Article

Patients' Perceptions of Caring and Uncaring Nursing Encounters in Inpatient Rehabilitation Settings

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Abstract

This study explores and describes caring and uncaring nursing encounters from the perspective of the patients admitted to inpatient rehabilitation settings in South Africa. The researchers used an exploratory descriptive design. A semi-structured interview guide was used to collect data through individual interviews with 17 rehabilitation patients. Content analysis allowed for the analysis of textual data. Five categories of nursing encounters emerged from the analysis: noticing and acting, and being there for you emerged as categories of caring nursing encounters, and being ignored, being a burden, and deliberate punishment emerged as categories of uncaring nursing encounters. Caring nursing encounters make patients feel important and that they are not alone on the rehabilitation journey, while uncaring nursing encounters make the patients feel unimportant and troublesome to the nurses. Caring nursing encounters give nurses an opportunity to notice and acknowledge the existence of vulnerability in the patients and encourage them to be present at that moment, leading to empowerment. Uncaring nursing encounters result in patients feeling devalued and depersonalised, leading to discouragement. It is recommended that nurses strive to develop personal relationships that promote successful nursing encounters. Further, nurses must strive to minimise the patients' feelings of guilt and suffering, and to make use of tools, for example the self-perceived scale, to measure this. Nurses must also perform role plays on how to handle difficult patients such as confused, demanding and rude patients in the rehabilitation settings.

Keywords: inpatients; rehabilitation nursing; caring encounter; uncaring encounter

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Introduction

Nursing encounters are subjective experiences which happen in the form of face-to-face interactions between the nurse and the patient (Halldórsdóttir 1996; Söderman, Rosendahl, and Sällström 2018; Wälivaara, Sävenstedt, and Axelsson 2013; Zotterman et al. 2015). An important attribute of a caring nursing encounter is the nurses' ability to listen intently and respond to the patients' individual needs (Lachman 2012; Söderman, Rosendahl, and Sällström 2018). It has been suggested that a caring nursing encounter becomes apparent through the nurse's openness and ability to perceive individual patient needs (Halldórsdóttir 1996; Söderman, Rosendahl, and Sällström 2018; Wolf 2012). An uncaring nursing encounter, on the other hand, is characterised by an unpleasant nurse-patient interaction that leaves the patient feeling vulnerable, uncared for (Halldórsdóttir 1996; Rantala, Ekwall, and Forsberg 2016; Wolf 2012), and unwanted by the nurse. Such encounters cause patients to feel less important or burdensome, making nursing encounters difficult. This can be very challenging for the patients admitted to rehabilitation settings, as their expectations of rehabilitation treatment may not be met if they experience contrasting nursing encounters.

Patients admitted to inpatient rehabilitation settings are usually stable physiologically but may be struggling physically and/or psychologically to cope with changes resulting from either injury or illness (Sigurgeirsdottir and Halldorsdottir 2008). Caring for this group of patients can be challenging for nurses as these patients are trying to adapt to existential changes in self-identity while at the same time trying to hold on to their "old self" (Sigurgeirsdottir and Halldorsdottir 2008; Camicia et al. 2014). The presence of existential changes makes patients extremely vulnerable and sensitive towards the outcome of nursing encounters. Nurses caring for rehabilitation patients need to be fully aware of patients' expectations, needs and challenges, so that they can provide appropriate care (World Health Organization 2011).

Study Background

Globally across care settings, researchers have reported some nursing encounters as unpleasant, with nurses being cold, distant and/or inaccessible to patients (Bramley and Matiti 2014; Gill et al. 2014; Grondahl et al. 2013; Skär and Söderberg 2012; Söderman, Rosendahl, and Sällström 2018; Weyant et al. 2017; Wolf 2012). Nurses have been perceived to be unkind, unapproachable, too busy to respond to patient requests, and to share little or no information with the patients regarding their conditions (Gill et al. 2014). Patients described their care as routine and unrelated to their specific needs (Bramley and Matiti 2014; Grondahl et al. 2013). In contrast, when nurses are friendly and supportive, patients describe them as excellent and consequently make fewer requests and do not complain about the nurses' busy schedules (Bramley and Matiti 2014; Gill et al. 2014). With contrasting encounters, patients become vulnerable, causing aggravated distress and reduced well-being, increasing their hospital stay in the rehabilitation facilities.

