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Nurses' perceptions of caring and uncaring nursing encounters in inpatient rehabilitation settings in South Africa: A qualitative descriptive study

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ABSTRACT

Background: Nursing encounters are face-to-face meetings and interactions occurring between the nurse and the patient and they can be experienced as being caring or uncaring. Caring nursing encounters are those that promote positive care experiences to the patient leading to satisfaction with care, and an improvement in their well-being. Uncaring nursing encounters promote negative care experiences, leading to patients' dissatisfaction with care and a decrease in patients' wellness.

Purpose: This study describes nurses' perceptions of caring and uncaring nursing encounters in inpatient rehabilitation settings.

Methods: This study utilized an exploratory and descriptive qualitative approach using manifest content analysis. Participants were purposively sampled and a semi-structured interview guide used to collect data through individual interviews. Data redundancy was reached after interviewing 21 participants. This is part of a larger case study aimed at developing guidelines to facilitate caring encounters in inpatient rehabilitation settings.

Results: Caring nursing encounters were "*keeping their hope alive*" and "*going the extra mile*," while uncaring nursing encounters were "*frustration with patients*," "*being inadequate*," and "*ignoring the patient*."

Conclusion: Caring nursing encounters promoted positive patient care experiences, easing their rehabilitation journey, while uncaring nursing encounters elicited strong negative emotions, giving patients feelings of being denied compassionate care.

Recommendation: Nurses must constantly encourage the rehabilitation patient to stay positive in the rehabilitation journey and empower them to self-manage their conditions. Nurses must strive to strike a balance in caring by building trust with rehabilitation patients and encourage them to air their grievances regarding uncaring nursing encounters as they happen.

1. Introduction

Nurses are the backbone of the healthcare system and make up the largest component in the healthcare system (Welton & Harper, 2016). Interactions between the nurse and the patients in healthcare occur through nursing encounters (Welton & Harper, 2016). Nursing encounters are face-to-face meetings and interactions occurring between the nurse and the patient (Wälivaara, Sävenstedt, & Axelsson, 2013; Welton & Harper, 2016) that can be caring or uncaring (Halldórsdóttir, 1996). Halldórsdóttir (1996) theory of caring and uncaring encounters, states two metaphors that symbolise nursing encounters which are the bridge and wall. The bridge symbolises a caring nursing encounter, and the wall represents an uncaring nursing encounter. The bridge allows nurses to build a trusting relationship with the patient while the wall leads to a distrusting relationship between the nurse and the patient (Halldórsdóttir, 1996). Therefore, researchers have reported caring nursing encounters as those that promote positive care experiences to the patient and these are attributed to the nurses' openness, patience, empathy, communication, and sensitivity towards the patient (Holopainen, Nyström, & Kasén, 2017; Wälivaara et al., 2013). On the other hand, uncaring nursing encounters are those that make the nurses feel like they are neglecting the patients' complaints, failing to notice the patients' verbal and non-verbal cues, and being cold, insensitive, and unkind to the patients (Friberg, Andersson, & Bengtsson, 2007; Hansson, Fridlund, Brunt, Hansson, & Rask, 2011; Macdonald, 2007; Nyström, Dahlberg, & Carlsson, 2003). With this contrast in nursing encounters, nurses may fail to provide compassionate care, and this can be very harmful to the rehabilitation patients. This is because nursing encounters are useful in shaping the patients' satisfaction or dissatisfaction with care (Holopainen et al., 2017; Wälivaara et al., 2013;

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Hansson et al., 2011). A slight variation in nursing encounters can make the already vulnerable patient feel depersonalised, unimportant and neglected (Halldórsdóttir, 1996).

Patients admitted to inpatient rehabilitation settings are dealing with temporary or permanent disabilities resulting from accident or disease. These disabilities cause the patient, who was previously independent, to lose autonomy and depend wholly or partly on nurses for care (St-Germain, 2014). These patients require the nurses managing them to individualise their care while adjusting it to their varying needs along their rehabilitation journey (Association of Rehabilitation Nurses, 2013; St-Germain, 2014; World Health Organization, 2011). Nurses are also expected to provide compassionate care and be empathetic, while at the same time encountering their inner self (Angel & Vatne, 2016; Dahlke & Stahlke Wall, 2017; Newham, 2017; Udo, Danielson, & Melin-Johansson, 2013). This means that nurses have to integrate their personal self and their professional role in caring for the rehabilitation patient while managing their emotions and conflicts arising in the practice environment (Angel & Vatne, 2016; Udo et al., 2013). However, this becomes challenging as traditional nursing training fails to teach nurses how to behave in modern practice environments with sophisticated technology and a diverse patient population (Ruth-Sahd, 2014). This leads to reports of difficulties and inadequateness by the nurses caring for patients in modern practice environments such as rehabilitation settings as they cannot keep up with the demands of the practice environment (Angel & Vatne, 2016; Andersson, Willman, Sjöström-Strand, & Borglin, 2015; Browall, Henoch, Melin-Johansson, Strang, & Danielson, 2014; Friberg et al., 2007; Holopainen et al., 2017).

