Original Article

The Influence of the Yoruba Culture on the Lived Experiences of Clinical Nurses following Death of Patients: A Qualitative Study from a Developing Country

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Abstract

Background: Nursing training focuses more on health promotion and saving lives rather than preparing for the end of life. Although nursing encompasses care at the beginning and end-of-life, nurses are not prepared for end-of-life care and death of patients. Studies have attempted to identify and describe the effects of patients' deaths on nurses, but very few studies have described the experiences of nurses dealing with paediatric death. The study determined τo explore the effect of the Yoruba culture on the lived experiences of clinical nurses following death of paediatric patients, and describe the coping strategies adopted by nurses to reduce the effect of the lived experiences in selected hospitals in Ilorin**.**

Method: A hermeneutic qualitative study design was used to describe and give meaning to the experiences of the participants at the University of Ilorin Teaching Hospital, Ilorin, and Children Specialist Hospital, Centre-Igboro, Ilorin, Kwara state. Data was collected using semi-structured in-depth interview guide, and face-to-face interviews were conducted among 21 participants. Content and thematic analysis, and Atlas TI were used to analyse data.

Findings: Four themes were identified; cultural and religious beliefs and practices about a child's death, reactions to a child's death, coping strategies learned on their first experience of a child's death, coping techniques adopted by nurses. Culture has a major influence on the nurses' lived experiences and grieving, due to the varying beliefs of the religious and ethnic cultures, nurses feel inadequate in providing comfort to grieving parents. They also feel it is unprofessional to cry or grieve openly following the death of patients. The major coping strategy adopted by nurses is that they are more committed to their work.

Linking Evidence to Action: The study found that nurses use work as their most effective coping strategy following the death of paediatric patients. They also strive to provide their best possible care in spite of their reactions to death

Key Words: Lived Experiences; Clinical Nurses; Death; Patients; Developing Country

Background

Dying and death as a phenomenon is rated by nurses as the second most challenging part of nursing (Faremi et al., 2019). It can be associated with feelings of depression and anxiety as nurses, who are the closest to families, have to suppress their own emotions to be able to provide comfort to the bereaved family, putting them at the risk of burnout (Faremi et al., 2019; Guo & Zheng, 2019; Kostka et al., 2021). Ethnic and religious culture influence how they view and react to death, and invariably affects their interaction with dying patients either positively or negatively (Faronbi et al., 2021). It can be assumed that, since most religions claim the existence of the afterlife, belief of nurses in any of such religions can provide some form of comfort for them. However, Faronbi et al. (2021) noted that an inability to convey spiritual assurance to the dying patient can leave nurses feeling helpless and inadequate, therefore increasing the stress the nurse is already going through, and negatively influencing his/her attitude and care of the dying patient and provision of emotional support to the patient's family.

As a result of the unique roles of nurses, they are at risk of burnout when caring for dying patients (Faremi et al., 2019; Guo & Zheng, 2019). Other challenges nurses face while caring for the dying are not limited to insufficient resources, staffing problems, no support from experienced nurses and poor communication. Very often, their physical and mental health is ignored for the "bigger picture" of providing care, but all these portends to exhaustion or compassion fatigue (Ajayi & Hamalainen, 2022). Nigeria is a multicultural country; its culture is made up of ethnic and religious beliefs. Culture being a way of life, has a strong influence on how nurses will react to situations occurring in the clinical setting (Chukwuneke et al., 2012; Galiana et al., 2017), and its influence on grieving of nurses after caring for dying patients and their eventual death has not been investigated robustly.

As people who interact closely and frequently with patients, nurses are frequently susceptible to grief (Karn & Yadav, 2018). Most studies on patients' death are interested in the response of the significant others, or how the nurse is expected to give emotional support and assist the relatives in the grieving process. Only very few address the nurses' emotional needs. It was observed that these studies are mostly on burnout, compassion fatigue and secondary stress syndromes, three phenomena that address a wide range of situations that affect the nurse, but rarely address death and how nurses manage their grief following the death of a child. It can be assumed that this is because death is a difficult topic to discuss, or because nurses are expected not to be too emotionally invested in their patients during the orientation and working phases of the nurse-patient interpersonal relationship, and to be able to completely detach themselves following the termination of said relationship at the death of the patient (Hagerty et al., 2017; Karn & Yadav, 2018).

As part of the nursing curriculum in Nigeria, psychology and sociology are expected to be taught to the students. Under sociology, they are taught the culture of their location of study, and the culturally accepted ways to relate with different age groups in that locality. During orientation lectures for newly employed nurses, the culture is explained so that the nurses can provide culturally acceptable care to the patients. The annual continuing education classes in one of the study centres (University of Ilorin Teaching Hospital) emphasise culturally acceptable care. All of these ensure that nurses who are not Yoruba can provide culturally acceptable care to a Yoruba patient.

Purpose: The purpose of this study was to determine if the Yoruba culture has an effect on the lived experiences of clinical nurses following death of paediatric patients in selected hospitals in Ilorin and to describe the coping strategies adopted by nurses to reduce the effect of the lived experiences of clinical nurses following death of paediatric patients in selected hospitals in Ilorin. Ilorin is primarily home to Yoruba patients, who represent the majority of the city's cultural population. Yoruba is the most widely used language of

conversation in Ilorin, Nigeria although English is the official language of the nation (Encyclopaedia Britannica, 2024).