The South African healthcare system reflects an imbalance between services to the public and the private sector (Mayosi and Benatar 2014). Although the public sector facilities serve 82 per cent of the population, they are usually underfunded, inefficient, and often overcrowded with patients seeking medical services and treatment (Coetzee et al. 2013; Mayosi and Benatar 2014). Private sector facilities, on the other hand, are adequately equipped with sophisticated equipment and facilities compared to those in developed countries and offer services mainly to patients with private health insurance (Coetzee et al. 2013; Mayosi and Benatar 2014).

There have been reports of patient abuse, verbal assault and neglect in South African public hospitals, among other professional misconducts. Also, nurses wilfully neglected patients, who they termed as having poor attitudes and this led to the delivery of sub-standard care (Haskins et al. 2014). Negative staff attitudes to patients lead to a decline in the delivery of quality care, undermining South Africa's healthcare system to provide quality care that improves the patients' well-being. Further, patients admitted to a public hospital indicated nurses' unprofessional behaviour, where nurses were rude, ignored patients or spoke to patients using a harsh tone (Hastings-Tolsma, Nolte, and Temane 2018; Jardien-Baboo et al. 2016). This made the patients afraid to approach the nurses, thus they were unable to communicate their needs to the nurses. A study done on birthing mothers admitted to private and public hospitals indicated that patients in public hospitals felt unwanted and feared the nurses, stating that failure to follow nurses' instructions led to negative repercussions (Hastings-Tolsma, Nolte, and Temane 2018). Further, researchers reported that patients in both private and public hospitals stated that their preferences for care were disregarded by the nurses (Hastings-Tolsma, Nolte, and Temane 2018). Patients in private hospitals were subjected to the overuse of technology, undermining their rights to choose the kind of treatment they wanted (Hastings-Tolsma, Nolte, and Temane 2018). This affects the patients' expectations of a nursing encounter, leading to negative feelings of being unwanted or unimportant to the nurses. With this imbalance, the services offered in the public and private sectors present a considerable variation in service delivery and this is detrimental to the provision of quality care to patients, especially in the rehabilitation settings.

Purpose of the Study

To explore and describe patients' perceptions of caring and uncaring nursing encounters in inpatient rehabilitation settings in KwaZulu-Natal, South Africa.

Theoretical Framework

The theory of caring and uncaring encounters by Halldórsdóttir (1996) guided this study, and it makes use of two metaphors to explain the concepts of caring and uncaring nursing encounters, namely the wall (uncaring encounter), and the bridge (caring encounter). The wall represents a disconnection or absence of a caring relationship

between the nurse and the patient. This leads patients to believe that the nurses are uncaring, which is manifested in a lack of communication and detachment from the patient. The bridge, on the other hand, represents the existence of a caring connection and a therapeutic relationship between the nurse and the patient in which there is open communication and the ability to connect with the patient (Halldórsdóttir 1996).

Definition of Terms

Caring nursing encounters: Reports of feelings that promote patient satisfaction with care, which include sensitivity to patient needs, showing genuine concern to the patient, being respectful of self and patient, being attentive in the present moment by being present physically and emotionally in dialogue, and listening and responding to the patient (Halldórsdóttir 1996).

Rehabilitation patient: Patients (18 years or older) admitted to an inpatient rehabilitation setting to receive treatment, which includes treatment such as physiotherapy, and occupational therapy (*Merriam-Webster Dictionary*, s.v. "patient"). Acute rehabilitation patients are patients admitted to the unit for a period of approximately 5 weeks and not longer than 180 days, while those chronic are those admitted to the unit for longer periods of time (more than 180 days).

Uncaring nursing encounters: Reports of feelings that promote patient dissatisfaction with care, which include inattentiveness to patient needs, indifference to the patient, short and unfriendly nursing encounters, and ignoring, mistreating or ridiculing the patient (Halldórsdóttir 1996).