Traditional nursing training teaches nursing students a combination of theoretical and practical nursing skills that the student then transfers as knowledge, skills, and attitude when providing nursing care (Nabolsi, Zumot, Wardam, & Abu-Moghli, 2012). Unlike the classroom environment, clinical training occurs in a complex environment that is influenced by many factors. This environment gives nursing students an opportunity to practically realign theoretical knowledge in relation to mental, psychological, and psychomotor skills, significant for patient care and management (Gaberson & Oermann, 2014; Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007). Nursing is a performance-based profession, and the clinical learning environment plays a role in shaping the professional abilities of nurses (Jonsén, Melender, & Hilli, 2013; Papastavrou, Lambrinou, Tsangari, Saarikoski, & Leino-Kilpi, 2010). Nursing education has however been blamed for not keeping up with the demands of the practice environment (Ruth-Sahd, 2014). When nurses are not well prepared for the modern practice environment, their behaviours and attitudes in the practice environment have the potential to mould their perceptions of future negative or positive nursing encounters (Jamshidi, Molazem, Sharif, Torabizadeh, & Najafi Kalyani, 2016).

Researchers in other parts of the world have reported that care delivered to patients does not meet patient needs (Angel & Vatne, 2016; Holopainen et al., 2017). Studies by Shattell (2004) and Zolnierek (2014) reported that patients want to be comforted, confirmed, affirmed, get to know, and befriend their nurses. It is interesting to learn from these studies that patients and nurses are consciously aware of this relationship; however, according to these researchers, nurses are either unwilling or ambivalent to patient experiences and opinions. Among nurses, there is a general feeling of doubt expressed especially in terms of personal relationship value they attach to the patients, which they most of the time see as lacking meaning. The authors further revealed the nurses' complacency in assuming that they spend sufficient time with patients in a day's shift, hence failing to go beyond, which is contrary to patient expectations and feelings (Angel & Vatne, 2016; Holopainen et al., 2017; Shattell, 2004; Zolnierek, 2014).

In South Africa, there have been reports of verbal and physical abuse, patient neglect, and substandard or poor quality care across care settings compounded by the challenges of heavy workloads, limited face-to-face time with patients, and inadequate or limited staffing (Andersson et al., 2015; Hastings-Tolsma, Nolte, & Temane, 2018; Silal, Penn-Kekana, Harris, Birch, & McIntyre, 2012; Vivian, Naidu, Keikelame, & Irlam, 2011; Westin & Danielson, 2006). There are numerous reports of systematic problems in South African hospitals, especially lack of accountability, resource constraints, emergency transport issues, staff supervision problems, and hiring and staffing concerns (Bohren et al., 2015; Bowser & Hill, 2010; Moszynski, 2011). Lower standards of care are prevalent in public settings, which account for 80% of the population who lack private health insurance (Hastings-Tolsma et al., 2018; Mayosi & Benatar, 2014).

The South African government responded to inequalities in healthcare delivery across South Africa by including the National Health Act, no. 61 of 2003, in the constitution to provide a framework for accessible healthcare for all. This was accomplished through the introduction of the National Health Insurance system, which is still in its initial stages (Republic of South Africa, 2004). Despite this government effort, healthcare services in public hospitals remain inaccessible in most parts of the country and poor quality care is still delivered (Mayosi & Benatar, 2014).

2. Problem statement

Substandard or poor quality care continues to be an issue in South African hospitals, with reports of abuse (verbal and physical), and patient neglect (Andersson et al., 2015; Bohren et al., 2015; Browall et al., 2014; Hastings-Tolsma et al., 2018; Holopainen et al., 2017; Mayosi & Benatar, 2014; St-Germain, 2014). Poor quality care has been reported in both private and public hospitals, however, lower standards of care is prevalent in public hospitals which caters for 80% of the population lacking private health insurance (Hastings-Tolsma et al., 2018; Mayosi & Benatar, 2014). There are also reports of systematic problems in South African hospitals, which include: a lack of accountability, resource constraints, emergency transport issues, staff supervision problems, and hiring and staffing concerns (Bohren et al., 2015; Bowser & Hill, 2010; Moszynski, 2011). Despite the South African government's effort to address the inequalities in the healthcare settings, healthcare services in many public hospitals remain inaccessible (Mayosi & Benatar, 2014).

