of respondents strongly agreed with this statement, supporting results in literature. It has been said it is the young professional nurse's responsibility to guide the family of the dying patient in creating a normal environment (Coombs et al., 2017:40). According to Khodabakhshi-Kool and Farhangi (2019:76), when young professional nurses support the patient's family, it helps them work through their own emotions regarding death and dying. Kübler-Ross (1985) claim once the family had full comprehension of their emotions, it gave them comfort and confidence in living in the present. Johns, Beck-Coon, Stutz, Talib, Chinh, Cottingham, Schmidt, Shields, Stout, Stump, Monahan, Torke and Helft (2020:89) found that once the family had processed their own feelings, it resulted in open and honest end-of-life care planning to ensure the promotion of a “good death”.

4.5.1.21 Statement 21: *It is beneficial for the dying person to verbalise his/her feelings*

Caring for dying patients is a challenging and demanding role. Nurses are expected to meet the dying patient’s physical needs and manage the emotional and psychological aspects of the situation (Hussain, 2020:284).

In this study, 61,3% (n=38) of respondents strongly agreed with this statement, and these results were consistent with those in literature emphasising the benefits of allowing dying patients to verbalise their feelings. According to Mgbekem and Nwakw (2019:4544), allowing patients to share their feelings helps alleviate their suffering and makes their lives meaningful, making their death more peaceful. This sentiment was shared by Kübler-Ross and Byock (1969:1), who believed by inviting dying patients to share their thoughts, experiences, and concerns, it gave young professional nurses a greater appreciation of the dying patient’s experience and their circumstances (Alicea-Planas, 2016:162). This enabled the young professional nurses to find meaning in shared experiences with the patient, promoting the development of a deepened authentic nurse-patient relationship (Kübler-Ross & Byock, 1969:1).

4.5.1.22 Statement 22: *Nursing care should extend to the family of the dying person*

The family of the dying patient is often confronted with different aspects of caregiver burden, such as physical symptoms, psychosocial distress, impaired social relationships, spiritual distress, financial crisis, role strain, disruption of daily life and uncertainty (Van Driel, Becqué, Rietjen, van der Heide & Witkamp, 2021:151434).

In this study, 45,2% (n=28) of respondents strongly agreed with this statement, supporting findings in literature regarding nursing care extending to the family. Kübler-Ross (1969:168) claims that the dying patient's family undergoes different stages of adjustment similar to the ones described for the patient. Initially, when the dying patient finds out their prognosis is poor, the family enters a state of denial. They may express this denial by going to different doctors in the hopes of receiving a different answer. Therefore, just as the dying patient goes through a stage of anger, the immediate family will experience the same emotional reaction, projecting this rage onto the young professional nurses caring for the dying patient. Once anger, resentment and guilt are resolved, the family will then go through a phase of preparatory grief (Kübler-Ross, 1969:168-169). Studies have shown the important role young professional nurses play in helping families deal with this complex emotion, which aid in the family's acceptance of death and ability to heal (Rosa et al., 2017:60).

4.5.1.23 Statement 23: *Nurses should permit dying persons to have flexible vising schedules*

Historically, hospital visitation has always been a controlled factor, especially in wards with bays. It was believed that restricting visiting hours to one hour a day or less reduced the risk of spreading infections; it gave patients time to rest, which 'improved' their recovery rate, and it allowed nurses to provide quality care meticulously (Ellis, 2018:18). However, various studies have disputed this notion over recent years, recommending flexibility in visiting time, especially when caring for the dying patient and their family (Zupanets, Dobrova, Ratushna & Silchenko, 2018:106; Ellis, 2018:18).

In this study, 50% (n=31) of respondents agreed with this statement regarding the concept of having flexible visiting schedules for dying patients in the hospital. These findings were consistent with literature emphasising the importance of young professional nurses' attitudes towards flexible visiting hours in quality end-of-life care. Dying patients' admission into the hospital is often stressful and devastating for them and their families (Hlahatsi, Lingela, Cwayi, Mabona & Gomes, 2017:48). It may be overwhelming and frustrating for patients in an unfamiliar environment at their most vulnerable time. Hlahatsi et al. (2017:48) found that the family would often feel anxious, which leads to anger towards nurses and dissatisfaction with care and disregard of a treatment regimen.

However, with flexible visiting hours, studies found dying patients were neither depressed nor angry about their fate. Having their family next to them provided them with a sense of calm that allowed them to positively submit to their fate (Kübler-Ross, 2014:109). For the family, flexible visiting hours in end-of-life care allowed them to find closure, as they felt they had been there for their loved one, till the end (Soroka et al., 2018:1543).

4.5.1.24 Statement 24: *The dying person and his/her family should be the decision-makers in charge*

Murali (2020:73) described end-of-life decision-making as a form of control the dying patient and their family exercises over their experience during end-of-life care.

In this study, 40,3% (n=25) of respondents agreed with this statement. These results are consistent with what was found in literature regarding young professional nurses' attitudes in assisting dying patients and their families when making end-of-life decisions. In end-of-life care, young professional nurses must provide the dying patient and their family with honest and truthful information for these individuals to make an informed decision regarding their care (Murali, 2020:74). According to Prater, Wickizer, Bower and Bose-Brill (2019:1090), this informed decision-making regarding end-of-life care means young professional nurses can facilitate advanced care planning. It provides insight into the dying patient's values and beliefs during end-of-life care, which is vital in facilitating a "good death".

4.5.1.25 Statement 25: *Addiction to pain-relieving medication should not be a nursing concern when dealing with a dying person*

Wilson et al. (2016:600) describe end-of-life care as the promotion of comfort among individuals with life-limiting illnesses. Nurses play an active and important part in assessing and relieving pain and suffering, as reflected by good pain management and holistic care at the end of life (Monterosso et al., 2016:724).

In this study, 27,4% (n=17) of respondents strongly disagreed with this statement. Literature reported similar findings regarding young professional nurses' concern of addiction when caring for dying patients. Although effective pain management during end-of-life care has been emphasised as a top priority (Khosla, Washington & Regunath, 2016:850), nurses still worry about addiction when administering medication to dying patients (Bruce & Beuthin, 2020:256). A study by Heckroth et al. (2021:43) found that although nurses understood the importance of effective pain management when providing quality end-of-life care, they were still cautious in administering opioids as they feared addiction among dying patients (Witham et all., 2019:2). Hannon, Zimmermann, Knaul, Powell, Mwangi-Powell and Rodin (2016:65) claim that the fear of addiction to pain-relieving medication was based on inadequate training among healthcare professionals, cultural and attitudinal barriers, and national regulatory controls related to concerns about abuse and dependence.

4.5.1.26 Statement 26: *I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying*

End-of-life care is inherently difficult for dying patients and nurses; not only due to the physical labour but also the emotional and spiritual labour that includes anxiety, powerlessness, uncertainty, distress, grief, and frustration (Liu & Chiang, 2017:31).

In this study, 32,3% (n=20) of respondents agreed with this statement, supporting what is often found in literature regarding nurses' discomfort when faced with the dying patient. Crying is an emotional trigger that is often a combination of sadness, anger and fear (Vingerhoets & Bylsma, 2016:208). It is associated with attachment-related issues, such as bereavement over separation. Griffith et al. (2015:146) propose that caring is a window to obtain greater insight into important developmental processes like empathy and morality. According to Vingerhoet and Byslma (2016:209), when nurses are uncomfortable with these cues, they are unable to facilitate social bonding or elicit empathy, which affects their ability to recognise and resonate with the dying patient's feelings during end-of-life care (Watson, 1979:16-19). These nurses frequently burn out and become emotionless, attending to their duties in a mechanical and prescribed manner that is detached (Tuomikoski et al., 2018:78).

4.5.1.27 Statement 27: *Dying persons should be given honest answers about their condition*

When a patient's condition first becomes incurable, information about how their function may deteriorate is important. It allows dying patients to pursue achievable goals and make practical plans before their passing (Chu, Anderson, White & Stone, 2020:2).

In this study, 61,3% (n=38) of respondents strongly agreed with this statement. Literature also claims that dying patients expect honest answers related to their condition, although these conversations may be difficult for young professional nurses (Terpe, 2016:5). These discussions create an opportunity for young professional nurses to reframe the dying patient's hopes regarding their illness and allow patients to embrace their reality; placing emphasis on symptom control (Chu et al., 2020:2). Various studies have reported that when young professional nurses accept death as a natural part of life, they are able to facilitate open and honest conversations with the patient regarding their condition (Schellinger et al., 2018:160; Bergenholtz, Timm & Missel, 2019:2; Chu et al., 2020:6).

4.5.1.28 Statement 28: *Educating families about death and dying is not a nursing responsibility*

When the dying patient and their family are confronted with death and dying, they frequently turn to the nurse for help and support (Dobson, 2017:1116). Therefore, young professional nurses must provide informative end-of-life care based on disease trajectory and pain management (Coombs et al., 2017:50). The content, delivery and timing of communication are tailored to the patient and the family's level of understanding, desire for information and current symptoms, while also taking into account the patient's and family's culture and religion (Anderson et al., 2019:120).

In this study, 40,3% (n=25) of respondents disagreed with this statement; these results were consistent with those found in literature. Clark (2017:3) claims when a young professional nurse provides the dying patients' families with appropriate education during end-of-life care, it helps them process their feelings regarding their loved one's impending death in a healthy manner (Kübler-Ross, 2014:286). Scheinfeld and Lake (2021:612) agree when dying patients' families are well-informed and given realistic expectations regarding the patient's condition, they are able to make informed decisions to promote a peaceful and safe passing.

4.5.1.29 Statement 29: *Family members who stay close to a dying person often interfere with the professionals' job with the patient*

The dying process is often marked by a gradual decline in physical and mental function (Beaty, 2015:304). This may cause a rollercoaster of emotions for the family that is already grieving their loved one. The family may have a desire to be close to the patient, monitoring their care. According to Clark (2017:3), this is their way of managing these terminal symptoms (Frivold, Ågård, Jensen, Åkerman, Fossum, Alfheim, Rasi & Lind, 2021:33).

In this study, 40,3% (n=25) of respondents agreed with this statement. These findings are consistent with literature that found most young professional nurses felt the constant presence of the family at the bedside interfered with their ability to perform their duties (Swan & Eggenberger, 2021:24; Clark, 2017:3). They felt the family meddle in their nursing care, as they would have to constantly stop to listen to their concerns and explain every procedure being done, which caused an additional workload (Pajnkihar et al., 2017:243). Ellis (2018:19) reported that in open wards, nurses often felt the presence of family would infringe on patients' privacy. They claimed it disturbed other patients who may be trying to sleep and, in some cases, caused adverse physiological and psychological effects, especially in patients with obscure family relationships (Frivold et al., 2021:33). Some patients may feel they have to entertain their families when, in fact, they are tired and want to be left alone to mourn the impending loss of everyone and everything they love (Ellis, 2018:19; Kübler-Ross, 2014:130).

4.5.1.30 Statement 30: *It is possible for nurses to help patients prepare for death*

Young professional nurses have the greatest contact with those at the end of their life, and their attitudes towards caring for the dying is important (Grubb & Arthur, 2016:83).

In this study, 41,9% (n=26) of respondents agreed with this statement, supporting literature regarding young professional nurses' attitudes in helping patients prepare for their death. Young professional nurses have played a vital role in preparing patients for their impending death by initiating end-of-life discussion early and not leaving it until close to death (Deckx, Thomas, Sieben, Foster & Mitchell, 2020:402). Wiener, Tager, Mack, Battles, Bedoya and Gerhardt (2020:5) describe end-of-life preparation as the clear and honest information given to the dying patient and their family about what to expect during this time. This is helpful for the patient and their family as it gives them enough time to work through their feelings, undoing any wrongs and mending relationships before the impending death (Kübler-Ross, 1971:31). According to Schellinger et al. (2018:160), end-of-life preparation gave dying patients and their families the privilege of having a "good death".

4.6 SUMMARY OF FINDINGS OF THE DESCRIPTIVE STATISTICS

Death is an inevitable part of human life (Temelli & Cerit, 2019:1). The ability to raise the nurses' awareness of the phenomenon of death transforms existing negative attitudes about death into positive ones (Bruce & Beuthin, 2020:270). This awareness is necessary for nurses to correctly manage their own perception of caring practices during patients' end of life and provide effective care (Temilli & Cerit, 2019:4). The findings from this study supported this notion, showing that nurses' attitudes are inversely correlated but not mutually exclusive in caring for the dying patient and their family. Table 4.8 shows the means and standard deviation from the FATCOD scale.

Table 4.8: The mean and standard deviation from FATCOD scale

STATEMENT	MEAN	STANDARD DEVIATION
Giving nursing care to a dying patient is a worthwhile learning experience	3.92	1.045
Death is not the worst thing that can happen to a person	2.84	1.416
I would be uncomfortable talking about impending death with the dying person	3.60	0.914

STATEMENT	MEAN	STANDARD DEVIATION
Nursing care for the patient*s family should continue throughout the period of grief and bereavement	4.16	0.909
I would not want to be assigned to care for the dying person	2.21	1.295
The nurse should not be the one to talk about death with the dying person	2.87	1.443
The length of time required to give nursing care to a dying person would frustrate me	2.53	1.352
I would be upset when the dying person I was caring for gave up hope of getting better	3.06	1.341
It is difficult to form a close relationship with the family of the dying person	2.82	1.325
There are times when death is welcomed by the dying person	3.81	1.114
When a patient asks “Nurse, am I dying?”, I think it is best to change the subject to something cheerful	3.35	1.202
The family should be involved in the physical care of the dying person	4.03	1.101
I would hope the person I am caring for dies when I am not present	3.13	1.385

STATEMENT	MEAN	STANDARD DEVIATION
I am afraid to become friends with a dying person	2.27	1.074
I would feel like running away when the person actually died	1.94	1.253
Families need emotional support to accept the behaviour changes from the dying person	4,47	0.844
As a patient nears death, the nurse should withdraw from his/her involvement with the patient	1.61	0.797
Families should be concerned about helping their dying member make the best of his/her remaining life	4.32	0.901
The dying person should not be allowed to make decisions about his/her physical care	1.82	1.195
Families should maintain as normal an environment as possible for their dying member	4.31	0.759
It is beneficial for the dying person to verbalise his/her feelings	4.53	0.718
Nursing care should extend to the family of the dying person	4.21	0.871
Nurses should permit dying persons to have flexible vising schedules	4.26	0.922

STATEMENT	MEAN	STANDARD DEVIATION
The dying person and his/her family should be the decision-makers in charge	3.90	1.155
Addiction to pain-relieving medication should not be a nursing concern when dealing with a dying person	2.90	1.468
I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying	2.97	1.318
Dying persons should be given honest answers about their condition	4.47	0.824
Educating families about death and dying is not a nursing responsibility	2.31	1.262
Family members who stay close to a dying person often interfere with the professionals* job with the patient	3.48	1.211
It is possible for nurses to help patients prepare for death	3.68	1.142

4.7 INFERENTIAL STATISTICS

FATCOD scale was subjected to PAF using SPSS version 27.0. Prior to performing the PAF, the data's suitability for the factor analysis was assessed. On inspection, the correlation matrices of the 30 statements on the FATCOD scale was r=0.788.