Research Design

The researchers used an exploratory and descriptive design. A semi-structured interview guide was used to collect data through individual interviews. Data were analysed using the manifest content analysis by Erlingsson and Brysiewicz (2017). The content analysis allowed the researchers to analyse textual data through familiarisation with the data, dividing the data into meaningful units, condensing the data, developing codes and then formulating categories in an attempt to uncover the perceptions of the participants.

Study Setting

The study took place in two inpatient rehabilitation settings (public and private) which are situated within a city in South Africa. The public inpatient rehabilitation setting is a low-resource setting, serving 82 per cent of the general public (Mayosi and Benatar 2014). This setting is under-resourced, overcrowded and with fewer human resources, usually with 3 to 4 nurses caring for 25 patients (Mayosi and Benatar 2014). The public setting admits longer-term or chronic rehabilitation patients. The private inpatient

rehabilitation setting is a high-resource setting with state-of-the-art facilities. The private setting is better resourced with a nurse-patient ratio of one nurse to three patients. The private setting admits acute patients to offer post-acute rehabilitation with length of stay at the rehabilitation unit not longer than 180 days.

Study Sample

Seventeen participants were interviewed. The inclusion criteria were: adult patients 18 years or older at the time of the study who had been admitted to the inpatient unit for at least one and a half weeks, receiving nursing care alongside rehabilitation services, in a medically stable condition and able to communicate in English or isiZulu (the indigenous language). Excluded were paediatric patients and patients not in a medically stable condition at the time of the study.

Sample Selection

The first step was to seek entry into the inpatient rehabilitation settings by getting in touch with the charge nurse of each setting. Contact was established and planned visits were then made to the inpatient rehabilitation settings. In the second step, eligible participants were purposively sampled and invited to participate in the study. The participants were sampled across the acuity spectrum, i.e. acute and chronic rehabilitation patients. Some participants in the public setting were ready for discharge but were still waiting for financial clearance to go home. The participants were approached individually, and verbal and written information regarding the study was given together with consent forms for signing. Those participants who were unable to sign the consent forms due to their disabilities, gave verbal consent and this was recorded. The participants were informed of the study benefits and risks.

Data Collection

Data were collected using a semi-structured interview guide to conduct individual interviews between June 2016 and August 2016. Interviews took place in a private and comfortable setting chosen by the participants. Those participants who were bedridden were interviewed at the bedside, where screens were applied for privacy. Sampling was concluded after data redundancy was determined by the research team, with no new data emerging. The interviews were conducted by a registered nurse with a masters' degree in nursing who was not known to the participants.

Interviews began with questions on caring nursing encounters, for example "Can you tell me what you understand by the nurse being caring?" and "Can you tell me a recent story of when this happened?" To get clarification, probing questions were asked, for example "At what point did you feel the nurse was open and perceptive to your needs?" Thereafter the participants were asked about uncaring nursing encounters, for example "Can you tell me what you understand by the nurse being uncaring?" and "Can you tell

me a recent story of when this happened?" An example of probing questions on uncaring nursing encounters asked is "Describe a situation where you felt the nurse was not interested in you." The interviews lasted approximately 30 to 45 minutes each.

Data Analysis

The data collection and analysis occurred simultaneously, guided by the principles of content analysis outlined by Erlingsson and Brysiewicz (2017). The content analysis allowed the researchers to organise and elicit meaning from the data so that realistic conclusions could be drawn. The content analysis started with the interview recordings being listened to before being transcribed verbatim by the principal researcher. The interview transcripts were then read and reread line by line several times to look for repetitions of words, sentences and paragraphs. Sections of the text (meaning units) illustrating perceptions of caring and uncaring nursing encounters were highlighted and condensed, while retaining their meaning. These condensations were then labelled with a code and categories developed from the codes (Erlingsson and Brysiewicz 2017). The researcher and her supervisor (an experienced qualitative researcher) worked together to analyse the data. Regular meetings were held to discuss the emerging findings and if the categories had been captured appropriately. The researcher frequently wrote, reviewed and rewrote the findings in an attempt to uncover the real meanings described by the participants. All interview data were stored in Microsoft Word in a password-protected computer.