Nurses are the backbone of the healthcare system and make up the largest component in the healthcare system (Welton & Harper, 2016). Interactions between the nurse and the patients in healthcare occur through nursing encounters (Welton & Harper, 2016). Caring nursing encounters promote positive care experiences to the patient, (Holopainen et al., 2017; Wälivaara et al., 2013) while uncaring nursing encounters promote negative care experiences (Hansson et al., 2011). The outcome of nursing encounters is an important indicator of patient satisfaction or dissatisfaction with care (Holopainen et al., 2017; Wälivaara et al., 2013; Hansson et al., 2011). Which means, a slight variation in nursing encounters can make the already vulnerable patient feel depersonalised, unimportant or neglected (Halldórsdóttir, 1996).

Patients admitted to inpatient rehabilitation settings are dealing with disabilities acquired from disease or accidents, which force them to depend partly or wholly on the nurses for care (St-Germain, 2014). These patients require the nurses managing them to individualise their care while adjusting it to their varying needs along their rehabilitation journey (Association of Rehabilitation Nurses, 2013; St-Germain, 2014; World Health Organization, 2011). Given the healthcare challenges of heavy workload, staffing issues, patient diversity, and the need for professional support during the rehabilitation journey, nurses may be subjected to undue pressure and stress, indirectly causing them to be uncaring. This research therefore allowed nurses to give an account of their perceptions of caring and uncaring nursing encounters. The findings from this study can influence policy change to improve the quality of care.

Table 1
Demographic profile of the participants.

Participants State and private	Age	Nursing qualification	Years of experience in rehabilitation settings	Inpatient rehabilitation setting
1	50 s	Enrolled nurse	20 years	State
2	40 s	Enrolled nurse	10 years	State
3	20 s	Enrolled nurse	3 months	State
4	40 s	Enrolled nurse	12 years	State
5	40 s	Enrolled nurse	10 years	State
6	50 s	Professional nurse	19 years	State
7	50 s	Professional nurse	18 years	State
8	30 s	Professional nurse	7 years	State
9	30 s	Professional nurse	12 years	State
10	50 s	Professional nurse	18 years	State
11	20 s	Professional nurse	9 years	State
12	40 s	Professional nurse	19 years	State
13	40 s	Enrolled nurse	3 months	Private
14	30 s	Enrolled nurse	8 years	Private
15	30 s	Enrolled nurse	6 months	Private
16	30 s	Enrolled nurse	2 years	Private
17	30 s	Enrolled nurse	$1^1/_2$ years	Private
18	30 s	Professional nurse	12 years	Private
19	30 s	Professional nurse	$3^1/_2$ years	Private
20	30 s	Professional nurse	9 years	Private
21	60 s	Professional nurse	1 year	Private

3. Purpose of this study

This study describes caring and uncaring nursing encounters from the perspective of the nurses caring for patients in a South African inpatient rehabilitation setting.

4. Operational definitions

4.1. Rehabilitation patients

Patients admitted to an inpatient rehabilitation setting for rehabilitation and 18 years or older during the study period.

4.2. Nurses

Nurses with either 4-year nursing training (professional nurse) or completion of 2-year nursing training (enrolled nurse) (Subedar, 2005). The nurses had to currently be working in an inpatient rehabilitation setting at the time of the study.

4.3. Inpatient rehabilitation settings

A rehabilitation setting where patients are admitted for inpatient rehabilitation within the hospital or in a separate building outside the hospital. The patients remain on the premises for treatment. This study excluded outpatients.

4.4. Caring nursing encounters

Reports of feelings that promote positive care experiences to the patient which include; ability to sense the patients' vulnerability, being attuned with patients' needs and being attentively present in nursing encounters (Halldórsdóttir, 1996).

4.5. Uncaring nursing encounters

Reports of feelings that promote negative care experiences to the patient which include; patient negligence, nurses' indifference, being unkind and unfriendly in nursing encounters (Halldórsdóttir, 1996).

5. Methods

5.1. Research design

This study utilized an exploratory and descriptive qualitative approach using manifest content analysis (Erlingsson & Brysiewicz, 2017). A semi-structured interview guide was used to collect data through individual interviews. This is part of a larger case study aimed at developing guidelines to facilitate caring encounters in inpatient rehabilitation settings.

5.2. Research setting

This study took place in one private (private health insurance) and one public (state-funded) inpatient rehabilitation setting in a South African city. The research settings vary as the public setting had fewer resources (materials, staff, etc.) than the private setting.