The KMO value was found to be 0.585 for the FATCOD scale. The *p* score for Bartlett's test was 0.00, as shown below in Table 4.9. From the visual inspection of the correlation matrices, the KMO test and Bartlett's test of sphericity strongly confirmed the data's appropriateness for factor analysis.

Table 4.9: Kaiser-Meyer-Olkin (KMO) and Bartlett's test

TEST	STATISTIC	SCORE
		FATCOD scale
Kaiser-Meyer-Olkin (KMO)	KMO	0.585
Bartlett's test of sphericity	Approx. Chi-Square	783.195
	df	435
	p	0.000

Using PAF, 10 factors had an Eigenvalue of 1 and above. Guided by the need for a simple solution with as few factors as possible, and the need to explain as much variance as possible in the data (Pallant, 2013:191), the PAF was the model of choice for the FATCOD scale. Tables 4.10 present the extracted factor.

Table 4.10: The FATCOD scale extracted by Kaiser's criterion (PAF)

FACTOR	EIGENVALUE		
	TOTAL	% OF VARIANCE	% OF CUMULATIVE VARIANCE
1	5.546	18.487	18.487
2	3.340	11.134	29.621
3	2.188	7.294	36.915
4	2.083	6.944	43.859
5	1.863	6.209	50.068
6	1.649	5.497	55.564
7	1.447	4.823	60.387
8	1.251	4.170	64.558
9	1.092	3.639	68.197
10	1.026	3.421	71.617

The Kaiser's criterion was complimented with Catell's scree test. Using this test, Eigenvalues were plotted and inspected for a point where the shape of the curve changed direction and became horizontal. It is recommended to retain all factors above the break in the plot as these explain most of the variance in the dataset (Pallant, 2013:191). Upon inspecting the scree plot, a vertical-horizontal break was visible at component 3 in the PAF (for nurses' attitude towards caring for the dying patient and their family). Figure 4.7 illustrates these observations.

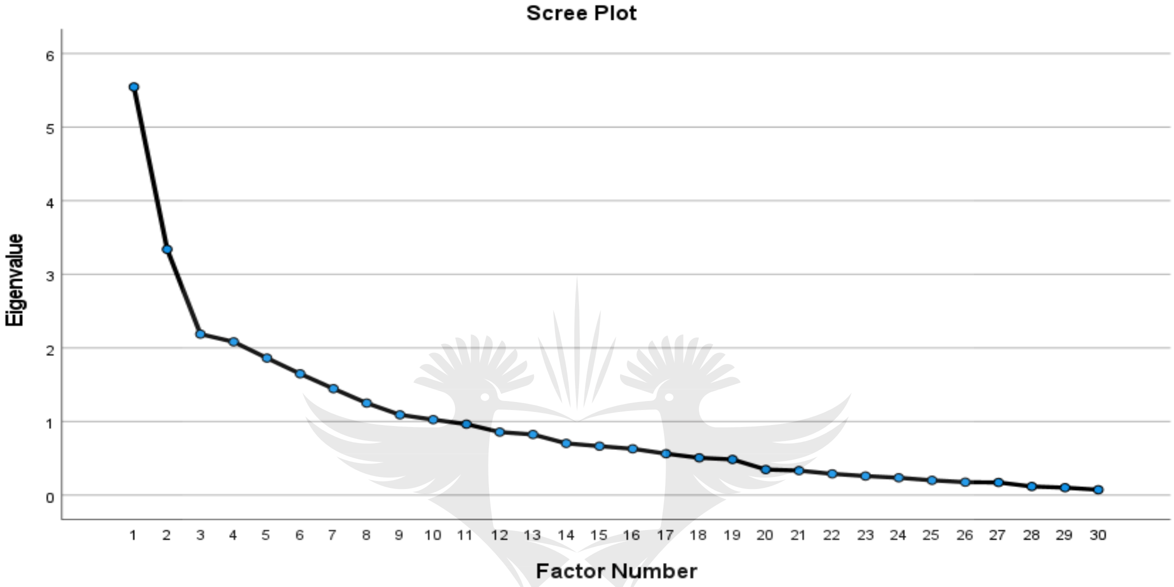


Figure 4.7: The scree plot for attitudes towards caring for the dying patient

The factor's items were extracted from relational attitudes in the original FATCOD scale. The FATCOD scale comprised 15 positively worded items (1, 2, 4, 10, 12, 16, 18, 20, 21, 22, 23, 24, 25, 27) and 15 negatively worded items (3, 5, 6, 7, 8, 9, 11, 13, 14, 15, 17, 19, 26, 28 and 29) (Frommelt, 1991). All negatively worded items were recoded in order for all the items to load positively, well above 0,788. Items loadings 0.3 and higher indicated that the items fit well with each other (Pallant, 2013:206). The lowest loading item was for statement 5, which was negatively worded (*I would not want to be assigned to care for the dying person*); it was recoded, and had a loading coefficient of 0.766. Statement 25 (*Addiction to pain-relieving medication should not be a nursing concern when dealing with a dying person*) loaded the highest coefficient of 0.811. Table 4.11 shows these results.

Table 4.11: The loading coefficient for FATCOD scale

STATEMENT	ITEM LOADING
Statement 1: Giving nursing care to a dying patient is a worthwhile learning experience.	0,786
Statement 2: Death is not the worst thing that can happen to a person.	0,796
Statement 3 RECODED: I would be uncomfortable talking about impending death with the dying person.	0,777
Statement 4: Nursing care for the patient's family should continue throughout the period of grief and bereavement.	0,787
Statement 5 RECODED: I would not want to be assigned to care for the dying person.	0,766
Statement 6 RECODED: The nurse should not be the one to talk about death with the dying person.	0,771
Statement 7 RECODED: The length of time required to give nursing care to a dying person would frustrate me.	0,776
Statement 8 RECODED: I would be upset when the dying person I was caring for gave up hope of getting better.	0,782
Statement 9 RECODED: It is difficult to form a close relationship with the family of the dying person.	0,774
Statement 10: There are times when death is welcomed by the dying person.	0,782
Statement 11 RECODED: When a patient asks *Nurse, am I dying?*, I think it is best to change the subject to something cheerful.	0,789
Statement 12: The family should be involved in the physical care of the dying person.	0,792
Statement 13 RECODED: I would hope the person I am caring for dies when I am not present.	0,773
Statement 14 RECODED: I am afraid to become friends with a dying person.	0,781
Statement 15 RECODED: I would feel like running away when the person actually died.	0,771
Statement 16: Families need emotional support to accept the behaviour changes from the dying person.	0,781
Statement 17 RECODED: As a patient nears death, the nurse should withdraw from his/her involvement with the patient.	0,779

STATEMENT	ITEM LOADING
Statement 18: Families should be concerned about helping their dying member make the best of his/her remaining life.	0,789
Statement 19 RECODED: The dying person should not be allowed to make decisions about his/her physical care.	0,770
Statement 20: Families should maintain as normal an environment as possible for their dying member.	0,791
Statement 21: It is beneficial for the dying person to verbalise his/her feelings.	0,784
Statement 22: Nursing care should extend to the family of the dying person.	0,775
Statement 23: Nurses should permit dying persons to have flexible vising schedules.	0,784
Statement 24: The dying person and his/her family should be the decision-makers in charge.	0,784
Statement 25: Addiction to pain-relieving medication should not be a nursing concern when dealing with a dying person.	0,811
Statement 26 RECODED: I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.	0,774
Statement 27: Dying persons should be given honest answers about their condition.	0,781
Statement 28 RECODED: Educating families about death and dying is not a nursing responsibility.	0,779
Statement 29 RECODED: Family members who stay close to a dying person often interfere with the professionals* job with the patient.	0,789
Statement 30: It is possible for nurses to help patients prepare for death.	0,776

The 30 items on the FATCOD scale were divided into three concepts: the young professional nurses' attitudes towards death and dying, their attitudes towards providing end-of-life care, and their attitudes towards caring for the family during end-of-life care. These concepts are depicted in Figure 4.8:

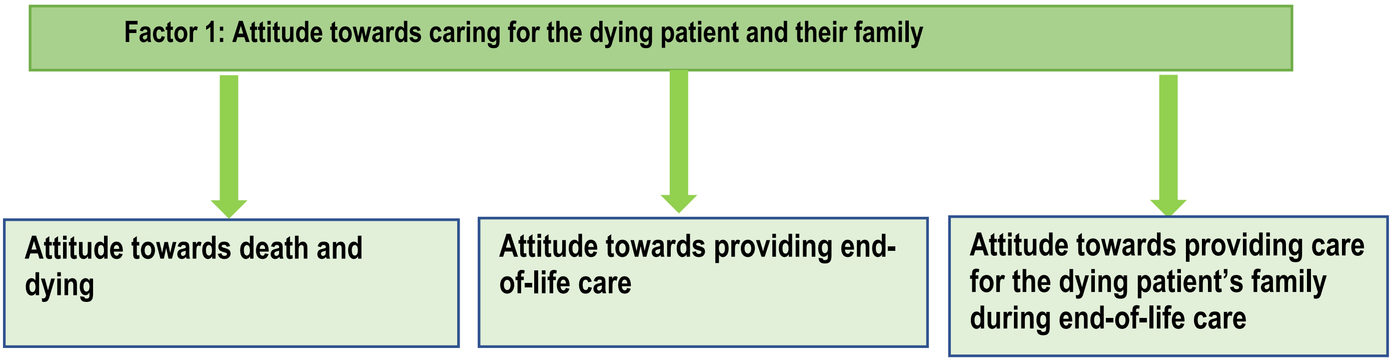


Figure 4.8: **Factor 1: Attitude towards caring for the dying patient and their family**

4.7.1 Attitude towards death and dying

As stated, dying and death are an inescapable part of life (Barry & Yuill, 2016:263-264). Young professional nurses are the ones faced with this phenomenon daily as part of their work. Therefore, the meaning they attach to their experiences of death and dying impacts their attitude towards the process (Barry & Yuill, 2016:280-281). Khalaf et al. (2017:233) found that young professional nurses' understanding of death and dying differ vastly across social classes, gender, ethnicity, and the particular context. Hence, when a patient dies, some young professional nurses may view the death as an end to long suffering. However, others may focus on how the patient suffered and associate their death with a 'failure' in care (Khalaf et al., 2017:229).

Ranse et al. (2018:2) postulated that young professional nurses' attitude towards death and dying is influenced by the meaning associated with their first experience. The earliest exposure to caring for the dying patient and their family occurs during the undergraduate years (Grubb & Arthur, 2015:84). This first experience fills the student nurses with different emotions (Ek, Westin, Prahl, Österlind, Strang, Bergh, Henoch & Hammarlund, 2014:512). Most student nurses describe their first experience with the phenomenon as scary, especially when the dying patient was gasping during their last moment (Khalaf et al., 2017:229). Garrino et al. (2017:130) proposed how each student internalised their first experience was different, and it influenced their attitude towards death and dying as professional nurses. Student nurses who avoided their feelings after seeing a patient die or who could not express their feelings of grief after their first encounter developed negative attitudes towards the process (Tuomikoski et al., 2018:78). However, student nurses who were able to accept and show how they felt after seeing a patient die the first time were able to process and resolve their grief, developed positive attitudes towards death and dying, and understood that it is part of life's cycle (Garrino et al., 2017:130-131).

4.7.2 Attitude towards caring for the dying patient

Caring for dying people is often considered one of the most challenging aspects of the young professional nurses' responsibilities. It forces nurses to connect to themselves and become aware of their attitudes (Hawthrone & Gordon, 2020:155). According to Pehlivan et al. (2019:2), as their level of exposure to death increases, so does the nurses' awareness of their attitude towards caring for the dying patient. Friedrich and Wüstenhagen (2017:189) believe this introspection can lead to the development of either negative or positive attitudes towards caring for the dying patient.

Young professional nurses with negative attitudes towards caring for the dying patient were found by Kondo and Nagata (2015:283-284) to have equal respect for life and death. However, they were overwhelmed by uncontrolled emotions of grief and suffering, death and dying when caring for the dying patients. To protect themselves, these nurses became cold and detached. They were often emotionally fatigued due to the frequent exposure to death and were thus caring for the dying patient in a prescribed manner (Tuomikoski et al., 2018:78). Majeed, Ali and Sudak (2019:141-142) found that these nurses, to avoid burnout, created an emotional distance between themselves and the dying patient, only focusing on and managing the patient's physical needs.

Positive attitudes towards caring for the dying patient were seen among young professional nurses that took the time to stop, listen, and build an authentic relationship with their patient (Ek et al., 2014:513). These young professional nurses felt pleasure and gratification when interacting and caring for dying patients, because they felt this interaction provided therapeutic healing processes for the patient and themselves when the patient eventually dies (Garrino et al., 2017:130-131). When caring for the dying patient, these young professional nurses understood the importance of a transpersonal relationship that transcends the illness and pathology, but focuses on the spiritual dimensions (Watson, 2002:15). According to Adams (2016:2), when young professional nurses have positive attitudes towards caring for a dying patient, they are able to employ their authenticity and allow for a personal connection to uncover the dying patient's fear, hopes and wishes. Their actions promote a “good death” to be experienced by the patient and their family (Schellinger et al., 2018:160).

4.7.3 Attitude towards providing care for the dying patient's family during end-of-life care

Family is defined as a group of individuals with strong emotional ties through blood affiliations, adoption, guardianship or marriage (Kaakinen et al., 2018:5). The family unit forms a crucible that provides physical, emotional and spiritual support to dying members during end-of-life care (Kaakinen et al., 2018:5). Kübler-Ross (2014:162) found that the dying patients' families also experience the illness and impending death in a similar fashion as the dying patient. The author (Kübler-Ross, 2014:162) thus advocated for nursing care to extend to patients' families even after the patient's death. Therefore, the goal of caring for the patient's family during end-of-life care should always be to help everyone involved face the crisis together in order to achieve acceptance of this final reality simultaneously (Kübler-Ross, 1969:152).

4.8 ANALYSIS OF THE LEVEL OF WORK SUPPORT QUESTIONNAIRE

Upon completing their training, young professional nurses in South Africa qualify as general, psychiatric and community nurses and midwives, according to Regulation 425 of 22 February 1985, as amended (Nursing Act, 33/2005:2). They are mandated to work for a period of one year (SANC, 2013:76) before they can register as professional nurses. During this time, young professional nurses gain work experience while developing their nursing care skills (Department of Health, 2016:4).

This study looked at how the level of support in the workplace affected young professional nurses' attitudes when caring for the dying patient and their family. The purpose of this objective was to develop and provide recommendations for young professional nurses in these circumstances. To achieve this objective, this study used the Level of Support in the Work Environment Questionnaire to assess the level of support young professional nurses received in the workplace when caring for the dying patient and their family. The questionnaire was developed by De Kock (2011), and questions were compiled from an analysis of previous studies by Traynor and Wade (1993) and Cashavelly et al. (2008:530). This questionnaire has six response categories ranging from 1 (never) to 6 (always) (De Kock, 2011:23). The mean, median, mode, standard deviation and percentiles of respondents' scores for each questionnaire item are discussed next.