Ethical Consideration

Ethics approval for the study was obtained from the Research Ethics Committee (HSS/0393/016D) of a university in South Africa and from the research settings. The participants were informed about confidentiality and that they could withdraw from the study at any stage and that this would not affect the care they were receiving in the inpatient rehabilitation settings. The participants gave consent for the interview to be recorded.

Trustworthiness

To ensure rigour of the qualitative findings, trustworthiness of the study was ensured using Lincoln and Guba's evaluation criteria, namely credibility, transferability, dependability and confirmability (Lincoln and Guba 1986). Credibility was achieved through prolonged engagement, where the principal researcher spent a considerable amount of time (approximately12 months) in the research settings to become familiar with the research setting and to build rapport with the participants. The data were collected from two different research settings to reduce the possible effects on the study of local factors which are specific to one setting. For dependability and confirmability, a detailed description of the research process has been given and an audit trail

documented. For transferability, the research context has been richly described to allow the reader to transfer findings from this study to other befitting contexts (Shenton 2004).

Profile of the Participants

Table 1 presents a demographic profile of the participants. As shown, the youngest participants were in their twenties and the oldest in their eighties. The length of stay in the inpatient rehabilitation setting ranged from one and a half weeks to six weeks. The participants were sampled from two research settings (private and public).

Table 1: Demographic profile of the participants

Participant	Age	Length of stay	Inpatient rehabilitation setting
1	30s	2 weeks	State
2	70s	1 month	State
3	50s	1 month	State
4	60s	4 months	State
5	60s	1½ weeks	State
6	30s	1 month	State
7	20s	2 weeks	State
8	70s	2 weeks	State
9	40s	1 month	State
10	20s	1 month	Private
11	40s	5 weeks	Private
12	40s	2 weeks	Private
13	40s	1 month	Private
14	80s	6 weeks	Private
15	60s	1½ weeks	Private
16	60s	1 month	Private
17	30s	1 month	Private

Study Results

In this study, the differences in the patients' perceptions of caring and uncaring nursing encounters between the private and public inpatient rehabilitation settings did not emerge in the categories. The participants in the public setting expressed empathy towards the nurses citing time and resource constraints, while voicing opinions to justify the reasons for poor nursing care or uncaring nursing encounters. All participants trusted the nurses' competence and professionalism by citing instances where they felt the nurses were exemplary in care. The participants from the private hospital setting also voiced uncaring nursing encounters.

Categories Identified

Five categories emerged from the data analysis; two related to caring nursing encounters, "noticing and acting" and "being there for you", and three related to uncaring nursing encounters, namely "being ignored", "being a burden" and "deliberate punishment".

Noticing and Acting

When asked about caring nursing encounters, the participants from both private and public inpatient rehabilitation settings expressed their trust in the nurses' ability to offer quality care. The nurses were reported as competent in noticing, pre-empting the patients' needs and acting with relevant responses in the interest of the patients. The nurses in these instances were reported as being sensitive to the patients' needs and as showing compassion by attending to these needs. The following participant comments cite relevant instances:

> It's the way they are caring … they care very well, they understand me. They know when I need something and they come and give it to me. Yeah, and when I look at them, they are responsible. They are caring that way. (P9-S)

> When I was having a bath and then she noticed that the bedsore, there was a small cut on it and straightaway she called the sister [registered professional nurse] to come and check on it and not just leave it and put the allevyn [special dressing] on it or whatever. Like some people do, she called and she said "please check". Told the main sister [senior registered professional nurse] to check on it and once I was cycling and my calf muscle was a bit hurt, she noted that down. (P11-P)

> So I came from another hospital. When I came here, my beard and hair was growing. The nurse came to me and asked if she could shave my beard and the head and I said yes. The nurse shaved me nicely with care. (P12-P)

Being There for You

In this category of caring nursing encounters, the participants from the private and public inpatient rehabilitation settings reported that nurses were attuned to the patients' needs and concerns, therefore performed intentional acts when administering care, without making the patients feel guilty or focusing on their insecurities. The participants stated that they felt cared for and listened to by the nurses.