5.3. Study participants

The inclusion criteria were nurses (professional or enrolled) working in an inpatient adult rehabilitation setting (caring for patients 18 years or older) for at least 3 months. The exclusion criteria were nurses who did not have direct day-to-day contact with patients (such as nurses in management positions). Data redundancy was reached after interviewing 21 nurses, both professional and enrolled nurses. There were 5 enrolled nurses from the state, 5 enrolled nurses from the private, 7 professional nurses from the state and 4 professional nurses from the private. Years of experience ranged from 3 months to 20 years, with the youngest participants being in their 20 s and the oldest in their 60 s (refer to Table 1). None of the participants had specialized in rehabilitation nursing training.

5.3.1. Recruitment process

Ethical approval was obtained from the research ethics committee (HSS/0393/016D) of the university and from the research settings. The first step was to gain entry into the research setting through the establishment of contact with the unit managers and planned visits. In the second step, eligible subjects were purposively sampled and invited to participate in the study. The participants were then provided with verbal and written information about the study, and consent forms were made available for signing. The participants were asked if they

Table 2
Shows examples of how each category emerged.

Meaning units	Codes	Categories
Caring nursing encounters		
Some patients get depressed because they want their treatment to be faster. So we are forced to motivate them even when they are not making progress. (N 3-S)	Kind untruth	Keeping their hope alive
The patient sometimes asks to contact their relatives at home for personal reasons, due to the fact that our ward's telephone number has to go through the switchboard, sometimes it's difficult to ask switchboard for personal things, so I do sometimes give my personal number to use. (N 6-S)	Extra effort	Going the extra mile
Uncaring nursing encounters		
I would say for a patient who was signing an RHT, refusal of treatment form, because we had spoken to him about not leaving the hospital. When he wanted his clothes. I just went to the kids and gave it to them. I didn't check whether they were dirty or what because like I was really fed up. (N 9-S)	Difficult patients	Frustration with patients
Sometimes we feel like we are not doing enough when patients sign a refusal of hospital treatment (RHT), yet they are not fit to go home. (N 11-S)	Feeling inadequate	Being inadequate
We sometimes are forced to ignore difficult patients but at the back of your heart you will be thinking that you have to go back to help that patient. (N 19-P)	Ignoring	Ignoring the patient

consented to be audio-recorded and were informed of the study risks and benefits. The participants were aware of measures to address confidentiality and that this would be maintained throughout the study. The participants were also informed that they could withdraw from the study at any stage and that this would not affect their employment. Ethical principles of the Helsinki declaration on research involving human subjects were adhered to (World Medical Association, 2013).

5.4. Data collection

Data were collected between September 2016 and November 2016 using a semi-structured interview guide during the individual interviews. The interviews took place in a private room near the nursing station which was chosen by the participants. The interviews started with general broad question about the nurses' perceptions of caring and uncaring nursing encounters in inpatient rehabilitation settings, for example, *"Can you tell me a recent story of when you felt you were caring towards the patient?"* Further probing questions were asked, for example; *"At what point did you feel you were open and perceptive to the patient needs, at what point did you feel you were genuinely concerned and interested in the patient? At what point did you feel you acted with moral responsibility?"* Questions on uncaring nursing encounters were also asked, for example, "*Can you tell me of a recent story of when you felt you were uncaring towards the patient?"* The interviews were conducted by the researcher (JCC), a registered professional nurse with a master's degree in nursing, who was not known by the participants. The interviews were tape-recorded and transcribed verbatim before the data analysis by JCC. All of the interviews were conducted in English, each approximately 45 min to one hour, for a total of 17 h of interviews. All of the interview data (de-identified) were stored in a Microsoft Word document on a password-protected computer. The interviews were stopped after data redundancy was achieved as determined by the research team.

5.5. Data analysis

Data collection and analysis occurred simultaneously. A content analysis guided by Erlingsson and Brysiewicz (2017) was used to look for repetitions of words and to determine the trends, word patterns, and meaning units. The data analysis was started by listening to the interview audio recordings. The interview transcripts were then read through line by line several times to obtain a sense of the data. The transcriptions were done by JCC. Words, sentences, and paragraphs illustrating the nurses' perceptions of caring and uncaring nursing encounters were extracted into meaning units and further condensed. The meaning units were assigned a code and then compared for similarities and discrepancies before being developed into categories while retaining their meaning (Erlingsson & Brysiewicz, 2017). The research supervisor (an experienced qualitative researcher) was involved throughout the data analysis process.