4.8.1 Descriptive statistics

The following descriptive statistics elaborate on the results of highest response rate for the Level of Support in the Work Environment Questionnaire.

4.8.1.1 Question 1: *To what degree do you receive good support and guidance from your seniors?*

Young professional nurses described their transition from university or college as daunting when confronted with the 'reality shock' of dealing with death and dying. There is often a mismatch between the expectations and reality of professional practice, and new graduates frequently require emotional support and guidance from senior professional nurses in the workplace (Lavoie-Tremblay, Sanzone, Primeau & Lavigne, 2019:66).

In this study, 27,4% (n=17) of respondents expressed how they very rarely receive support from their seniors. These results were consistent with those found in literature, claiming young professional nurses are not supported by senior professional nurses, especially when caring for the dying patient (Garrino et al., 2017:130-131). Studies have found that the lack of support from senior professional nurses was often attributed to the heavy workload, dying patients with complex care demands, and staff shortages (Ten Hoeve, Brouwer & Kunnen, 2020:836). This left senior nurses emotionally and physically exhausted and led to their diminished ability to support young professional nurses (Downing et al., 2017:4373). Watson (1988:54) believed these uncaring environments promote uncaring behaviours, which is frequently the case for unsupported young professional nurses caring for the dying patient and their family (Tuomikoski et al., 2018:78).

4.8.1.2 Question 2: *To what degree do you feel valued and respected in your job?*

Employees value and desire respect in the work environment because it makes them feel valued most in their employer (Rogers & Ashforth, 2017:1578). Rogers and Ashforth (2017:1578) found that when young professional nurses feel valued and respected in the workplace, they go above and beyond their scope of practice to provide quality end-of-life care.

In this study, 23% (n=14) of respondents felt very rarely valued and respected in their job, and this finding was consistent with literature. Kox, Groenewoud, Bakker, Bierma-Zeinstra, Runhaar, Miedema and Roelofs (2020:6) determined when senior nurses were not accepting of young professional nurses' ideas and changes in order to improve nursing care, it often made them feel disrespected and unvalued. Although nursing is always evolving to find better and safer ways of caring for patients and their families, senior nurses are often reluctant to change. According to Kodama and Fukahori (2016:209), this is likely because change involves alterations in senior nurses' attitudes and behaviours, which may be a difficult task.

4.8.1.3 Question 3: *To what degree do you feel part of a team?*

Team is defined as a group of two or more people with a common and valuable goal who interact dynamically, reciprocally, and harmoniously (Küçükakça Çelik, Taylan, Güven, Çakir, Kiliç & Akoğlu, 2019:849). Nursing teams are important in ensuring patients' positive health outcomes as they produce greater quality of care, fewer errors, and more satisfied patients. In teams, nurses deliver safe care that affects their physical and emotional well-being (Zawawi & Nasurdin, 2017:286).

In this study, 30,6% (n=19) of respondents frequently felt part of the team when caring for the dying patient and their family. These findings were inconsistent with literature claiming young professional nurses seldom feel part of the team due to the lack of support they receive from their peers (McKelvy, 2018:41). A study by Kox et al. (2020:6) reported that a lack of support from senior nurses made young professional nurses' feel like they did not belong. Ten Hoeve et al. (2020:836-837) found this contributed to the young professional nurses' intention to leave the profession.

4.8.1.4 Question 4: *To what degree do you feel a good relationship with your patients will benefit a supportive work environment?*

Humanism and caring are the core and the starting point of nursing. Humanistic nursing is a mutually subjective interaction between nurse and patient; it is a response to the situation aimed at facilitating recovery (Zamaniniya, Khademi, Toulabi & Zarea, 2021:114). This interaction is influenced by the work environment and the dynamics within the workplace (Lu, Zhang, Wang, Xu & Yan, 2021:3204).

In this study, 41,9% (n=26) of respondents felt having a good relationship with a patient always benefits a supportive work environment. Literature agrees that good relationships with patients are an essential indicator of good work environments (Molina-Mula & Gallo-Estrada, 2020:835). Watson (1988:54) believes this is because a caring environment emulates caring behaviours. These caring moments between the young professional nurse and the dying patient allow them to recognise their personal value while developing their professional abilities and improving their work satisfaction (Zamaniniya et al., 2021:114).

4.8.1.5 Question 5: *To what degree do you feel open communication with co-workers will benefit a supportive work environment?*

Communication and teamwork are the backbones of nursing and help safeguard patients' safety (Amudha, Hamidah, Annamma & Ananth, 2018:1). Good teamwork is vital when providing end-of-life care because patient outcomes are highly dependent on the quality of communication during their interaction with nurses (Azizan, Arifin, Shahidan & Othman, 2021:551).

In this study, 59,7% (n=37) of respondents felt that open communication with co-workers always benefited a supportive work environment. These results were consistent with literature regarding the benefits of open communication in a supportive work environment. According to Vermeir, Degroote, Vandijck, Mariman, Deveugele, Peleman, Verhaeghe, Cambré and Vogelaers (2017:4), interprofessional teamwork is achieved by the interactive efforts of all team members in terms of good communication and respect for each team member's role. Yanchus et al. (2017:314) agree that open communication made young professional nurses feel valued, translating into improved performance.

4.8.1.6 Question 6: *To what degree do you feel that regular debriefing groups will benefit a supportive work environment?*

Debriefing is defined as a critical, systematic review of an event after it has occurred through questioning and reflection (Merriam Webster Dictionary, 2020:1850). Debriefing provides young professional nurses with an opportunity to decipher distressing experiences into meaningful learning experiences, where they can learn from one another and other staff in a clinical setting (Smith-Han et al., 2016:1).

In this study, 45,2% (n=28) of respondents believed that regular debriefing groups would always promote a supportive work environment when caring for the dying patient and their family. These findings were consistent with what was found in literature. Debriefing is an essential supportive strategy that allows young professional nurses to explore, reflect and synthesise their thinking processes and emotional status when confronted with caring for the dying patient and their family (Coutinho, Martins & Pereira, 2016:127). According to Knott (2021:13), debriefing normalises the sharing of emotions, improves the communication gap, and increases peer support among young professional nurses caring for the dying patient and their family.

4.8.1.7 Question 7: *To what degree do you experience your workplace as supportive?*

Nurses are directly in contact with death and dying. Their frequent exposure to this phenomenon as part of their work routine over a long period may create pressure in the work environment, which plays a significant role in the nurses' attitude towards caring for the dying patient and their family (Ay & Öz, 2019:1442). Evidence suggests that without adequate support in the workplace, this exposure may result in young professional nurses' physical and emotional distress and the development of dysfunctional coping mechanisms (Agarwal, Brooks & Greenberg, 2020:58).

In this study, 25,8% (n=16) of respondents felt they rarely experienced support in the workplace. These results were consistent with literature. A supportive work environment is essential for young professional nurses when they are exposed to caring for the dying patient and their family. It enables them to feel comfortable sharing their experiences and asking for help when they feel overwhelmed by the situation (Kox et al., 2020:7). However, when young professional nurses are not supported in the workplace, the high levels of exposure to death may negatively influence their attitudes and behaviours toward the dying patient and their family, thus creating obstacles in striving to provide quality care for those living in the face of death (Ay & Öz, 2018:2). Kox et al. (2020:7) also found that not being supported in the workplace, especially when dealing with death and dying, was a major contributor to young professional nurses leaving the profession.

4.8.1.8 Question 8: *To what degree do you take emotional burden home at the end of the shift?*

Caring for dying patients at the end of their life is described as emotionally taxing and often leaves young professional nurses feeling emotionally burnt out (Lief, Berlin, Maciejewski, Westman, Su, Cooper, Ouyang, Epping, Derry, Russell, Gentzler, Maciejewski & Prigerson, 2018:1459). Tahghighi, Rees, Brown, Breen and Hegney (2017:2065) stated the chronic workplace stress might result in some young professional nurses developing psychological syndromes and disorders such as depression, anxiety, anger and irritability, which potentially permeate into their personal life.

In this study, 22,6% (n=14) of respondents felt they 'rarely' took an emotional burden home after each shift. These results were consistent with reports in literature regarding young professional nurses' ability not to take their emotional burden home. Ek et al. (2014:512) found this was possible for young professional nurses who had an authentic transpersonal caring relationship with the dying patient. Therefore, the mutual interaction brought healing for the young professional nurses instead of an emotional burden. According to Stuart et al. (2019:678), these young professional nurses were able to find peace when the patient passed away as they had done everything following the patient's wishes to ensure they and their family had a "good death".

4.9 SUMMARY OF FINDINGS OF THE DESCRIPTIVE STATISTICS FROM THE LEVEL OF WORK SUPPORT QUESTIONNAIRE

Young professional nurses spend up to one-third of their waking lives at work, so the level of support in the workplace is an important facet to assess. Research has also shown that various factors affect nurses' work environment when caring for the dying patient and their family (Oshodi, 2016:4). Oshodi, Bruneau, Crockett, Kinchington, Nayar and West (2019:879) found that the level of support young professional nurses receives in the workplace influence the quality of nursing care provided. The mind map below was adapted from Oshodi et al. (2019:882) to illustrate this concept:

Figure 4.9: Nurses' work environment and quality, adapted from Oshodi et al. (2019:882)

The findings from this study concur that the level of support in the work environment affects the care provided to the dying patient and their family. Table 4.12 shows the means and standard deviations from the Level of Support in the Work Environment Questionnaire.

Table 4.12: The means and standard deviations from the Level of Support in the Work Environment Questionnaire

QUESTION	MEAN	STANDARD DEVIATION
To what degree do you receive good support and guidance from your seniors?	3.4	1.584
To what degree do you feel valued and respected in your job?	3.16	1.529
To what degree do you feel part of a team?	4.39	1.323
To what degree do you feel a good relationship with your patients will benefit a supportive work environment?	5.00	1.056
To what degree do you feel open communication with co-workers will benefit a supportive work environment?	5.23	1.122
To what degree do you feel that regular debriefing groups will benefit a supportive work environment?	4.48	1.753
To what degree do you experience your workplace as supportive?	3.23	1.593
To what degree do you take the emotional burden home at the end of the shift?	3.60	1.741

4.10 INFERENTIAL STATISTICS

The Level of Support in the Work Environment Questionnaire was subjected to PCA and PAF using SPSS version 2.0. Prior to performing PCA and PAF, the data's suitability for the factor analysis was assessed. On inspection of the correlation matrices, several correlations greater than r=0.675 were found.

The KMO value was 0.763 for this questionnaire. The *p* score for Bartlett's test was 0.00, as shown in Table 4.13. These findings from the visual inspection of the correlation matrices, reflect the KMO test and Bartlett's test of sphericity strongly confirm the data's appropriateness for factor analysis.

Table 4.13: The KMO and Bartlett's test scores for the Level of Support in the Work Environment Questionnaire

TEST	STATISTIC	SCORE
		Level of work support questionnaire
Kaiser-Meyer-Olkin (KMO)	KMO	0.763
Bartlett's test of sphericity	Approx. Chi-Square	96.422
	df	10
	p	0.000

Using PCA, a total of five factors in the Level of Support in the Work Environment Questionnaire were identified. Of these, only one had Eigenvalue scores greater than 1. The one retained factor in the questionnaire explained a total variance of 54,619%. Using PAF, the number of factors with an Eigenvalue of 1 and above was one. The choice of model was PAF for the Level of Support in the Work Environment Questionnaire. Table 4.14 present the extracted factor.

Table 4.14: The level of work support extracted by Kaiser's criterion (PAF)

FACTOR	EIGENVALUE		
	TOTAL	% OF VARIANCE	% OF CUMULATIVE VARIANCE
1	2.731	54.619	54.619

The Kaiser's criterion was complimented with Catell's scree test. Using this test, Eigenvalues were plotted and inspected for a point where the shape of the curve changed direction and became horizontal. It is recommended to retain all factors above the break in the plot as these explain most of the variance in the dataset (Pallant, 2013:191). On inspection of the scree plot, a vertical-horizontal break was visible at component 2 in the PAF (level of support in the workplace). This suggested the possibility of having a one-factor solution that cannot be rotated. Figure 4.10 illustrate these observations.

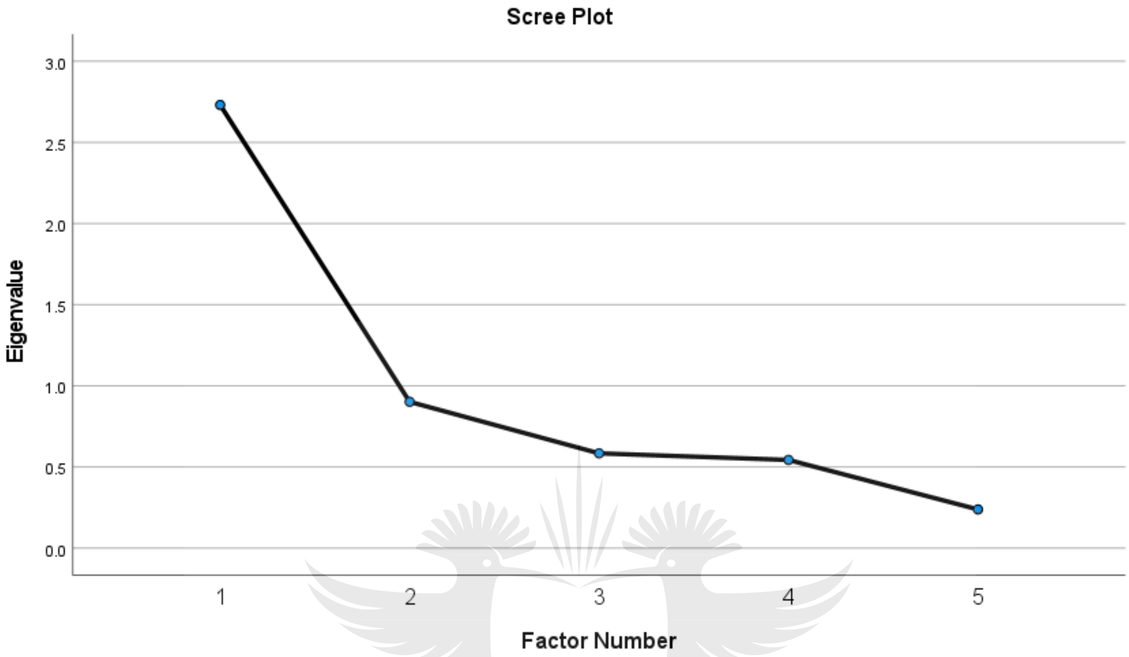


Figure 4.10: Scree plot for level of support in the workplace

4.10.1 The level of support in the workplace: Factor 1

Factor 1 comprised five questions. Only four items loaded positively, well above 0,788. According to Pallant (2013:206), loadings of 0,3 and higher indicate that the items fit well with each other. The lowest loading item was for question 5 *(to what degree do you feel open communication with co-workers will benefit a supportive work environment?),* with a loading coefficient of 0,334. Question 2 (*to what degree do you feel valued and respected in your job?)* loaded the highest coefficient of 0,860. Table 4.15 shows these results.