> When they give us food, they give us with respect, they go a long way for us. If you can't walk, they even fetch water for you. And everything they do for you without even facial expression. They are so wonderful. (P5-S)

> Yesterday they took the clips out from my leg and it was very sore. It's about 30 stitches clips here on my leg and my knee. I cried a bit because it was very sore. It's getting

better now. The nurse was there to comfort me and she was telling me that I must calm down, that everything will be fine. (P8-S)

Being a Burden

When asked about uncaring nursing encounters, the participants from the private and public settings stated the need to silently put up with the feelings of being a burden to the nurses. The participants reported feelings of being a burden when they had to keep calling for assistance from nurses who seemed too busy to attend to them. The participants' comments nonetheless showed sympathetic awareness of the difficulties the nurses had to cope with, and recognised a need to bear with the circumstances:

> They are so busy. You can understand they are exhausted. Like for example in this in this ward here, there are about four nurses or three nurses and you can see it is a very big ward and they run all over the place, they [are] bound to be exhausted. (P2-S)

The nurses' failure to attend to patients' needs reportedly led to feelings of guilt on the part of the patients and reluctance to bother the nurses who seemed preoccupied.

> I feel like I'm boring them when I'm calling them. I have to keep calling them. (P10-P)

Along with complaints about inadequate care, there was, at the same time, acknowledgement of the nurses' busy schedules. One participant noted that the nurses had a lot of things to attend to and that there might be shortcomings in care if the nurses were pressed for time. This was not only highlighted in the public setting, but also in the private setting.

> Maybe they got other duties to do but some will quickly do it. They don't wipe properly uhm … when a nurse wipes you properly, then you know they really care because when you [are] lying, it causes rashes and other problems. So sometimes they are obviously in a rush and they just do it quickly. (P15-P)

Being Ignored

In this category of uncaring nursing encounters, the participants from the public and private setting reported feeling that the nurses were ignoring them when they walked away, failed to answer patient calls, or pretended that they did not hear the patients calling them. Being ignored makes the patients feel unimportant and demotivated, as suggested in the following participant quotes:

> Some nurses will ignore you, if you have an urgency and you call the nurse, the nurse will ignore you and look away and actually just shout at you if you want something, yeah, some of them are that way. (P6-S)

> I got this bandage on my leg and it was coming off. I called the nurse to help me … she was standing next to me. The nurse ignored me and it's only the nurse from the next shift that helped me with my bandage. (P7-S)

The participants in the private setting felt they were being ignored when nurses gave them the impression that they had no interest in creating a cheerful environment for them by failing to greet them.

> They walk in fast, they won't greet you. Just to say "hallo, good morning?" Then uuhm … the attitude of the way they walk around … but there are some that are different that I agree, that's why you people must pick the right one and make the place pleasant, they would [should] be smiling. (P14-P)

Deliberate Punishment

A further category of uncaring nursing encounters was deliberate punishment. The participants from the private and public inpatient rehabilitation settings spoke of nurses deliberately punishing patients by refusing requests, making patients wait, being aggressive, or abusing the powerlessness of the patients, thus causing intentional distress. The participants felt that nurses were neglecting them, despite the different kinds of limitations they had. In the public setting, it was evident that the patients are being subjected to long waiting times before being attended to by the nurses and this led to patient suffering. A participant explained:

> Like yesterday for instance, I am very heavy, and I get scared of falling off the bed. So, it's hard for them [the nurses] to turn me. I got to turn myself. And when I did eventually, and because of my shingles, I got a pillow behind my back. The nurse took the pillow out and after the bed was made, she didn't put it back. And yet I told her "put the pillow back". Under my foot too I need a pillow. She didn't put that pillow back. So I had to lie like that from 3 o'clock in the afternoon till 9 pm … then the night staff came … she doesn't care. (P4-S)

Patients in the public settings were subjected to deliberate suffering if they were absent when the nurses were undertaking their routine in the ward:

> I went out for a cigarette, I came back she said "oh you went out for a cigarette, you didn't get your tablets". She didn't just kindly tell me, she told me in a nasty way, uhm … she basically fought with me and shouted at me. She didn't tell me, she shouted at me and told me "oh but you went for a cigarette. So you not getting your tablet". She refused to give me my tablet. (P1-S)