5.6. Trustworthiness

Lincoln and Guba (1986) suggested four categories for determining the rigour of qualitative studies: credibility, transferability, dependability, and confirmability. Credibility and dependability were ensured through familiarisation with the research setting through planned visits by the researchers before the start of data collection. The researcher (JCC) spent a considerable amount of time in the research settings (12 months) to build rapport with the research participants and to become familiar with the research setting. Data were collected from two differing research settings to prevent local factors that are specific to one research setting from affecting the findings. To allow for transferability, detailed descriptions of the research settings have been provided. Purposive sampling was used to focus on key participants with sufficient experience with the phenomena under investigation. Decisions made throughout the study have been described in detail, together with the data collection methods. This will allow the reader to decide to what extent they can transfer the study to other contexts. To achieve confirmability, the researchers have described how the emerging categories were arrived at to allow the reader to decide how far these can be accepted. The researcher (JCC) analysed the data together with the active involvement of the research supervisor throughout the study to be aware of bias and to discuss and address any inconsistencies that arose. Table 2 provides an example of the analysis.

6. Findings

Table 1 presents the demographic profile of the participants. To ensure anonymity, the abbreviation N represents both the professional and enrolled nurse participants. The abbreviations P and S indicate the inpatient rehabilitation settings (private or state, respectively).

Five categories emerged from the data (see Table 2). Caring nursing encounters were; *"keeping their hope alive"* and *"going the extra mile,"* while uncaring nursing encounters were; "*frustration with patients,"* "*being inadequate,"* and *"ignoring the patient."*

6.1. Keeping their hope alive

When asked about caring nursing encounters, the participants stated that they helped the patients cope with their disabilities or rehabilitation journey challenges by encouraging them to maintain a fighting spirit. The participants constantly maintained and promoted levels of hope in the lives of these patients by telling them that they were making satisfactory progress, even if they were not. They hoped this would help the patients move from hoping for recovery to aspiring for

independence as expressed in the following response;

Some of them do get depressed…they want their treatment to be faster and see results a bit faster…and you have to assure them all the time that they are making progress, even though sometimes they might not be, but you need to keep them motivated…it's not easy seeing them like that but you need to kind of be their strength and pillar, for them to lean on throughout the day…no matter what day you are having you need to be there for them (N 3-S).

The participants stated that they had to encourage the rehabilitation patients to remain positive and push harder in the rehabilitation process. The participants said they helped the patients redefine realistic goals in the ever-changing rehabilitation journey in an attempt to keep the patients' hope alive.

I had one case with a patient here. She was saying she was hurt at her back and it's like she had lost on life, that she gave up on life and we were there with the rest of my team. We would go and talk with her and say things to make her smile. And to be herself and to accept everything that is going on in her life (N 4-S).

Just asking for their treatment, why they are not getting better, or this doctor saw that patient and he told them that he started her on treatment, but she is still the same. So, in that case you got to sit down and sort of reassure the patient and you know, try to make her understand that things don't happen all at once and you really got to take one day at a time…and really some things do work out and some things unfortunately don't work out the way we want them to work out (N 21-P).

The participants stated that some patients felt embarrassed doing some procedures in the rehabilitation units. The participants understood that patients undergoing rehabilitation had previously been independent and were now feeling uncomfortable with the changes that had taken place in their bodies because of their acquired disabilities. The participants put in some effort to keep the patients' hope alive by giving the patients information regarding their diagnosis and letting the rehabilitation patients know that their current condition was not as bad as it seemed.

I would say, it's like all the time because people here in rehabilitation depend on you like for self-catheterisation. They feel very embarrassed you know you have to be there to make them feel comfortable and reassure them all the time that what they doing is not a bad thing, what they going through is part and parcel of the situation that they are going through…you know it's like changing a nappy, helping a patient with self-catheterisation, bathing the patient is like some close up but the fact that I'm there, I keep reassuring them that…it's not a bad thing or embarrassing thing it's just part and parcel situation that they are going through (N 13-P).

6.2. Going the extra mile

This category was identified as a caring nursing encounter. The rehabilitation centre is an unfamiliar environment for patients undergoing rehabilitation and they may not be able to communicate what they want to the nurses. The participants stated that they had to go out of their way to promote positive care experiences for the rehabilitation patients. The participants had to sacrifice their time and energy to provide extra support to the rehabilitation patients to ease their burdensome rehabilitation journey. Despite an increase in workload and limited resources, the participants in the public settings stated that they strived to work against all odds as expressed in the following responses:

The patient sometimes asks to contact their relatives at home for personal reasons, due to the fact that our ward's telephone number has to go through the switchboard, sometimes it's difficult to ask the switchboard for personal things, so I do sometimes give my personal number to use (N 6-S).

It's when there was a patient in the ward where he was abandoned by the wife and then I did research on the patient to get information. Where does this wife stay then I went to the home of the patient to try get the ID [national identification document] *so that we can refer to the social worker so that the patient can get a grant and then at least get a placement in a step-down facility (N 8-S).*

We had a patient here who told me that the relatives do not know that he is admitted because he was from another hospital and by that time he could not remember the cell numbers of the relatives. So I had to phone relatives and even involve the social worker and the parents came and the patient was very happy (N 10-S).