Table 4.15: The loading coefficient scores for Factor 1 of the Level of Support in the Work Environment Questionnaire

ITEM NUMBER	ITEM DESCRIPTION	ITEM LOADING
2	To what degree do you feel valued and respected in your job?	0.860
1	To what degree do you receive good support and guidance from your seniors?	0.813
3	To what degree do you feel part of a team?	0.627
7	To what degree do you experience your workplace as supportive?	0.613
5	To what degree do you feel open communication with co-workers will benefit a supportive work environment?	0.334

The five items on the Level of Support in the Work Environment Questionnaire were divided into two concepts: being part of a team and the effects of the nursing environment.

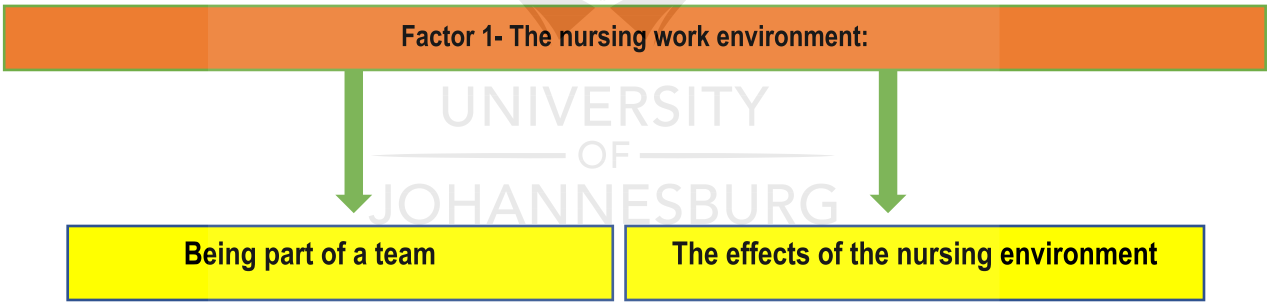


Figure 4.11: Factor 1: The nursing work environment

4.10.2 Being part of a team

Teamwork is essential in delivering high-quality care and is central to nursing (Anderson, Ross, Lim, Kodate, Thompson, Jensen & Cooney, 2019:119). Oshodi et al. (2019:878) identified being part of a nursing team as an essential aspect in the workplace; it influenced young professional nurses' attitudes and behaviours towards caring for the dying patient and their family.

According to Küçükakça Çelik et al. (2019:849), being part of an effective team can help young professional nurses achieve the goal of providing safe, efficient, and quality end-of-life care to dying patients and their family. Watson (1988:54) believed when young professional nurses are part of an effective team, they feel supported and cared for, which is often reflected in their caring attitude and behaviour. The interpersonal relationship among co-workers cultivates a culture that assists in immediate hands-on assistance in handling difficult situations; provides emotional support and advice that fosters resilience; and promotes young professional nurses' positive attitude towards caring for the dying patient and their family (Wang, Hong, Bowers, Brown & Zhang, 2018:658).

However, Kox et al. (2020:6) reported that young professional nurses who felt they were not part of the team had a feeling of a lack of belonging. Kox et al. (2020:6) associated the theme "lack of a feeling of belonging" with young professional nurses feeling useless when caring for the dying patient and their family. These young professional nurses were hesitant and scared of being judged as "too soft for the profession", so they often avoided sharing their feelings in these contexts. This left them feeling isolated and alone (Ten Hoeve et al., 2020:837), resulting in negative attitudes such as insensitivity, apathy and aloofness when caring for the dying patient and their family (Garrino et al., 2017:132).

4.10.3 The effects of the nursing environment

Over the last two decades, the nursing environment has been at the centre of attention in healthcare organisations globally (Mihdawi, Al-Amer, Darwish, Randall & Afaneh, 2020:384). The nursing work environment is an important factor when assessing young professional nurses' attitudes towards caring for the dying patient and their family, as it affects the quality of care they provide (Mihdawi et al., 2020:384).

According to Rivaz, Momennasab, Yektatalab and Ebadi (2017:1), evidence indicates a strong link between the elements of the nursing practice environment and the quality of care provided at the end of life. The ICN emphasises that work environments that are positive and supportive promote the development of positive attitudes (Kundu & Lata, 2017:1). In these contexts, young professional nurses were encouraged to be empathetic, compassionate and resilient when caring for the dying patient and their family (Kudu & Lata, 2017:5).

However, in unsupportive work environments, young professional nurses were overwhelmed with their own death anxiety, resulting in maladaptive coping mechanisms (Draper, 2019:272). These young professional nurses developed a negative attitude towards caring for the dying patient and their family (McKenzie & Brown, 2017:30) as they were emotional and physical exhausted with a diminished ability to empathise or feel compassion for others (Nolte et al., 2017:4373).

4.11 CORRELATION

Correlation is the measurement used to identify the extent to which the values of two variables or factors are related or change in an identifiable pattern. The correlation coefficient ranges from −1.0 (the values for two factors change in opposite directions) to +1.0 (the values for two factors change in the same direction). It is used to identify a pattern in terms of the direction and strength of a relationship between two factors (Leavy, 2016:101). The strength of a relationship between two factors is described by the value of the correlation coefficient (r), with values closer to r = ±1.0, indicating a stronger relationship between two factors (Leavy, 2016:101).

4.11.1 Influence of demographic characteristics on attitude towards caring for the dying patient and their family

4.11.1.1 The relationship between age and attitude towards caring for the dying patient their family

The relationship between respondents' age and attitude was investigated using Pearson's product-moment correlation coefficient. The correlations between age and attitude towards caring were r= -.087, p <.05, 2-tailed, n=62. However, there was a strong correlation between age and death anxiety: r=. 282, <.05, 2-tailed, as shown in Table 4.16.

Table 4.16: Age versus attitude towards caring for the dying patient and their family

Age	Attitude towards caring for the dying patient	Death anxiety
Pearson Correlation	-.087	.282*
Sig (2-tailed)	.501	.026
n	62	62

These results suggest that although there was no correlation between respondents' age and attitude towards caring for the dying patient, there was a strong correlation between age and death anxiety. This suggests that age does not influence young professional nurses' attitude towards caring for the dying patient and their family, but their anxiety regarding death and dying influences their attitude towards this task. Older respondents reported higher levels of death anxiety. These findings were in line with the results of other studies conducted during the COVID-19 pandemic that found the level of death anxiety increased as the young professional nurses got older (Li, Ge, Yang, Feng, Qiao, Jiang, Bi, Zhan, Xu, Wang, Zhou, Zhou, Pan, Lui, Pan, Lui, Zhang, Yang, Zhu, Hu, Hashimoto, Jia, Wang, Wang, Lui & Yang, 2020:917-918; Nobahar et al., 2021:4; Pehlivan et al., 2020:131-132). According to Sreberny (2021:889), the heightened level of anxiety amongst older young professional nurses was caused by the misconception that COVID-19 only affected and killed older people. This made the older young professional nurses conscious of their own vulnerability to death and dying (Draper et al., 2019:267).

4.11.1.2 The relationship between years of experience and attitude towards caring for the dying patient and their family

The relationship between respondents' years of experience and attitude was investigated using Pearson's product-moment correlation coefficient. This analysis was conducted in order to test the following hypotheses:

H_1: *Positive attitudes towards caring for the dying patient and their family are prevalent among more experienced young professional nurses.*

H_0: *Positive attitudes towards caring for the dying patient and their family are not related to years of experience.*

The correlations between years of experience and attitude were r= -.103, p<.05, n=62, as shown in Table 4.17.

Table 4.17: Years of experience versus attitude towards caring for the dying patient and their family

Years of experience	Attitude towards caring for the dying patient
Pearson Correlation	-.0103
Sig (2-tailed)	.425
n	62

These results suggest there was no correlation between respondents' years of experience and attitude towards caring for the dying patient and their family. This means that years of work experience does not impact the young professional nurses' attitude towards caring for the dying patient and their family. These findings were contrary to literature, which found that although longer clinical experience can help consolidate clinical knowledge, it might not automatically guarantee positive attitudes towards caring (Dimoula et al., 2019:12). However, most studies reported a positive correlation between attitude toward caring for the dying patient and nurses' years of clinical experience (Faronbi et al., 2021:6; Ingebretsen & Sagbakken, 2016:31170; Fathi & Simamora, 2019:1; Wittkowsk, 2016:316). According to Faronbi et al. (2021:6), more experienced young professional nurses had learnt the art of establishing better relationships and communicating with terminally ill patients, potentially serving as an impetus for better coping with the requisite emotional demands of interacting with death and dying. Ingebretsen and Sagbakken (2016:31170) also found more experienced young professional nurses were more likely to sustain a positive perspective about death and dying.

4.11.1.3 The relationship between estimated number of dying patients cared for in the last six months and attitude towards caring for the dying patient and their family

The relationship between the estimated number of dying patients respondents cared for in the last six months and attitude towards caring for the dying patient and their family was investigated using Pearson's product-moment correlation coefficient. This analysis was conducted in order to test the following hypotheses:

H_1: *The more frequently young professional nurses are in contact in caring for the dying patient and their family, the more positive their attitude.*

H_0: *There is no relationship between the attitude and the frequency the young professional nurse is in contact with the dying patient and their family.*

The correlations between the estimated number of patients cared for in the last six months were r=.035, p >.05, n=62, as shown in Table 4.18.

Table 4.18: Estimated number of dying patients cared for in the last six months versus attitude towards caring for the dying patient and their family

Estimated number of dying patients cared for in the last six months	Attitude towards caring for the dying patient
Pearson Correlation	.035
Sig (2-tailed)	.789
n	62

These results suggest there was no statistical relationship between the young professional nurses' attitude towards caring for dying patients and their families and the estimated number of dying patients cared for in the last six months. Although the results from this study show no correlation between these two factors, various studies found high levels of exposure to death and dying negatively impact young professional nurses' attitudes and behaviours toward caring for the dying patient and their family (Faronbi et al., 2021:6; Ay & Öz, 2018:2; Nolte et al., 2017:4365). According to Orrù, Marzetti, Conversano, Vagheggini, Miccoli, Ciacchini, Panait and Gemignani

(2021:337), most young professional nurses consider caring for dying patients a very stressful part of the profession. This high level of distress frequently caused post-traumatic stress, depressive symptoms and, in some cases, even professional burnout. These adverse reactions potentially lead to negative attitudes towards caring for the dying patient and their family.

4.11.2 The relationship between death anxiety and attitude towards caring for the dying patient and their family

The relationship between respondents' death anxiety and attitude towards caring for the dying patient and their family was investigated using Pearson's product-moment correlation coefficient. The correlations between death anxiety and attitude towards caring for the dying patient were r= -.404**, p <.01, 2-tailed, n=62. These findings are shown in the table below.

Table 4.19: Influence of death anxiety on attitude towards caring for the dying patient and their family

Death anxiety	Attitude towards caring for the dying patient
Pearson Correlation	-.404
Sig (2-tailed)	.001
N	62

The results suggest there was a negative correlation between death anxiety and attitude towards caring for dying patients and their families. This means if the young professional nurse had high scores on Templer's DAS, they scored low on the FATCOD scale. These findings were reflected in various studies that determined young professional nurses with high levels of death anxiety had negative attitudes towards caring for the dying patient and their family. Thus, young professional nurses with low levels of death anxiety had positive attitudes towards caring for the dying patient and their family (Pehlivan et al., 2020:128; Draper, 2019:272; Kondo & Nagata, 2015:279). Pehlivan et al. (2020:129) also found that nurses' attitudes towards caring for the dying patient was often influenced by their personal perceptions of death and dying. Differently stated, young professional nurses who embraced death and dying as a part of life's journey had positive attitudes towards caring for the dying patient. Conversely, young professional nurses who were fearful of death and dying illustrated negative attitudes towards caring for the dying patient and their family (Seo, 2021:1; Garrino et al., 2017:132). The researcher then concluded that there was a correlation between death anxiety and attitudes towards caring for the dying patient and their family.

4.11.3 The relationship between education on death and dying and the young professional nurses' attitude towards caring for the dying patient and their family

The relationship between the different types of education on death and dying and its effect on attitude towards caring for dying patients and their families was investigated using a comparative analysis. An independent sample t-test was used to compare the relationship between different end-of-life education experiences and its effect on the FATCOD score. The independent sample t-test is a parametric procedure for testing differences in independent group means (Polit & Beck, 2012:413). These tests were conducted to test the following hypotheses:

H_1: *Education on death and dying positively affects the attitudes of young professional nurses towards caring for the dying patient*

H_0: *There is no relationship between education on death and dying and young professional nurses' attitude towards caring for the dying patient and their family*

Results showed no significant difference in scores between the different types of end-of-life education and its effect on the attitudes towards caring for the dying patient. The results for the independent sample t-tests can be seen in Table 4.20.

Table 4.20: Independent sample t-test for different types of end-of-life education and their effect on attitudes towards caring for the dying patient and their family

	Yes			No		
	N	Mean	SD	N	Mean	SD
I took a course in death and dying as part of my basic nursing education	54	109,98	12,69	8	108,75	14,31
I received in-service training in the hospital, on death and dying	5	122,60	14,96	57	108,70	12,09
No information dealing with death and dying was included in my basic nursing education	16	107,31	13,62	46	110,69	12,52
I feel that nursing education prepared me adequately to deal with death and dying	27	109,74	15,24	35	109,88	10,76
I feel that nursing education did not prepare me adequately to deal with death and dying	18	109,11	13,38	44	110,11	12,68
I feel that in-service training in the hospital prepared me adequately to deal with death and dying	9	112,55	16,91	53	109,35	12,09

These results concur with literature that once off end-of-life education results in short-lived success, as the skills learnt fade over time and have no effect on attitudes towards caring for the dying patient and their family (Cox et al., 2018:21). Wallace et al. (2019:55) found that regular end-of-life education, whether it is formal or informal, changes the nurses' beliefs about death and dying; increases knowledge about ethical dilemmas in caring for dying patient and their family; enhances personal, professional, and interpersonal learning with regards to end-of-life care and increases competence and confidence in interdisciplinary practice during end-of-life care. This helps in improving the nurse's confidence and attitudes towards caring for the dying patient and their family (Dimoula et al., 2019:7). The researcher thus concluded that young professional nurses' attitudes towards caring for the dying patients is not significantly affected by any end-of-life education that is consistent.

4.11.4 The relationship between support in the work environment and attitude towards caring for the dying patient and their family

The relationship between the nature of support in the work environment and respondents' attitude towards caring for dying patients and their families was investigated using Pearson's product-moment correlation coefficient. The correlations between the nature of support in the work environment and attitude towards caring for the dying patient and their family were r= .121, p<.05, n=62. These findings are shown in the table below.