The participants in the private settings reported being deliberately made to wait before the nurses attended to them, being given the impression that the nurses had other more important priorities. A participant said:

> There was a time I rung the bell and then she didn't come over … and then she just switched it off and then moved to another place and do [did] some other things, and then she said I have to wait, someone will come. And do some stuff. So it happened like that. (P17-P)

In another instance an account was given of a patient's powerlessness which was very frustrating to the patient concerned:

> Sometimes when they bath you, they just pull your sore shoulder and they just pull it, they don't care. That's not nice. I realised there is [are] a lot of people to bath. But you got to be careful with people, what injuries they've got because they pulled my shoulder, it was out of place. So they pulled it so hard. (P3-S)

Discussion

Caring nursing encounters were reported when the nurses noticed the patients' needs and acted on them, and when the nurses were there for the patients. On the other hand, uncaring nursing encounters were reported as being made to feel a burden to the nurses, being ignored and being deliberately punished by the nurses. Uncaring nursing encounters made the participants feel unimportant and unwanted by the nurses.

Noticing and Acting

The nurses' ability to notice the rehabilitation patients' needs and act on them evoked praise and admiration from the study participants. While noticing and acting, the nurses showed awareness of the patients' vulnerability and exhibited an emotional reaction in responding to that vulnerability. In literature, noticing is described as the activity that stimulates action before words are exchanged between the nurse and the patient (Watson and Rebair 2014). Noticing allows the nurses to pre-empt the patients' needs, interpret what they noticed and respond to that need (Watson and Rebair 2014). The nurses' actions have been characterised as "knowing how" when they recognised and provided quick solutions to a patient's concerns; nurses were termed "inadequate" when they failed to give patients information regarding subsequent care (Tejero 2012; Watson and Rebair 2014). In rehabilitation settings, there are patients who may not be able to communicate their needs. The nurses need to be able to notice the patients' change in behaviour or other subtle cues so that they can provide timely relevant intervention. Failure to notice patient needs can have serious consequences on nursing encounters, leading to poor quality care and eventually to reports of uncaring nursing encounters (Watson and Rebair 2014).

Being There for You

Being there for the patient was identified as a caring nursing encounter, where the participants reported feeling comfortable in the presence of the nurses. Literature highlights that being there for the patient means being attentive to the present moment, present in dialogues, listening and responding to patient concerns, and being present in the patients' situation, both physically and emotionally. Being there for the patient allows the nurse to give full attention to the patient, and this leads to a genuine and meaningful interaction between the two (Boeck 2014; Bozdoğan and Öz 2016; Kostovich and Clementi 2014). It is through nursing care that nurses empathise with

patients, and deliberately use their nursing knowledge to bring about a therapeutic change to the patient (Boeck 2014; Bunkers 2012; Kostovich and Clementi 2014). Empathetic presence of the nurse when the patient is experiencing difficulties contributes to therapeutic healing which is essential for rehabilitation patients (Bozdoğan and Öz 2016; Komatsu and Yagasaki 2014; Kostovich and Clementi 2014; Lillekroken, Hauge, and Slettebø 2015).

Findings from this study echo previous research where patients reported that they were in "good" hands (Holopainen, Kasén, and Nyström 2014) because the nurses made them feel comfortable and did not judge them. Similarly, patients appreciatively noted instances where the nurses' presence helped in their follow-up care, clarification of treatment and acting as companions during the experience of care (Kostovich and Clementi 2014; Mohammadipour et al. 2017). This was made possible by the nurses' full presence with the patients. Some nurses were, however, reported as lacking compassion, and patients suggested that such nurses needed to put themselves in the patients' shoes and experience how they felt (Bramley and Matiti 2014).