The participants from the private setting also went the extra mile for patients; however, they had to be accountable for their actions because of constant supervision from their superiors.

It was involving a relative, I knew this relative. He used to come to visit the patient. He committed suicide, and then they wanted to open the door to see if he is inside because he didn't report for work. So they wanted me to give them numbers of the relatives, but I can't give out numbers. So he wanted consent from the patient to open the flat [apartment]. *Cognitively, the patient was not intact, so I didn't ask the patient for permission, I asked the doctor if I can give them numbers, they hadn't told me what was going on then. So when I started digging trying to find out what had happened, they told me that they think that the relative is there inside and it is the only relative this patient has. So that's when I started doing counselling because there was no social worker because it was the weekend. And they found the dead body there. So that's when now I had to intervene. There was no doctor around to help them (N 20-P).*

6.3. Frustration with patients

When asked about uncaring nursing encounters, the participants stated that they perceived certain patients as frustrating and difficult. This forced the participants to struggle between understanding the suffering rehabilitation patient and their own frustration over what they considered as problematic patient behaviours such as being demanding, irritating, and annoying. This strongly came out in the public setting.

When the patient is calling me now and then you know now and then for example when patient says please nurse pass me a urinal then I will go then when I come back, another patient will say please pass me a urinal. They are supposed to all say at one time (N 1-S).

I would say for a patient who was signing an RHT, refusal of treatment form, because we had spoken to him about not leaving the hospital when he wanted his clothes. I just went to the kids and gave it to them. I didn't check whether they were dirty or what because like I was really fed up (N 9-S).

I've noticed that when I was working that side, patients were aggressive to nurses, they just shout at nurses…swearing at them. I feel like eh…that we like giving nursing to patients, but others don't like nurses, so I feel like not giving the proper nursing because sometimes the patient doesn't want to be touched (N 12-S).

The following participant quoted from the private setting demonstrates that despite working under favourable environments, the nurses stated that sometimes they did not know how to behave when they encountered confused patients.

Sometimes the patients…some of them are confused and then when you are giving them medication, or whatever. And they ring the bell 2 minutes later and then they ask you again for their medication and stuff like that. Then you will say but I gave you just now and then they will say okay then after 5 minutes they will ask someone else for their medication. And that person comes to you and asks why you never gave the medication to the patient. So you like get irritated with the patient and think like I am

just with this patient like other patients. So that's like being insensitive. You know what I mean? Even though you know that the patient is confused and stuff like that, you just get irritated and then you go to the patient and just tell them, but I just gave you the medication you know (N 17-P).

6.4. Being inadequate

This category was identified as an uncaring nursing encounter. The participants understood that the rehabilitation process takes time and that successful rehabilitation requires patient cooperation. The participants believed they had the necessary rehabilitation experience to care for the rehabilitation patients; however, they felt they were not able to connect with the patients. This gave the participants mixed feelings of inadequacy and powerlessness, especially when they encountered patients who refused to cooperate with the rehabilitation treatment, leading the nurses to feel guilty and self-criticise, as expressed in the following response:

For all the patients, that sign the RHT [refusal of hospital treatment]*, that's where I feel maybe we are not doing enough. Maybe our counselling is not good enough to reach that part of their understanding or, maybe we are not trained enough or patient enough. Because I remember when I was working in the TB ward too, we used to get a lot of RHT, because you know patients get frustrated with Rifafour* [TB drug] *because of the size you know, and they become rude and use vulgar language towards the nurses and they end up signing RHT (N 11-S).*

Nurses are bound by ethical principles such as non-maleficence and thus are answerable for their actions and omissions. The participants felt that they were not doing enough to protect the patients and prevent them from harm.

Sometimes these patients, the CCF [congestive cardiac failure] *patients, they sometimes just die. You can talk to the patient and then go out there to the duty room when someone will say but I don't see the patient then you find the patient dead. Then you feel (sigh), there's nothing you can do. There are these situations that happen like that and then if the patient falls out of bed and you didn't see then we say, "Oh God, why didn't we see this?" (N 7-S).*

This participant's quote illustrates how the nurses feel unhappy when they fail to promote patient safety. The participants in the private setting felt that, because of the organisational pressures they are facing, they will tend to take blame for things that are beyond them:

I would feel unhappy if things happened and it's your fault. The nurses' fault because we are here to do the right things. So if the patient falls and gets injured, or something happens to the patient, then it will be the negligence of the nurses and it's not nice. (N 15-P).