Table 4.21: The nature of support in the work environment versus attitude towards caring for the dying patient and their family

The nature of support in the work environment	Attitude towards caring for the dying patient and their family
Pearson Correlation	.121
Sig (2-tailed)	.351
N	62

These results suggest there was no statistical relationship between the nature of support in the work environment and the young professional nurses' attitude towards caring for the dying patient and their family. These findings were contrary to what was reported various studies exploring the influence a supportive work environment has on young professional nurses' attitudes towards caring for the dying patient and their family (Alshehri, Olausson, Öhlén & Wolf, 2020:13-15; Ay & Öz, 2018:2; Nolte et al., 2017:4373). Gilster, Boltz and Dalessandro (2018:S106-S107) claim a supportive work environment encourages young professional nurses to share their emotions, which helps them cope with the emotional distress caring for the dying patient may trigger. The researcher then concluded there was no correlation between the nature of support in the work environment and the young professional nurses' attitude towards caring for dying patients and their families.

4.12 PHASE 2: QUALITATIVE PHASE

This section provides a detailed presentation of the research findings on young professional nurses' attitude towards caring for dying patients and their families as narrated by the participants themselves. Six participants were selected using a purposive sampling method (Gray et al., 2017:345). Three of these participants had high scores on the FATCOD scale, and three participants had low scores on the FATCOD scale and consented to a follow-up focus group. Table 4.21 shows the demographic data of the outliers.

Table 4.22: Outliers' demographic data

Outlier	Age	Gender	Years of experience	FATCOD score	Estimated number of patients cared for in the last six months	Previous education on death and dying: I took a course in death and dying as part of my basic nursing education	Previous education on death and dying: I received in-service training in the hospital on death and dying	Previous education on death and dying: No information dealing with death and dying was included in my basic nursing education	I feel that nursing education prepared me adequately to deal with death and dying	I feel that previous education did not adequately prepare me to deal with death and dying
Participant 24	30	Female	4 years	116	15	Yes	No	No	No	No
Participant 42	36	Female	1 year	88	20	Yes	No	No	Yes	No
Participant 52	30	Female	5 years	86	40	Yes	No	Yes	Yes	No
Participant 19	35	Male	5 years	116	50	Yes	No	Yes	Yes	No
Participant 11	30	Female	2 years	103	8	Yes	No	No	No	No
Participant 25	29	Female	5 years	118	40	Yes	No	Yes	Yes	No

4.12.1 Presentation of findings

The final descriptions of the young professional nurses' experience caring for dying patients and their families was organised into themes, subthemes, and categories. Two themes and sub-themes were identified through a data analysis process that used Giorgi's phenomenological qualitative data analysis method (Giorgi, 2009). The stages of the data analysis, according to Giorgi, are: (1) assuming a phenomenological attitude; (2) reading the interview to attain a sense of the whole; (3) determining the primary meaning units; (4) transforming meaning units to psychological statements; and (5) synthesising the psychological general or essential structure of experience based on constituents. A literature control was used to integrate the findings with existing literature. Due to the limited available literature regarding young professional nurses' attitudes towards caring for the dying patient in South Africa, international and national literature of related health professions and other associated literature were used to discuss and critique the findings.

4.12.1.1 Theme 1: Being transformed by the experience

Theme 1:
Being transformed by the experience

Sub-theme 1.1:
Appraising the first experience to construct a meaning

Sub-theme 1.2:
Influence of the first experience on current attitude towards caring for the dying patient

Death is a natural and unavoidable occurrence, which is a difficult and grim topic for every individual, especially young professional nurses who must deal with such incidences daily in their line of work. Death and dying may cause intense emotions that are memorable, powerful, inspiring, and transformative (Ho, Kow, Chia, Low, Lai, Lauw, How, Tan, Ngiam, Chan, Kuek, Kamal, Chia, Abdurrahman, Chiam, Ong, Chin, Toh, Mason & Krishna, 2020:7).

a) Sub-theme: Appraising the first experience to construct a meaning

According to Hornby (2015:60), to appraise a situation means a person is able to form an opinion of a situation's nature and significance. Appraisals are typically related to encounters considered to affect an individual's emotional experience (Vanderspank-Wrigh, Efstathiou & Vandyk, 2017:5). Participants were asked to use one word to describe their first experience caring for a dying patient. The participants' narratives regarding their first experience with death and dying patients showed they appraised their first experiences as follows:

> *"uhm the first word that came to mind was shock. I was shocked and cause it is the first experience it is the first time"* - Participant 25

> *"Uhm you feel kind of good that you know are the last person that the patient sees or talks to or whatever. You are the last person to take care of this person before they pass on"* - Participant 19

> *"it was a very traumatic experience cause number one you keep blaming yourself, like you wish you could have done more*" - Participant 11

These reflections demonstrated that not all participants appraised their experiences in the same manner. These positive and negative affective descriptions of their first encounter when caring for a dying patient shows contrasting emotions and feelings. According to Thompson, Allan, Carverhill, Cox, Davies, Doka, Granek, Harris, Ho, Klass, Small and Wittkowski (2016:173), emotional differences to stimuli involve a thought process formed by experiences and triggered within a given social context.

b) Sub-theme: Influence of the first experience on current attitude towards caring for the dying patient

The participants then reflected on how their first experience has influenced their current attitude towards caring for the dying patient, as demonstrated in the following quotes:

> *"I still shy away from the dying patient and deliberately if allocation is done you know, I try by all means not to be allocated. But if I have to face it, like worst-case scenario, I have to face it… I think It is very draining"* - Participant 24

> *"its was more of me using empathy more then sympathy. So like that's how I could be hurt and what not. But for now arg every since then now my with experience, as much as it is painful. I have stopped using empathy*" - Participant 52

These reflections demonstrate that not all the participants' first encounters caring for the dying patient resulted in the same attitudes towards caring for the dying patient and their family. This reflected the notion that not every individual will experience a similar situation in the same manner (Biggs, Brough & Drummond, 2017:351). These differences were likely based on how each participant internalised their experience. While some participants had developed negative attitudes towards caring for the dying patient and their family, others used their experience to develop positive attitudes to performing this role.

> *"So that was my takeaway is to always learn and just use it as a tool to be a better nurse"* - Participant 42

This participant found the first encounter with death and dying gave them opportunities to gain professional skills and knowledge to handle these incidents effectively in the future. This is based on the coping mechanism they developed after the first experience, which influenced their attitude towards caring for the dying patient and their family (Ranse et al., 2018:2). Hence, they did not feel defeated by the experience but used it to develop their understanding and skills when caring for the dying patient and their family (Astin et al., 2015:191). Being able to enjoy a sense of achievement through developing and learning to confidently and comfortably handle encounters with death and dying patients led to more positive appraisals of an experience and elicited a positive attitude (Zheng, Lee & Bloomer, 2016:327).

4.12.1.2 Theme 2: The impact of the work environment on the young professional nurses experience with death and dying

Theme 2:
The impact of the work environment on the young professional nurses experience with death and dying

Sub-theme 1.1:
Factors attached to the negative experiences when caring for the dying patient and their family

Sub-theme 1.2:
Factors that would facilitate the process of perceiving the experiences as positive

The participants shared their experiences and continuously alluded to specific factors that influenced how they perceived their experiences with death and dying patients. These factors related to the participants themselves and workplace circumstances surrounding their experience. The factors were categorised into three distinct groups: factors that were inconsequential to how the participants perceived the experience; factors that mitigated negative perceptions about the experience; and factors that intensified the negative perceptions surrounding the experience. These factors were closely associated with the meaning attached and responses elicited during participants' encounters with death and dying patients.

a) Sub-theme: Factors attached to the negative experiences when caring for the dying patient

The participants shared how the work environment influenced how they were able to cope with the death of a patient. Most participants expressed there was no time to process the death of the patient:

> *"It so busy guys, there is no time to say today we are going to be busy with Mr Whatwhat who died, people die every day and we are expected to just go on"* - Participant 24
>
> *"Once one patient is out in ICU, we already know that there is patient waiting for that bed"* - Participant 25

The participants felt the constant need to move on to the next patient to get through their workload with little to no time to reflect and process these events. According to Davies (2016:i5597), failure to process such experiences increases the risk of young professional nurses feeling compassion fatigue, which diminishes their ability to comfort others.

> *"I have gotten numb to the feeling. Like the way it just happens every time, its gotten to a point of I don't feel anymore. Its just a matter of getting the job done at that time, its its (arg) I feel numb towards it*" - Participant 25

> *"I do not have the ability to comfort people when it comes to death, you know dying. I cannot."* - Participant 19

This led to young professional nurses caring for the dying patient in a prescribed manner, hiding their true emotions in the name of being professional when they faced death and dying patients.

> *"I am a professional and have a very specific conduct on how I conduct myself…I am very cautious on how I speak and how I conduct myself and how I process information across, how my tone is. So I always keep my professional attire on at all cost"* - Participant 24

This young professional nurse practiced emotional dissonance in order to suppress their true feelings and conform with what is acceptable behaviour when caring for the dying patient and their family. This results in caring for the dying patient as a performance of professionalism instead of sincerity (Cunningham & Ducar, 2019:469). According to Davies (2016:5), this is often a result of grief left unattended, which may cause burnout.

b) Sub-theme: Factors that would facilitate the process of perceiving the experience as positive

Participants recounted several factors that could facilitate more positive perceptions about their experiences with death and dying patients. The participants believed these would lead to more positive appraisals of their experiences, promoting their increased positive attitudes towards caring for the dying patient and their family.

> *"senior sisters we just need to give the younger people a bit of support"* - Participant 19

This support was identified as encouraging compassion. According to Sharma et al. (2016:7), when senior nurses support young professional nurses, it creates an environment where caring is observed, felt, and thus learnt. Watson (1988:54) believes this encourages positive and caring attitudes towards caring for the dying patient and their family.

> *"it's very important and essential for us to have debriefing"* - Participant 42

> *"Debriefing is very important ukuthi for us to heal and carry on"* - Participant 25

Post-event debriefing was also identified by most of the participants as something that could assist them in developing coping mechanisms that would positively impact their attitudes towards caring for the dying patient and their family. Post-event debriefing following a patient's death is a strategy used among nurses to assist them in normalising the situation so that everyone knows that feeling pain, frustration, and sorrow in the face of stressful, sometimes overwhelming situations, is acceptable (Davidson, Accardi, Sanchez & Zisook, 2020:17). Debriefing is described by Keene et al. (2010:189) as an effective form of workplace support for healthcare professionals. It enables them to process their grief following the loss of a patient and assists young professional nurses to develop positive attitudes towards caring for the dying patient and their family.

4.13 PHASE 3: INTERGRATION OF QUANITATIVE AND QUALITATIVE RESULTS

The final stage of data analysis in mixed-method research is the integration of quantitative and qualitative results (Creswell, 2013:13). According to Shorten and

Smith (2017:74), the integration of data helps researchers seek for a more panoramic view of research. It allows the researcher to view a phenomenon from different perspectives and through diverse research lenses (Harrison et al., 2020:3). The integration of data can occur at four possible points during the research process: interpretation, data analysis, data collection, and design (Creswell, 2003:66). In this study, the integration of results occurred at the interpretation point, which allowed the researcher to present a broadened and deepened understanding of young professional nurses' attitudes towards caring for dying patients and their families.

Data gathered from the quantitative phase revealed that 74% (n=46) of the respondents had positive attitudes towards caring for dying patients and their families as they viewed death as a worthwhile learning experience (45.2%; M=3.92; SD=1.045). These positive attitudes were seen in the young professional nurses not being afraid of forming a relationship with the dying patient (33.9%; M=2.27; SD=1.074); their eagerness to be assigned to caring for a dying patient (33.9%; M=2,21; SD=1.295); their commitment to not withdrawing their involvement when they see the patient is nearing the end (54.8%; M=1.61; SD=0.797); and being present when the patient actually dies (50.0%; M=1.94; SD=1.253). This may have been due to their belief that, at times, death is welcomed by the dying patient (43.5%; M=3.81; SD=1.14).

The young professional nurses in this study had positive attitudes towards caring for the family and believed in the importance of extending nursing care to the family (45.2%; M=4.21; SD=0.871) who may need emotional support as they accept the behavioural changes from the dying patient (61.3%; M=4.47; SD=0.844). This support should continue throughout the period of grief and bereavement (43.5%; M=4.16; SD=0.909). These young professional nurses expressed the importance of involving the dying patient and their family in decision-making (40.3%; M=3.90; SD=1.155) and involving the family in the physical care of the patient (41.9%; M=4.03; SD=1.101). Although they sometimes felt the family of the dying patient might interfere with their professional job (40.3%; M=3.48; SD=1.211), they embraced the idea of being flexible with the visiting times in the hospital (50%; M=4.26; SD=0.922), expressing the importance of giving the families a chance to have their final moments with their loved one.

During the qualitative phase, participants were asked to describe their lived experience caring for dying patients and their families. Their descriptions highlighted how their first experience shaped their current attitude towards caring for the dying patient and their families. Participants also recalled how their workplace influenced their experience when caring for the dying patient, although there was no correlation between the work environment and the young professional nurses' attitudes towards caring for dying patients and their families. However, they highlighted aspects that could help in developing a more positive perspective towards death and the dying experience. Therefore, the integrated findings suggested that young professional nurses have a positive attitude towards caring for dying patients and their families.

4.14 SUMMARY OF THE FINDINGS

This chapter gave a detailed presentation of the study's findings regarding young professional nurses' attitudes towards caring for the dying patient and their family. Quantitative results were discussed in terms of descriptive, factor analysis and correlations. Qualitative findings were presented through identified themes. It concluded with the integrated finding from the study. Chapter 5 evaluates this study based on its objectives. Recognised limitations are highlighted, suggested recommendations are put forward, the researcher's reflective journey is described, and conclusions are drawn.

CHAPTER 5

EVALUATION OF THE STUDY, LIMITATIONS, RECOMMENDATIONS, CONCLUSIONS AND REFLECTION ON THE JOURNEY

5.1 INTRODUCTION

The purpose of this study was to explore and describe young professional nurses' attitudes towards caring for t dying patients and their families at a secondary academic hospital in Gauteng, to formulate recommendations for professional nurses when caring for the dying patient and their family. In this chapter, an evaluation of the study, limitations of the study, and recommendations for nursing practice are discussed. The chapter concludes with a summary of the conclusions of the study and the researcher's personal reflections.

5.2 EVALUATING THE STUDY

This study was conducted to fulfil the requirements for a master's degree in Nursing Science in Professional Nursing Science and Ethos (RD). In conducting the study, the researcher acquired knowledge and skills in the practice of nursing research, particularly in the area of end-of-life care.

Dying is an important facet of life that is often neglected in nursing and medicine, as it contradicts the values of life preservation (Khalaf et al., 2017:229). It was considered taboo in some settings yet has been exacerbated by the impact of the COVID-19 pandemic, which is associated with high mortality and morbidity rates. This has resulted in reframing nursing approaches and attitudes toward death and dying (Bellamy, Clark & Anstey, 2020:3).

Nurses have the greatest contact with those at the end of their life and their attitudes in caring for the dying are important in the type of care conveyed (Grubb & Arthur, 2016:83). Studies conducted across the globe have found positive links between quality of care and nurses' attitudes towards caring for the dying patient and their family (Garrino et al., 2017:127; Grubb & Arthur, 2016:84; Ranse et al., 2018:2). As a result, attitudes towards caring for the dying patient and their family is considered an essential quality indicator for end-of-life care.