Being a Burden

Being a burden emerged as an uncaring nursing encounter, where the participants felt they were a burden to the nurses who were too busy to attend to their needs. The participants from the private and public settings reported having to keep calling for a nurse until they almost gave up. Patients' feeling like a burden to the nurses comes as a result of dependence on nurses for care and frustration with illness or worry, leading to feelings of guilt (Geng et al. 2017). Feelings of being a burden can affect the patients' preferences for care because they will be reluctant to seek attention from the nurses. Patients receiving care for chronic pain rated emotional and social burden as the highest in their self-perceived burden with caregivers (Wilson et al. 2017). The feelings of being a burden towards caregivers were associated with suicidal ideation among this group of patients receiving treatment for chronic pain (Wilson et al. 2017). These authors suggested the need to assess the patients' self-perceived burden using the self-perceived scale as this helps to minimise the patients' feelings of guilt and suffering (Wilson et al. 2017).

Being Ignored

The participants cited instances where the nurses ignored them by pretending not to hear when being called or failing to greet them. Trauma patients receiving care in a Swedish hospital concurred and gave an account of instances where the nurses ignored them, excluded them from discussions, did not take them seriously and abandoned them (Granström et al. 2019). Patient neglect or omission of care has been associated with systemic culture (high workload, staff shortage, poorly described procedures, lack of training) in that negative staff attitudes lead to failure to meet the standards of care outlined by the institutions. This leads to delivery of substandard care giving patients the impression that nurses are not concerned about their physical or emotional well-

being (Reader, Gillespie, and Mannell 2014). A lack of concern or attention from nurses leads patients to believe that they are invisible and/or are being taken for granted, thus the defensive use of unreasonable demands to constantly remind the nurses of their existence (Hansson et al. 2011; Widar, Ek, and Ahlström 2007). However, when nurses are friendly and attentive, patients make fewer requests and show their appreciation of what nurses do (Bramley and Matiti 2014; Gill et al. 2014). Ignoring patients can therefore have a negative impact on their physical and emotional well-being (Reader, Gillespie, and Mannell 2014).

Deliberate Punishment

The participants reported instances where the nurses deliberately punished them by not attending to their needs, and mention was made of patients' bells being deliberately switched off, nurses refusing to take patient requests, and being aggressive or abusing the patients' powerlessness. These instances made patients feel neglected in rehabilitation settings. A systematic review of patient neglect in healthcare institutions reported that neglect could be understood in symbolic, material and relational contexts (Reader and Gillespie 2013; Reader, Gillespie, and Mannell 2014). In the symbolic context, patients symbolise care in terms of close and continuous relationships, therefore patient neglect becomes evident when patients are excluded from decision-making or when there is a lack of continuity of their care. Material context was argued based on the fact that resource constraints would lead healthcare providers to behave in a certain way, leading to gaps in provision of nursing care. Lastly, the relational context was attributed to the development of personal relationships with caregivers, to allow nurses to provide continuous care to the patients in their trajectory through the health services (Reader and Gillespie 2013; Reader, Gillespie, and Mannell 2014).

These aspects of neglect lead patients to feel depersonalised and deliberately punished by the nurses. Further, a study conducted in a South African maternity ward stated that the nurses neglected and were rude and unkind to the patients (Chadwick, Cooper, and Harries 2014; Honikman, Fawcus, and Meintjes 2015). The patients reported nurses as having negative interpersonal relationships with them, thus treating them badly. The patients were denied information on their treatment, were left alone without attention from the nurses, and felt they lacked relational connection between them and the nurses (Chadwick, Cooper, and Harries 2014; Honikman, Fawcus, and Meintjes 2015). This made the patients feel invisible, forgotten and gave them a feeling that the nurses were punishing them.

Limitations of the Study

This study was conducted in only two research settings, limiting its representation of wider cultural diversity in South Africa.

Conclusion

Caring nursing encounters give nurses an opportunity to notice and acknowledge the existence of vulnerability in patients and encourage them to be present at that moment. These encounters lead to patient empowerment. Uncaring nursing encounters lead to patients feeling devalued and depersonalised, and this can have serious consequences on the rehabilitation of patients. Uncaring encounters make patients vulnerable and easily set off balance, leading to discouragement.

Recommendations

Nurses must strive to develop personal relationships that promote successful nursing encounters. Nurses must strive to minimise patients' feelings of guilt and suffering, and they could make use of tools to measure this, for example the self-perceived scale. Nurses must also perform role plays on how to handle difficult patients such as confused, demanding and rude patients in the rehabilitation settings.

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