6.5. Ignoring the patient

This category was identified as an uncaring nursing encounter. The participants' responses implied that the nurses would ignore or exclude demanding or difficult rehabilitation patients from nursing care. The participants confessed to creating an emotional distance between them and the patients so that they could avoid dealing with stressful rehabilitation patients. The participants stated that they acted in their professional capacity in the nurse-patient encounter and despite ignoring patients, they acknowledged that they were denying the rehabilitation patients compassionate care.

I don't ignore them every day, sometimes a minute and then check up on them, I don't ignore them the whole day, because sometimes today he calls you and is not a nuisance, he needs you seriously (N 5-S).
You know, sometimes the difficult ones you tend to ignore them but you know at the back of your heart you will be thinking, "hey, I have to go back" because at the end of the day, I will be answerable because I am like for the afternoon, so whatever happens at that time, even if you don't go to the patient, it will come back to you. Because you tend to say at the time "you know this patient is difficult" but before I leave, I normally go and check because you never know, maybe it's something minor. But because it is a patient that complains, everybody tends to run away from the patient (N 19-P).

The participants also stated that they would ignore confused patients because they felt the patients were requesting what at that moment was beyond the nurses' ability.

You see here at the rehab you get even confused patients then a person says I want to go upstairs but there is no upstairs here and I say you want to go and they say then I say OK and continue with my work cause you know he is confused but not a really a person who needs to be assisted in any way (N 18-P).

The participants from both the public and private settings stated that they tried to behave in a manner that would not be perceived as ignoring, but sometimes they could not attend to all of the rehabilitation patients' needs at once. The participants ignored the patients when they were pressed for time or when there was no available nurse to attend to the patients who needed help at that time. The participants were more focused on task completion, thus invoking patient feelings of being ignored.

I can say ignoring, but it's not that you do it intentionally. You see, maybe the other patient needs help before that one, maybe that patient doesn't know that you are busy with something else and you are passing by that patient while you are holding something. Maybe it's a basin with water and you passing by. So that patient will call you and he's unaware that you busy with another patient. So you can't attend to that one while you are busy with the other one (N 2-S).
You tell her I am busy, but I will attend to you or get somebody else to attend to you. This place really gets busy and if you don't do something there and there, sometimes you forget. So you go back and say am sorry but am here now to attend to you, it happens. It does happen (N 14-P).
There was an emergency, so one patient wanted the urinal, so I said I am coming back. The emergency bell was ringing and then I went to the emergency and forgot about the urinal but after the emergency, I went back to him and I apologised. There was a situation, so I needed to attend to it (N 16-P).

7. Discussion

There were no notable differences in the nurses' perceptions in the public and private settings.

7.1. Keeping their hope alive

Patients need continuous support and encouragement throughout their rehabilitation journey to remain hopeful (Nierop-van, Grypdonck, Van Hecke, & Verhaeghe, 2016). Hope helps patients cope better by maintaining a fighting spirit to face the disabilities and demands that they encounter in the ever-changing rehabilitation journey. A British study by Tutton, Seers, Langstaff, and Westwood (2012) noted that giving hope helps patients deal with their disease while they work towards their recovery. The study also reported that it is necessary to set realistic goals when dealing with patients so that they are better able come to terms with their current condition. The participants in the current study stated that they had to support the patients and maintain a close relationship to help the patients stay motivated and to continue their rehabilitation journey. A thematic analysis by Broadhurst and Harrington (2016) on patients receiving palliative care similarly reported that support given by nurses helped boost the patients' optimism. It is therefore important for nurses to constantly provide hope

and support and be kind to rehabilitation patients to keep their hopes alive, as decreased optimism and motivation leads to insufficient patient support, which becomes a weak point in caring.

7.2. Going the extra mile

The participants were going the extra mile by putting in extra effort to make it easier for the patients to undergo the rehabilitation process. This was identified as a caring nursing encounter. When nurses go the extra mile in caring for vulnerable rehabilitation patients, they act as agents of change and this builds a relationship between the nurse and the patient and helps with the development of motivation (Tyrrell & Pryor, 2016). This is important for rehabilitation patients because going the extra mile promotes positive care experiences and eases their transition through the rehabilitation process (Papadopoulos & Ali, 2016). According to Gallagher, Horton, Tschudin, and Lister (2009), patients perceived a good nurse as one who would "go the extra mile" by going out of their way to assist all patients.

7.3. Frustration with patients

Frustration with patients was identified as an uncaring nursing encounter. The participants reported frustration with certain patients they perceived as difficult or confused. The rehabilitation process takes time; therefore, patients undergoing rehabilitation stay in the rehabilitation unit for a long time and have many requirements, which heightens their need for the nurses' attention. Length of stay and heightened needs may increase the likelihood of a patient becoming difficult or demanding, forcing the nurses to avoid such patients (Edgoose, Regner, & Zakletskaia, 2014). Avoiding difficult or demanding patients negatively impacts the patient as it causes the nurse to lose contact with the patient, leading to social and health problems (Andersson et al., 2015; Michaelsen, 2012). Feelings of frustration may arise when nurses do not understand things from the patients' perspective (Edgoose et al., 2014; Ross, Tod, & Clarke, 2015).