In South Africa, most studies conducted with nurses were tailored towards specific cases such as HIV/AIDS and cancer, and none were mixed-method studies assessing young professional nurses' attitudes towards caring for the dying patient and their family. The lack of evidence-based knowledge on this phenomenon prompted the formation of three objectives that guided the study. The objectives were:

- To determine young professional nurses' attitudes towards caring for the dying patient and their family.

- To explore and describe the outliers' attitudes towards caring for the dying patient and their family.

- To formulate recommendations for professional nurses when caring for the dying patient and their family.

The study was conducted at a secondary hospital in Gauteng. A mixed-method (quantitative and qualitative methods) design was used to meet the study objectives, employing a sequential explanatory strategy that was executed in three phases. In Phase 1, a quantitative method (descriptive and correlational) was applied. It focused on surveying 62 young professional nurses who were recruited using snowball sampling and convenience sampling. Data were collected using a demographic questionnaire and Likert scale consisting of three sections. Section A comprised Modified Templer's DAS, section B comprised the Frommelt FATCOD, and section C comprised the Level of Support in the Work Environment Questionnaire. An analysis of data was done by a statistician consultant using SPSS version 27.0. Analyses included descriptive analysis, factor analysis and correlation analysis. Descriptive statistics (the mean, percentage, frequency, and standard deviation) and inferential statistics (Pearson correlation) were used to present the findings.

In Phase 2, a qualitative, phenomenological design was applied. The outliers in Section B of the Likert scale were recruited for a focus group aimed at understanding their experiences when caring for the dying patient and their family. Six young professional nurses – three participants with low scores and three participants with high scores – were recruited using purposive sampling. Data were transcribed verbatim and analysed using Giorgi's phenomenological method to obtain themes from the young professional nurses' experience caring for the dying patient and their family.

The section that follows discusses each research objective in order to determine if the research purpose was achieved.

5.2.1 First objective: To determine the young professional nurses' attitudes towards caring for the dying patient and their family

The first objective sought to determine young professional nurses' attitudes towards caring for the dying patient and their family. Young professional nurses' attitudes towards caring for the dying patient and their families were assessed using the FATCOD scale. Findings showed that 74% (n=46) of young professional nurses had positive attitudes towards caring for dying patients and their families. Therefore, the first objective was achieved.

5.2.2 Second objective: To explore and describe the outliers' attitudes towards caring for the dying patient and their family

The second objective was to explore and describe the outliers' attitudes towards caring for the dying patient and their family. Participants' narratives revealed that caring for the dying patient at first was not an easy task due to their fear and inexperience in dealing with death and dying. The participants attested to how their first experience caring for a dying patient influenced their current attitude towards the process. Some participants shared how they used their first experience as a learning tool to become better nurses. They embraced the experience and have since tried to make caring for the dying patient as meaningful as possible for the patient and their family. Other participants verbalised how, from their first experience, they became pessimistic and despondent, caring for the dying patient in a mechanical and prescribed manner. They said they avoid any emotional connections with the patient due to the emotional burden they experience when the patient dies.

They all recognised the importance of family involvement when caring for the dying patient, highlighting how the nurse needs to be conscious of the dynamics within the family as they affect patients' end-of-life care. Therefore, the second objective was also achieved.

5.2.3 Third objective: To formulate recommendations for professional nurses when caring for the dying patient and their family

The third objective was to formulate recommendations for professional nurses when caring for the dying patient and their family. A recommendation can be described as a course of action derived from implications and generalisations made in the study's findings and in line with findings from similar studies in the same area of interest (Gray, Grove & Sutherland, 2016:589). Based on the findings in this study and the integrated literature, recommendations were proposed for nursing practice, nursing research, nursing education, and nursing policy. These recommendations are described in the following section.

5.3 RECOMMENDATIONS

Recommendations are the most important part of the analysis phase. This is where the researcher suggests specific interventions or strategies to address the issues and constraints identified through data collection and analysis (Karalasingam, 2019:17). These were the recommendations made by the researcher:

5.3.1 Recommendations for nursing practice

Findings in this study and from literature suggest that quality care during end-of-life is positively related to young professional nurses' attitudes towards caring for the dying patient and their family. This greatly impacts the notion of a "good death" experienced by the patient and their family and can have long-term effects on the healing process of the family and nurse.

Crucial aspects of nurses' attitudes that exert the greatest influence in caring for the dying patient and their family were identified as the nurses' ability to process the death of a patient and express how this made them feel. Allowing nurses to reflect on their experiences when caring for the dying patient was found to have longstanding positive effects on their attitudes towards caring for the patient and their family. The following recommendations were proposed:

5.3.1.1 Provide opportunities for nurses to take time out to process death and dying immediately after the incident

Dying is a part of the cycle of life (Beaty, 2015:304). Still, increased exposure to unexpected patient deaths, prolonged dying patients, and actively grieving families generates overwhelming feelings of grief and loss, even for the most experienced nurses (Volek, 2021:20). Participants in this study indicated negative experiences related to death and dying patients because they had no time to process these encounters due to the workload in the hospital.

The fast-paced environment and workload in the hospital limit the time available for nurses to grieve and emotionally process their patient's death, often leading to their feelings going unrecognised (Kapoor, Morgan, Siddique & Guntupalli, 2018:1338). The usual expectation is to conceal grief, swallow the sorrow, and care for the next patient; expressing grief feelings may be considered 'unprofessional' and 'weak', with others labelling nurses that do express their feelings as 'unfit' to be a nurse (Kapoor et al., 2018:1338). Studies have shown that repeated exposure to death and grief leads to occupational stress, compassion fatigue and emotionally dissociation when caring for the dying patient and their family (Davies, 2016:i5597).

Literature suggests that taking time out after the death of a patient gives nurses the time to process experiences that influence their attitude (Van de Venter, 2021:255). This personal and meaningful ritual after a patient's death increases compassion and a sense of connectedness, meaning, and support, and decreases burnout among nurses. Watson (1979) believes introspections are a source of value and strength that further exemplify the experiences and assist nurses in dealing with their own grief (Kapoor et al., 2018:1339). The ‘pause’ is a common practice in mediation: pausing after the patient dies has been found to assist the nurses to relate better to the patient and acknowledge and share pain after the loss of life, without feeling overwhelmed. It allows nurses to create a positive experience in a ‘negative’ situation (Kapoor et al., 2018:1339). This can be orchestrated by the unit manager or shift leader on duty on a regular basis.

5.3.1.2 Create regular debriefing sessions

Debriefing is a critical, systematic review of an event after it has occurred through questioning and reflection (Keene, Hutton, Hall & Rushton, 2010:189). Debriefing provides nurses with an opportunity to translate distressing experiences into meaningful learning experiences where they can learn from one another and (Smith-Han et al., 2016:1; Ek et al., 2014:509). In this study, the participants identified the importance of debriefing in assisting them with dealing with the death of a patient.

Regular debriefing sessions where nurses share their experiences with death and dying in the work environment can contribute to establishing camaraderie and connected relationships representative of collegial support and empathy for each other’s experiences (Smith-Han et al., 2016:2). The unit manager or shift leader can implement this strategy. Debriefing sessions can potentially be expanded to become interprofessional-oriented so that different professionals can learn from one another to establish a supportive culture throughout the hospital, since young professional nurses also interact with other healthcare professions in the ward.

5.3.1.3 Improving educational programmes within the hospital

The lack of knowledge and skills regarding caring for the dying patient has been found as a basic contributor to the development of negative attitudes in caring for the dying patient and their family (Cerit, 2019:343). Professional nurses often feel ill-equipped when interacting with the dying patient and their family because they are unable to efficiently answer when confronted with questions regarding end-of-life care (Singh, Davidson, Macdonald & Newton, 2019:550). Participants expressed a similar sentiment in this study. To maintain and develop caring and positive attitudes among young professional nurses in the hospital, the researcher thus recommends that:

- an end-of-life care educational component be developed and introduced into the orientation programmes of all new nurses employed in the hospital; and
- continuous and regular in-service educational programmes in end-of-life care should be planned, developed and implemented for nurses in all wards, especially those with high death tolls.

5.3.2 Recommendations for nursing education

This study identified that young professional nurses were educationally unprepared to offer quality end-of-life care to patients and families. This is because end-of-life curricular content in the education programme is often considered insignificant, as it contradicts the values of life preservation (Scheinfeld & Lake, 2019:2). In South Africa, only a few institutions offer palliative care courses despite literature emphasising the importance of end-of-life education. These courses focus on training needs related to working with patients and their families towards the end of life; communication skills; understanding grief and bereavement; understanding spiritual diversity; and understanding common symptoms at the end of life (Brighton, Koffman, Robinson, Khan, George, Burman & Selman, 2017:845). Moreover, specific information on exploring the feelings, attitudes and beliefs of self and others regarding death and dying (Frommelt, 1991:37) should be taught in the nursing curriculum, as it affects the development of positive attitudes towards caring for the dying patient (Corr, 2016:180; Coban et al., 2015:665).

An end-of-life educational strategy gaining momentum in nursing education is end-of-life simulation-based education (Shiner, 2018:262). End-of-life simulation-based education is said to imitate a real-life scenario to enable students to acquire coping strategies before interacting with the actual dying patient and their family (Tamaki et al., 2019:7). There are three main components to a simulation: briefing, whereby the nurse is introduced to others, the environment and learning objective; intervention, taking the form of a scenario, activity or task; and finally, the debrief, arguably the most important stage, offering feedback and time to reflect (Shiner, 2018:262). Marshall and McIntosh (2018:155) found that end-of-life simulations had positive effects on nurses' attitudes towards caring for the dying patient and their family.

5.3.3 Recommendations for nursing research

Nursing research is vital to professional nursing practice as it generates knowledge to guide practice and improve patient care (Gray et al., 2017:8). The following suggestions are put forth for future research:

- A similar study with a larger sample size should be conducted in different hospitals sampled from across the country to gain a broader picture of nationwide-nurses' attitudes towards caring for the dying patient and their family.

- Intervention studies could be conducted to establish the influence of the proposed recommendations on young professional nurses' caring for the dying patient and their family.

- A comparative study could be considered between the newly qualified professional nurses and older nurses to establish any variances and possible reasons for these variations.

5.3.4 Recommendations for nursing policy development

Nursing managers and healthcare administrators should create a healthy work environment that promotes mindfulness, increases compassion satisfaction, and the ability to deal with caring for the dying patient and their family (Kapoor et al., 2018:1339). Participants in this study expressed how the working environment affects how they process the death of a patient. Kapoor et al. (2018:1339) found that unresolved grief becomes cumulative and presents a risk factor for burnout. The researcher thus formulated the following possible recommendations:

- Improve the staffing in wards where nurses are exposed to high degrees of death and dying.

- Introduce a mentoring programme for new nurses to assist young professional nurses with the transition into the workplace and help them adopt healthy coping mechanisms when faced with caring for the dying patient and their family.

- Introduce mandatory debriefing sessions in the wards after a patient has died to assist the nurses on duty to reflect and share the emotions triggered by the death of the patient.

- Introduce monthly mandatory mental health wellness checks for all nurses working in the hospital to assist nurses in adopting healthy coping strategies when caring for the dying patient and their family.

5.4 LIMITATIONS OF THE STUDY

Study limitations have been described as weaknesses or restrictions that can potentially reduce research results' generalisability (Gray et al., 2017:590). The following limitations are recognised in this study:

- This study was conducted when the country was in the midst of the COVID-19 pandemic. The young professional nurses in this study were part of the front-liners, confronted with high workload pressure. The immense burden of the COVID-19 pandemic (Shoja, Aghamohammadi, Bazyar, Moghaddam, Nasiri, Dashti, Choupani, Garaee, Aliasgharzadeh & Asgari, 2020:2) was seen in the poor response rate in the study. The sample size of 62 respondents and 6 participants for the focus group may have limited the generalisability of the study's findings.

- Death and dying is a sensitive topic due to the personal intimacy attached to the phenomenon. Therefore, the insights that the participants shared are only representative of what they were comfortable sharing. There may be more facets underpinning their experiences during the time that data were gathered.

5.5 CONCLUSIONS

Caring for dying patients in the hospital has become a pronounced trend, and young professional nurses' attitudes play an important role when caring for patients in their final days. The purpose of this study was to explore and describe young professional nurses' attitudes towards caring for the dying patient and their family at a secondary academic hospital in Gauteng, to formulate recommendations for professional nurses when caring for the dying patient and their family. This goal was achieved by employing mixed-method research using an explanatory sequential approach, executed in three phases: the quantitative, qualitative, and interpretation and integration phases.

The findings of this study have shown that young professional nurses working in the tertiary academic hospital under study had positive attitudes towards caring for the dying patient and their family. Findings revealed that the older (in age) young professional nurses had higher levels of death anxiety. However, this did not affect their attitude towards caring for the dying patient, as it was established there was no significant relationship between age and attitude. The study also found no significant relationship between the young professional nurses' attitude, the number of dying patients they had carried for, their years of work experience, and their work environment.

To enhance the quality of end-of-life care in the hospital, recommendations were formulated. Firstly, opportunities for taking time out to process death and dying immediately after the incident are recommended. Secondly, regular debriefing sessions should be created, and lastly, the hospital should improve its educational programme regarding death and dying. In nursing education, the curriculum can be improved to facilitate aspects of death and dying that may be useful in preparing young professional nurses when caring for the dying patient and their family. More research was recommended to further explore young professional nurses' attitudes towards caring for the dying patient and their family on a larger scale in order to broaden the picture nationwide. Intervention and comparative research were recommended to establish the influence of the proposed recommendations, any variances, and possible reasons for these variations.

In terms of nursing administration and policy issues, it is imperative that nursing managers be encouraged to maintain a healthy work environment that fosters care for young professionals. The whole process is a cycle; if the work environment is supportive of the young professional nurse when caring for the dying patient and their family, they are able to demonstrate a caring attitude to their dying patient. This ensures that quality of end-of-life care is upheld and allows for a “good death” to be achieved.

5.6 REFLECTION ON THE RESEARCH JOURNEY

As a novice researcher who was exposed to bringing life into the world and not death and dying in the workplace embarking on this journey, the task of conducting this research was initially undermined until the country was confronted with the COVID-19 pandemic. There was a rise in the number of deaths daily, which resulted in the country being placed in lockdown in an attempt to reduce the infection rate. For the researcher, this meant going back to the drawing board, from the sampling method to the mode of data collection. At this point, the researcher was optimistic, because the sample was young professional nurses, so using an online platform was not going to be a challenge, because this sample spends most of their time on social media. However, after months of data collection, the researcher began to feel discouraged with poor traction and response rates as the data collection process was going very slow. Yet the researcher was still confident and asked for assistance from the research supervisors and friends.

As things were looking up with the study, the researcher was confronted with a great deal of death of loved ones and tested positive for COVID-19. The researcher was confronted with their own anxiety regarding death and dying and self-doubt. This made it hard for the researcher, who felt like they should throw in the towel as writing about death and dying triggered uncomfortable emotions. However, with the assistance of the supervisors and loved ones, these conflicting and worrisome reflections gradually dissipated.

The researcher was able to remember the importance this research would have in improving end-of-life care for all dying patients and their families and produce work that could provide insight into young professional nurses’ attitudes towards caring for the dying patient and their family.

The new knowledge gained has opened new avenues to further explore the phenomenon studied in this thesis from different perspectives. This will further assist in improving care for the dying patient and their family, because the researcher believes “*how people die remains in the memory of those who live on” – Dame Cicely Saunders (1988)*

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ANNEXURE 1: Demographic questionnaire

Demographic Questionnaire

Tick with a **X** at the applicable box and complete open-ended questions

1. Age: ……………………. (in complete years, last birthday)

2. Gender:

Female		Male	

3. Years of experience:

1 year	
2 years	
3 years	
4 years	
5 years	

4. Type of ward currently working in:

	Adult	Pediatric
Medical ward		
Surgical ward		
Theatre		
ICU		
High Care		
Casualty		
Maternity		
Labor ward		

Other: …………………………………………………..

5. Previous experience in caring for the dying patient and their family in the last 6 months:

Yes		No	

6. If you answered yes in Question 5, provide the estimated number of dying patients you cared for in the last 6 months:

………………………………..

7. Previous education on death or dying:

	Yes	**No**

I took a course in death and dying as part of my basic nursing education		
I received in-service training in the hospital, on death and dying		
No information dealing with death and dying was included in my basic nursing education		

8. Feelings about previous education on the subject of death and dying

	Yes	No
I feel that nursing education prepared me adequately to deal with death and dying		
I feel that nursing education did not prepare me adequately to deal with death and dying		
I feel that in-service training in the hospital prepared me adequately to deal with death and dying		

SANC number

ANNEXURE 2: Likert scale

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Section A: Modified Templer's Death Anxiety Scale (DAS)

These statements are about how you feel regarding your own death. As you read the following statements, please tell me how often you felt this way in the 6 months. Please make an **X** at each statement which corresponds to your own personal feelings. Please respond to all 5 statements. The meaning of the letter is:

R: Rarely or none of the time
S: Some of the time (in less than 1 day)
O: Occasionally (3-4 days)
M: Most of the time (5-7 days)

	R	S	O	M
1. I worry about dying				
2. I worry that I may be very ill for a long time before I die				
3. It upsets me to think that others may see me suffering when I die				
4. I worry that dying may be painful				
5. I worry that I may be alone when I am dying				

Section B: Frommelt attitude towards care for the dying (FATCOD) scale

In these items the purpose is to learn how nurses feel about certain situations in which they are involved with patients. All statements relate to the provision of nursing care to the dying patient and their family. Where there is reference to a dying patient, assume it refers to a person with gradual decline of health, marked by acute episodes of exacerbation; associated with disability and eventually leading to death.

Please make an **X** at each statement which corresponds to your own personal feelings about the attitude or situation presented. Please respond to all 30 statements on the scale. The meaning of the letter is:

SD: Strongly Disagree **D: Disagree** **U: Uncertain** **A: Agree** **SA: Strongly Agree**

	SD	D	U	A	SA
6. Giving nursing care to a dying patient is a worthwhile learning experience.					
7. Death is not the worst thing that can happen to a person.					
8. I would be uncomfortable talking about impending death with the dying person.					
9. Nursing care for the patient's family should continue throughout the period of grief and bereavement.					
10. I would not want to be assigned to care for the dying person.					

	SD	D	U	A	SA
11. The nurse should not be the one to talk about death with the dying person.					
12. The length of time required to give nursing care to a dying person would frustrate me.					
13. I would be upset when the dying person I was caring for gave up hope of getting better.					
14. It is difficult to form a close relationship with the family of the dying person.					
15. There are times when death is welcomed by the dying person.					
16. When a patient asks “Nurse, am I dying?”, I think it is best to change the subject to something cheerful.					
17. The family should be involved in the physical care of the dying person.					
18. I would hope the person I am caring for dies when I am not present.					
19. I am afraid to become friends with a dying person.					
20. I would feel like running away when the person actually died.					
21. Families need emotional support to accept the behavior changes from the dying person.					
22. As a patient nears death, the nurse should withdraw from his/her involvement with the patient.					
23. Families should be concerned about helping their dying member make best of his/her remaining life.					
24. The dying person should not be allowed to make decisions about his/her physical care.					
25. Families should maintain as normal an environment as possible for their dying member.					
26. It is beneficial for the dying person to verbalize his/ her feelings.					
27. Nursing care should extend to the family of the dying person.					
28. Nurses should permit dying persons to have flexible vising schedules.					
29. The dying person and his/her family should be the decision makers in charge.					
30. Addiction to pain relieving medication should not be a nursing concern when dealing with a dying person.					
31. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.					
32. Dying persons should be given honest answers about their condition.					
33. Educating families about death and dying is not a nursing responsibility.					
34. Family members who stay close to a dying person often interfere with the professionals’ job with the patient.					

	SD	D	U	A	SA
35. It is possible for nurses to help patients prepare for death.					

Section C: Nature of supportive work environment

Read each question carefully and choose one of the possibilities next to each question. Indicate your answer by placing a **X** in the relevant box next to each question. The meaning to the letters:

Never: N **Very Rare: VR** **Rare: R** **Frequent: F** **Very Frequent: VF** **Always: A**

	N	VR	R	F	VF	A
36. To what degree do you receive good support and guidance from your seniors?						
37. To what degree do you feel valued and respected in your job?						
38. To what degree do you feel part of a team?						
39. To what degree do you feel a good relationship with your patients will benefit a supportive work environment?						
40. To what degree do you feel open communication with co-workers will benefit a supportive work environment?						
41. To what degree do you feel that regular debriefing groups will benefit a supportive work environment?						
42. To what degree do you experience your workplace as supportive?						
43. To what degree do you take emotional burden home at the end of the shift?						

SANC number

ANNEXURE 3: Consent to use the FATCOD scale

On Apr 13, 2019, at 5:07 PM, Zwa Zulu <zwazulu@gmail.com> wrote:

Dear Mrs. Frommelt

I am a masters student studying at the University of Johannesburg, in South Africa. I am conducting a mixed method study, on young professional nurses' attitude towards caring for the dying patient and their families. I would like your permission to use the Frommelt Attitude Towards Care of the Dying scale in my research project. I would like to use the original form of the instrument, because it relates to nurses (Frommelt, 1991). Thank you for your assistance.

Kind regards,
Zwa Zulu

From: Katherine Frommelt kay.frommelt@gmail.com
Subject: Re: Permission to use the FATCOD scale
Date: 16 April 2019 at 17:47:45 SAST
To: Zwa Zulu <zwazulu@gmail.com>

Dear Zwa,

I had the privilege of visiting your country as part of the First Nursing delegation to travel to South Africa as part of the People to People Program to work with and learn about HIV/ AIDS. It was a wonderful experience. I am happy to give you permission to use the FATCOD in your study.

Best of luck with your research

Katherine H Murray Frommelt, PhD, RN, PDE, CGC, FT

ANNEXURE 4: Consent to use the Level of Work Support in the Workplace Questionnaire

Downing, Charlene
to PJ,, estel@sun.ac.za, me

Dear Prof Jordan and Prof Stellenberg

Trust you are both well.

I am currently supervising a candidate that would like to use a part of the attached Master study completed at US. We have been unable to locate her contact details via a number of avenues. We would like to use Section C of the Likert scale.

Would there be any possibility to assist u
s in locating her contact details please?

Greetings and thank you, CD

Dr Charlene Downing
Senior Lecturer: Department of Nursing
Telephone: 011 559 9063
E-mail: charlened@uj.ac.za
Website: www.uj.ac.za
Office: 6105d, John Orr Building, Doornfontein

Stellenberg, EL, Prof [elstel@sun.ac.za] <elstel@sun.ac.za> May 23, 2019, 9:58 PM

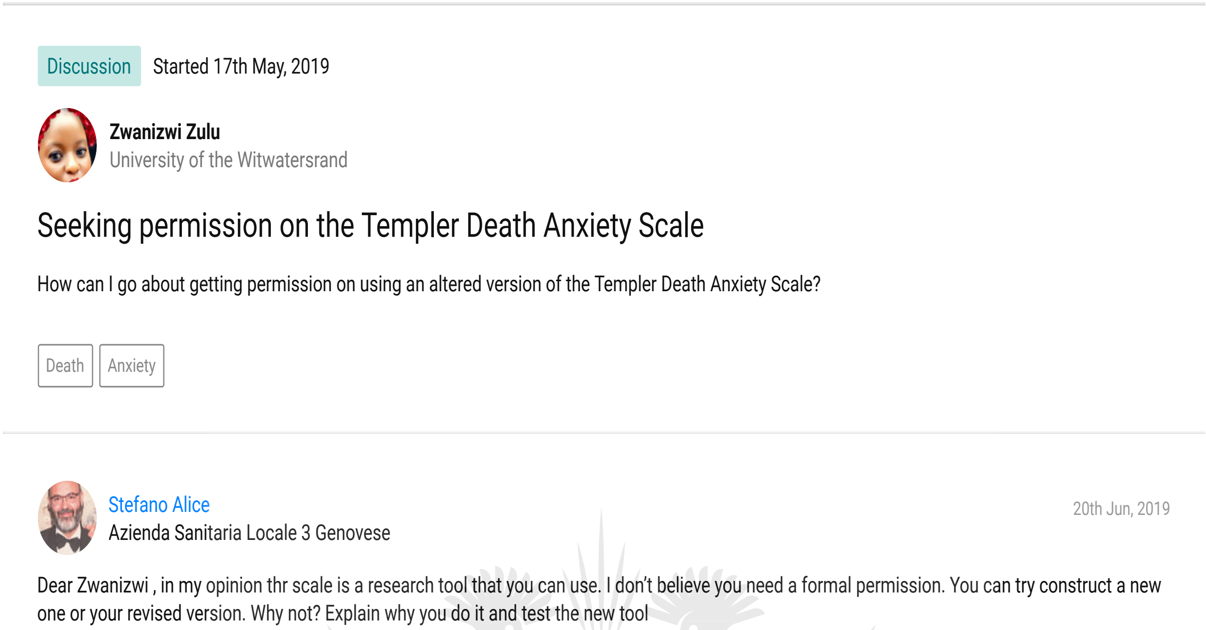
to Charlene, PJ,, me

Good evening Charlene
The student worked at TBH Oncology. However I am not sure whether she is still there. The supervisor is at TBH in a managerial position and I was co-supervisor. I don’t see any objection to using the information as required. Stellenbosch owns copyright and acknowledgement to the study should be done.

Kind regards
Ethelwynn

Prof Ethelwynn L Stellenberg| D CUR MCUR BHON (Education & CHN) BCUR (Gen, MW, Psychology) ICU, DNA, DPN
Associate Professor
elstel@sun.ac.za | +27 21 9389297 | Education Building, Franzie Van Zijl Drive

ANNEXURE 5: Feedback on permission for Templer's Death Anxiety Scale



Discussion Started 17th May, 2019

Zwanizwi Zulu
University of the Witwatersrand

Seeking permission on the Templer Death Anxiety Scale

How can I go about getting permission on using an altered version of the Templer Death Anxiety Scale?

Stefano Alice
Azienda Sanitaria Locale 3 Genovese

20th Jun, 2019

Dear Zwanizwi , in my opinion thr scale is a research tool that you can use. I don't believe you need a formal permission. You can try construct a new one or your revised version. Why not? Explain why you do it and test the new tool

ANNEXURE 6: Ethical clearance letter from the research ethics committee and higher degrees committee of the faculty of health science from the University of Johannesburg

FACULTY OF HEALTH SCIENCES
RESEARCH ETHICS COMMITTEE

NHREC Registration: REC 241112-035

ETHICAL CLEARANCE LETTER
(RECX 2.1)

Student/Researcher Name	Zwanizwi Zulu	Student Number	216059945
Supervisor Name	Prof. C. Downing	Co-Supervisor Name	Dr S. Matlala
Department	Nursing Science		
Qualification	Masters of Nursing Science in Professional Nursing Science and Ethos		
Research Title	YOUNG PROFESSIONAL NURSES' ATTITUDE TOWARDS CARING FOR THE DYING PATIENT AND THEIR FAMILIES		
Date	9 June 2020	Clearance Number	**REC-131-2019**

Approval of the research amended research proposal with details given above is granted, subject to any conditions under 1 below, and is valid until 9 June 2021.

1. Conditions*:
None.

**Please note that failure to comply with the conditions above (if any) prior to implementation of the research will invalidate this ethical clearance.*

2. Renewal:
It is required that this ethical clearance is renewed annually, within two weeks of the date indicated above. Renewal must be done using the Ethical Clearance Renewal Form (REC 10.0), to be completed and submitted to the Faculty Administration office. *See Section 12 of the REC Standard Operating Procedures.*

3. Amendments:
Any envisaged amendments to the research proposal that has been granted ethical clearance must be submitted to the REC using the Research Proposal Amendment Application Form (REC 8.0) prior to the research being amended. Amendments to research may only be carried out once a new ethical clearance letter is issued. *See Section 13 of the REC Standard Operating Procedures.*

4. Adverse Events, Deviations or Non-compliance:
Adverse events, research proposal deviations or non-compliance must be reported within the stipulated time-frames using the Adverse Event Reporting Form (REC 9.0). *See Section 14 of the REC Standard Operating Procedures.*

The REC wishes you all the best for your studies.

Yours sincerely.

Prof. Christopher Stein
Chairperson: REC
Tel: 011 559 6564
Email: cstein@uj.ac.za

ANNEXURE 7: Permission from the Department of Health

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Gauteng Department of Health
Helen Joseph Hospital
Enquiries: Dr. R .Masilela
Acting Chief Executive Officer
Tel :(011) 489-0306/1087
Fax :(011) 726-5425
E mail:Ronnie.masilela@gauteng.gov.za
Date: 21 May 2020

Dear Z Zulu

STUDY: Young professional Nurses attitude towards caring for the dying patient and their families.
RESEARCHERS: Z Zulu
GP_202003_029
Ethics Number : HDC-01-58-2019

Above the study was discussed at the Research Committee meeting. We recommend that permission be granted for Helen Joseph Hospital to be used as a site for the above research, However , since this is individual /Patients.

Upon completion of the study, copy thereof should be submitted to Helen Joseph Hospital. It is duty of the researcher to collect the data to the relevant department after the Research Committee approved the study.

Thank you

Dr. M Mukansi
Helen Joseph Hospital
Chairperson
DATE:

Approved

ANNEXURE 8: Research information letter

DEPARTMENT OF NURSING
RESEARCH STUDY INFORMATION LETTER

Good Day

My name is Zwanizwi (Zwa) Zulu, I would like to invite you to participate in a research study on young professional nurses' attitude towards caring for the dying patient and their families. I would like to invite you to participate in a research study on **Young professional nurses' attitude towards caring for the dying patient and their families.**

The study is part of a research project being completed as a requirement for a research project being completed as a requirement for a Master's Nursing Science in Professional Nursing Science and Ethos (RD) through the University of Johannesburg.