Nursing encounters with difficult patients may lead to nurse burnout, fatigue and avoidance (Breiten, Condie, Vaillancourt, Walker, & Moore, 2018). To avoid this, researchers suggest the use of the ROAR (Reflective, Objective, Assessment, Reassurance) mnemonic to help healthcare providers deal with difficult patients (McCarthy, Cheatham, & Singla, 2018). The ROAR mnemonic helps healthcare providers minimize frustration through engaging in patient-centred approach by reflecting on the patients' distress, engaging patients when taking their history, assuring and reassuring the patients (McCarthy et al., 2018). This in turn leads to successful nursing encounters.

7.4. Being inadequate

Nurse inadequacy was identified as an uncaring nursing encounter. The participants reported feeling inadequate when they were unable to connect with the patient during a nursing encounter and found it difficult to understand why some patients refused to adhere to the treatment regimen that was for their own benefit. The participants believed that they had enough experience to care for rehabilitation patients; however, they questioned their own competence and self-criticised when they were unable to prevent patients from harm. The literature supports this response, wherein nurses reported feelings of insufficiency and inadequacy in nursing encounters when they were unable to support patient safety because of an increase in workload (Browall et al., 2014; Welp, Meier, & Manser, 2015; Westin & Danielson, 2006). Nurses in these circumstances felt vulnerable when they had the impression of failing to provide adequate care to patients (Holopainen et al., 2017).

7.5. Ignoring the patient

Another nursing encounter identified as uncaring was "ignoring." Participant feedback identified challenging situations nurses were dealing with in inpatient rehabilitation, such as increased workload and scant resources (human). Nurses working in rehabilitation settings have to continually deal with the physical and emotional needs of rehabilitation patients and this can be very stressful. Not paying attention to the emotional needs of patients can have deleterious effects and cause them to disengage from care (Reader & Gillespie, 2013). A Swedish study conducted in psychiatric settings reported that nurses ignored patients who were not expressive of their suffering and attended to those who were more expressive (Vincze, Fredriksson, & Wiklund Gustin, 2015). The non-prioritisation of the non-expressive patients made them seem invisible to the nurses. When the patients expressed anger or aggression, the nurses attributed this to the patients' illness and not as the patients' way of getting the nurses' attention (Vincze et al., 2015). Nurses need to view the patient as a unit and be sensitive to provide care according to individual patient needs because ignoring the patient means denying them compassionate care. This can have a negative effect on the vulnerable rehabilitation patient and can positively or negatively shape their perception of future nursing encounters.

8. Study limitations

This study was conducted in two research settings limiting its representation of a culturally diverse South African inpatient rehabilitation settings. This study did not quantify caring and uncaring nursing encounters in inpatient rehabilitation settings. Nurses work across healthcare settings, therefore they could have been presenting perceptions across healthcare settings.

9. Conclusion

The participants reported caring nursing encounters as those that promoted positive care experiences among patients. The nurses recognised the need to continually motivate and support rehabilitation patients to keep them hopeful as they undergo the rehabilitation process. The nurses put in extra effort to ease the rehabilitation journey for their rehabilitation patients.

Uncaring nursing encounters were reported as those that led to negative care experiences, which is detrimental to the provision of compassionate care. Nurses deal with challenging situations in rehabilitation settings, which might become very overwhelming if they fail to cope. This can lead to a variation in the care administered.

10. Recommendations

Nurses must constantly encourage the rehabilitation patient to stay positive in the rehabilitation journey, and continue providing holistic support to them.

Nurses must empower rehabilitation patients to be self-managers of their conditions through the use of the patient-centred care models. This will help nurses put patients' needs first, through patient education on their role in the rehabilitation treatment process, engaging patients in their treatment, and providing an environment that encourages patient participation.

Nurses must strive to strike a balance in caring by building trust with rehabilitation patients by being kind, courageous, and calm. They also need to continue providing physical comfort and educational, emotional, and spiritual support.

Nurses must encourage the rehabilitation patients to air their grievances regarding uncaring nursing encounter as they happen, so that they can get proper help. This can be done through the encouragement of open comments and suggestions from the patients.

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Contributions

Both authors were involved in the entire process. The principal researcher prepared the study design, collected and analysed the data, and wrote the manuscript, all under the supervision of the research supervisor.

Declaration of Competing Interest

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

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