THE PURPOSE OF THIS STUDY is to investigate and understand young professional nurses' attitude towards caring for the dying patient and their families at a tertiary hospital in Gauteng, in order to propose recommendations for facilitating quality end-of-life care.

Below, I have compiled a set of questions and answers that I believe will assist you in understanding the relevant details of participation in this research study. Please read through these. If you have any further questions I will be happy to answer them for you.

1. **DO I HAVE TO TAKE PART?** Participation in this study is entirely voluntary. If you agree to take part, you will be asked you to sign a consent form and scan and email it back.

2. **WHAT EXACTLY WILL I BE EXPECTED TO DO IF I AGREE TO PARTICIPATE?** This study has two phases. For the first phase you will be asked to sign a consent form and email it back. This will be done prior to the administration of the demographic questionnaire and the Likert scale questionnaire. You will also be expected to write your SANC number on the demographic questionnaire as this will link you to your questionnaire. The Likert scale questionnaire is made up of 3 sections: Section A is the Templer's Death Anxiety Scale (DAS); Section B is Frommelt Attitude Towards Care of the Dying (FATCOD) scale and Section C is the level of support in the working environment questionnaire. Section A is assessing your level of anxiety regarding death; Section B is assessing your attitudes towards caring for the dying patient and their family and Section C is assessing the level of support in your working environment. The demographic questionnaire and Likert scale will be sent online to the participants. When you are done filling in the questionnaire you will be expected to send it back to the researcher. Based on your score on Section B which is FATCOD scale, you may be asked to come back and participant for the second phase of the study. The second phase of the study will be a focus group, made up of 6 young professional nurses. The

aim of the focus group is to understand your experience better. The focus group will be done via Zoom call because of the social distancing regulations due to the COVID-19 pandemic.

3. **APPROXIMATELY HOW LONG WILL MY PARTICIPATION TAKE?** It takes approximately 30- 45 minutes to fill in the questionnaire and it would take approximately 60-120 minutes to participant in the focus group.

4. **WHAT WILL HAPPEN IF I WANT TO WITHDRAW FROM THE STUDY?** If you wish to withdraw from the study, you are free to do so at any time without giving a reason and without consequences. You can even withdraw from the focus group at any point if you wish to without any consequences

5. **ARE THERE ANY OTHER POSSIBLE REASONS WHY MY PARTICIPATION MIGHT BE STOPPED?** No.

6. **IF I CHOOSE TO PARTICIPATE, WILL THERE BE ANY EXPENSES FOR ME, OR PAYMENT DUE TO ME?** If you chose to participate, you will not bear any expenses or receive any payment

7. **IF I CHOOSE TO PARTICIPATE, WHAT ARE THE RISKS INVOLVED?** There is potential for temporary emotional distress from some of the statements on the Likert scale questionnaire. You can contact me either if you need to be referred for counselling.

8. **IF I CHOOSE TO PARTICIPATE, WHAT ARE THE BENEFITS INVOLVED?** There are no direct benefits of participating however it may elicit introspection, and self-awareness regarding death and dying, which you may benefit indirectly from by starting to reflect on the relationship between attitude and caring. Taking part will assist in generating and refining nursing knowledge for evidence-based practice needed to better facilitate quality end-of-life care.

9. **WILL MY PARTICIPATION IN THIS STUDY BE KEPT CONFIDENTIAL?** Yes. All participants in the focus group will be asked not to record or capture any images during the interview. All data, transcripts and back-ups will be kept in a locked safe, for at least two years. The research supervisors and I will be the only person's privy to that information. Permission will be requested from you for the use of direct quotes from the interviews when reporting the findings. The master list with your information will be kept separately from the demographic questionnaire, the Likert questionnaire and transcripts, in a safe. The research supervisors and I will be the only ones privy to that information. A pseudonym will be used when reporting the findings to protect your true identity.

10. **WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY?** The results will be written into a research report that will be assessed. The results will also be submitted to Gauteng Department of Health, published in accredited journals, presented in conferences. In cases, results are published in a scientific journal or in either event, you will not be identifiable in any documents, reports or publications. You will be given access to the study results if you would like to see them, by contacting me.
11. **WHAT WILL YOUR RESPONSIBILITIES BE, AS THE RESEARCHER?** I am responsible for ensuring that your confidentiality is respected and privacy is maintained. The focus group will be conducted by me. I will be facilitating it, not taking part in the discussion and taking down notes

12. **WHO IS ORGANISING AND FUNDING THIS RESEARCH STUDY?** The study is being organised by me, under the guidance of my research supervisor at the Department of Nursing at the University of Johannesburg. The funding of the research is independent of the supervisor's bursary and the academic merit award bursary. The research will be funded by the researcher.

13. **WHO HAS REVIEWED AND APPROVED THIS STUDY?** Before this study was allowed to start, it was reviewed in order to protect your interests. This review was done first by the Department of Nursing, and then secondly by the Faculty of Health Sciences Research Ethics Committee at the University of Johannesburg. In both cases, the study was approved.

14. **WHAT IF THERE IS A PROBLEM?** If you have any concerns or complaints about this research study, its procedures or risks and benefits, you should ask me. You should contact me at any time if you feel you have any concerns about being a part of this study. My contact details are:

Contact for further information or clarity about this research:

Researcher:	Zwa Zulu, Registered Professional Nurse *Email*: zwazulu@gmail.com *Call:* 0614183416
Research Supervisor:	Prof Charlene Downing, Department of Nursing *Email:* charlened@uj.ac.za *Call:* 011 559 6818
Research Supervisor:	Dr Sidwell Matlala, Department of Nursing *Email:* sidwellm@uj.ac.za *Call:* 011 559 6818

If you feel that any questions or complaints regarding your participation in this study have not been dealt with adequately, you may contact the Chairperson of the Faculty of Health Sciences Research Ethics Committee at the University of Johannesburg:

Prof. Christopher Stein
Tel: 011 559-6564
Email: cstein@uj.ac.za

FURTHER INFORMATION AND CONTACT DETAILS:
Should you wish to have more specific information about this research project, have any questions, concerns or complaints about this research study, its procedures, risks and benefits, you should communicate with me using any of the contact details given above.

Researcher:

Zwanizwi (Zwa) Zulu

ANNEXURE 9: Participation consent form

DEPARTMENT OF NURSING
RESEARCH CONSENT FORM

Young professional nurses' attitude towards caring for the dying patient and their families

Please initial each box below:

☐ I confirm that I have read and understand the information letter for the above study.

☐ I understand that my participation is voluntary and that I am free to withdraw from this study at any time without giving any reason and without any consequences to me.

☐ I agree to take part in the above study.

____________________	______________________________	_______________
Name of Participant	Signature of Participant	SANC number
____________________	______________________________	_______________
Name of Researcher	Signature of Researcher	Date

ANNEXURE 10: Invitation for the focus group

young professional nurses' attitude towards caring for the dying patient and their family:focus group

When Mon Aug 23, 2021 3pm – 4pm South Africa Standard Time

Where https://us04web.zoom.us/j/7134583099?pwd=bGpHVVlKNWxHTVAwMmxKWDBUTHY5Zz09 (map)

Joining info Join with Google Meet
meet.google.com/ios-ykem-ycy

Calendar zwazulu@gmail.com

Who
- zwazulu@gmail.com - organizer
- charlened@uj.ac.za
- [redacted]
- sidwellm@uj.ac.za
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Zwa Zulu is inviting you to a scheduled Zoom meeting.

Join Zoom Meeting
https://us04web.zoom.us/j/7134583099?pwd=bGpHVVlKNWxHTVAwMmxKWDBUTHY5Zz09

Meeting ID: 713 458 3099
Passcode: 9a9wec

ANNEXURE 11: Language editing certificate

Between the lines editing

Leatitia Romero
Professional Copy Editor and Proofreader
(BA HONS)

Cell: 083 236 4536
leatitiaromero@gmail.com
www.betweenthelinesediting.co.za

18 November 2021

To whom it may concern:

I hereby confirm that I edited the dissertation entitled: “YOUNG PROFESSIONAL NURSES’ ATTITUDE TOWARDS CARING FOR THE DYING PATIENT AND THEIR FAMILY”. Any amendments introduced by the author hereafter are not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations, and it remains the author’s responsibility at all times to confirm the accuracy and originality of the completed work. Research participants’ verbatim quotes were not grammatically altered or checked for contextual accuracy. The author is responsible for ensuring the accuracy of the references and its consistency based on the department’s style guidelines.

Leatitia Romero

Affiliations

PEG: Professional Editors Group (ROM001) – Accredited Text Editor
SATI: South African Translators’ Institute (1003002)
REASA: Research Ethics Committee Association of Southern Africa (104)

ANNEXURE 12: Research information letter for the Zoom Focus group

DEPARTMENT OF NURSING
RESEARCH STUDY INFORMATION LETTER

Good Day

My name is Zwanizwi (Zwa) Zulu, I would like to invite you to participate in a research study on young professional nurses' attitude towards caring for the dying patient and their families. I would like to invite you to participate in a research study on **Young professional nurses' attitude towards caring for the dying patient and their families.**

The study is part of a research project being completed as a requirement for a research project being completed as a requirement for a Master's Nursing Science in Professional Nursing Science and Ethos (RD) through the University of Johannesburg.

THE PURPOSE OF THIS STUDY is to investigate and understand young professional nurses' attitude towards caring for the dying patient and their families at a tertiary hospital in Gauteng, in order to propose recommendations for facilitating quality end-of-life care.

Below, I have compiled a set of questions and answers that I believe will assist you in understanding the relevant details of participation in this research study. Please read through these. If you have any further questions I will be happy to answer them for you.

15. **DO I HAVE TO TAKE PART?** Participation in this study is entirely voluntary. If you agree to take part, you will be asked you to sign a consent form and scan and email it back.

16. **WHAT EXACTLY WILL I BE EXPECTED TO DO IF I AGREE TO PARTICIPATE?** The aim of the focus group is to understand your experience better. The focus group will be done via Zoom call because of the social distancing regulations due to the COVID-19 pandemic.

17. **APPROXIMATELY HOW LONG WILL MY PARTICIPATION TAKE?** It takes approximately 60-120 minutes.

18. **WHAT WILL HAPPEN IF I WANT TO WITHDRAW FROM THE STUDY?** If you wish to withdraw from the study, you are free to do so at any time without giving a reason and without consequences. You can even withdraw from the focus group at any point if you wish to without any consequences

19. **ARE THERE ANY OTHER POSSIBLE REASONS WHY MY PARTICIPATION MIGHT BE STOPPED?** No.

20. **IF I CHOOSE TO PARTICIPATE, WILL THERE BE ANY EXPENSES FOR ME, OR PAYMENT DUE TO ME?** There will no costs to you. If you choose to participate the researcher will send you 2G of data so that you will be able to download Zoom and remain logged in throughout the duration of the focus group.

21. **IF I CHOOSE TO PARTICIPATE, WHAT ARE THE RISKS INVOLVED?** There is potential for temporary emotional distress from the discussion. You can contact me either if you need to be referred for counselling.

22. **IF I CHOOSE TO PARTICIPATE, WHAT ARE THE BENEFITS INVOLVED?** There are no direct benefits of participating however it may elicit introspection, and self-awareness regarding death and dying, which you may benefit indirectly from by starting to reflect on the relationship between attitude and caring. Taking part will assist in generating and refining nursing knowledge for evidence-based practice needed to better facilitate quality end-of-life care.

23. **WILL MY PARTICIPATION IN THIS STUDY BE KEPT CONFIDENTIAL?** Yes. All participants in the focus group will be asked not to record or capture any images during the interview. All data, transcripts and back-ups will be kept in a locked safe, for at least two years. The research supervisors and I will be the only person's privy to that information. Permission will be requested from you for the use of direct quotes from the interviews when reporting the findings. The research supervisors and I will be the only ones privy to that information. A pseudonym will be used when reporting the findings to protect your true identity.

24. **WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY?** The results will be written into a research report that will be assessed. The results will also be submitted to Gauteng Department of Health, published in accredited journals, presented in conferences. In cases, results are published in a scientific journal or in either event, you will not be identifiable in any documents, reports or publications. You will be given access to the study results if you would like to see them, by contacting me.
25. **WHAT WILL YOUR RESPONSIBILITIES BE, AS THE RESEARCHER?** I am responsible for ensuring that your confidentiality is respected and privacy is maintained. The focus group will be conducted by me. I will be facilitating it, not taking part in the discussion and taking down notes

26. **WHO IS ORGANISING AND FUNDING THIS RESEARCH STUDY?** The study is being organised by me, under the guidance of my research supervisor at the Department of Nursing at the University of Johannesburg. The funding of the research is independent of the supervisor's bursary and the academic merit award bursary. The research will be funded by the researcher.

27. **WHO HAS REVIEWED AND APPROVED THIS STUDY?** Before this study was allowed to start, it was reviewed in order to protect your interests. This review was done first by the Department of Nursing, and then secondly by the Faculty of Health Sciences Research Ethics Committee at the University of Johannesburg. In both cases, the study was approved.

28. **WHAT IF THERE IS A PROBLEM?** If you have any concerns or complaints about this research study, its procedures or risks and benefits, you should ask me. You should contact me at any time if you feel you have any concerns about being a part of this study. My contact details are:

Contact for further information or clarity about this research:

Researcher:	Zwa Zulu, Registered Professional Nurse *Email*: zwazulu@gmail.com *Call:* 0614183416
Research Supervisor:	Prof Charlene Downing, Department of Nursing *Email:* charlened@uj.ac.za *Call:* 011 559 6818
Research Supervisor:	Dr Sidwell Matlala, Department of Nursing *Email:* sidwellm@uj.ac.za *Call:* 011 559 6818

If you feel that any questions or complaints regarding your participation in this study have not been dealt with adequately, you may contact the Chairperson of the Faculty of Health Sciences Research Ethics Committee at the University of Johannesburg:

Prof. Christopher Stein
Tel: 011 559-6564
Email: cstein@uj.ac.za

FURTHER INFORMATION AND CONTACT DETAILS:
Should you wish to have more specific information about this research project, have any questions, concerns or complaints about this research study, its procedures, risks and benefits, you should communicate with me using any of the contact details given above.

Researcher:

Zwanizwi (Zwa) Zulu

ANNEXURE 13: Consent for participation in the Zoom Focus Group

DEPARTMENT OF NURSING
RESEARCH CONSENT FORM FOR PARTICIPATION IN THE ZOOM FOCUS GROUP

Young professional nurses' attitude towards caring for the dying patient and their families

Please initial each box below:

☐ I hereby give consent for my participation in the Zoom focus group, conducted as part of the above study

☐ I understand that I may not record or capture any images during the interview as this infringes in the privacy of all others in the group

______________________	______________________	______________
Name of Participant	Signature of Participant	SANC number
______________________	______________________	______________
Name of Researcher	Signature of Researcher	Date

ANNEXURE 14: Example of the type of master list used

Name	Surname	SANC number	Telephone number