Methods

A hermeneutic qualitative study design was used to interpret and find meaning in the individual's experience (Polit & Beck, 2010).

The study was conducted at the paediatric units (Emergency, Medical and Surgical wards, Neonatal Intensive Care Unit) of the University of Ilorin Teaching Hospital, Ilorin, Kwara State, and the Emergency unit, and admission ward of Children Specialist Hospital, Centre-Igboro, Ilorin, Kwara State, between November and December, 2022.

Nurses were included in the study if they had at least one year of working experience in the clinical area and were working in paediatric medical and surgical wards, and paediatric emergency units, while nurses who have been away from the clinical area for at least 3 months were excluded. Data saturation was used to determine sample size (Chew et al., 2021; Lawrence, 2021; Polit & Beck, 2010), which was achieved at the 19th participant and 2 additional participants were interviewed to ensure no new information was received from the participants, a total of 21 participants. Using maximum variation sampling, nurses who have cared for dying children, of different cadres, years of experience, and cultural backgrounds were selected from each ward to add variety, particularly within the context of the study's aim.

Rigour: The framework proposed by Lincoln and Guba in 1985 to achieve rigour in qualitative studies was used. This includes credibility, dependability, confirmability, and transferability (Bochner, 2018; Merriam & Tisdell, 2015; Polit & Beck, 2010; Squires & Dorsen, 2018). Credibility was achieved by allowing the participants to discuss fully their experiences taking into consideration their different cadres, years of experience in paediatric units and different cultural backgrounds to ensure variation which captured the human reality as lived experiences are not the same. Dependability was ensured by audit trail; confirmability was achieved through thorough review of the results by members of the research team so that results were objective. Any disagreements on the meaning of the transcribed interviews were resolved by going back and listening to the original interviews. Transferability was achieved by using maximum variation.

Ethical Approval: The Ethical approval was granted by the state Ministry of Health Ethical Research Committee (Approval number: ERC/MOH/2022/09/073), and the teaching hospital's Ethical Research Committee (Approval Number ERC PAN/2022/11/0332). The participants were required to give informed consent before they participated in the study, all interaction with the participants was with the strictest confidentiality, and interview sessions were individual and not grouped, participants were not required to provide any means of identification to ensure anonymity, and they were also free to disengage at any point they feel uncomfortable. Sincerity was maintained in reporting findings

Data collection: Data were obtained using semi-structured interview guide to carry out face-to-face in-depth interviews with the participants. Data were collected between November and December, 2022, the duration was for a period of 6 weeks; 2 weeks at Children Specialist Hospital and 4 weeks at University Ilorin Teaching Hospital.

Data analysis: Content and thematic analysis were used to analyse the interview data based on grounded theory as proposed by Braun & Clarke (2006). The phases were reading the interview transcripts until the researchers had been familiarised with the interview contents, coding the transcripts based on emerging ideas from the interviews, recoding to remove redundant ideas, and generating themes and subthemes. Three independent coders generated the initial set of themes and a fourth independent coder reviewed the themes and reorganised the thematic ideas. The analysis was done using ATLAS, version 23.0.

Results

The Socio-demographic Features of Participants are displayed in table 1.

From the analysis of the interviews four themes emerged and are discussed below:

Cultural and Religious Beliefs and Practices about Child Death

All respondents stated that they had lived in Ilorin throughout their professional lives and were employed there at the time of the interview. Each has completed at least one academic nursing program in Ilorin and has at least ten years of experience interacting with Yoruba people. Additionally, every respondent can communicate in Yoruba. Since it was a part of the Old Oyo Empire, Ilorin, a town primarily made up of Yoruba people, has strong ties to the South Western region of Nigeria, which is home to other Yoruba states (Encyclopaedia Britannica, 2024).

The respondents shared their opinions about Yoruba cultural beliefs about the causes of child death (Figure 1)

Table 1: Socio-demographic Features of Participants

Variables	Frequency	Percentage
Age at last birthday		
20-30	3	14.3
31-40	4	19.0
41-50	6	28.6
51-60	8	38.1
Marital Status		
Single	3	14.3
Married	18	85.7
Religion		
Christianity	12	57.1
Islam	9	42.9
Ethnicity		
Yoruba	19	90.5
Igbo	2	9.5
Years of Experience		
1-10	3	14.3
11-20	8	38.1
Above 20	10	47.6
Qualification		
RN Only	2	9.5
RN/RM Only	6	28.6
RN/RM/RPdN Only	2	9.5
RN/Other	1	4.8
Diploma and BNSc	10	47.6
Cadres		
Nursing Officer I	2	9.5
Nursing Officer	3	14.3
Senior Nursing Officer	1	4.8
Principal Nursing Officer	5	23.8

Assistant Chief Nursing Officer	1	4.8
Chief Nursing Officer	4	19.0
Assistant Director of Nursing	1	4.8
Deputy Director Nursing	4	19.0

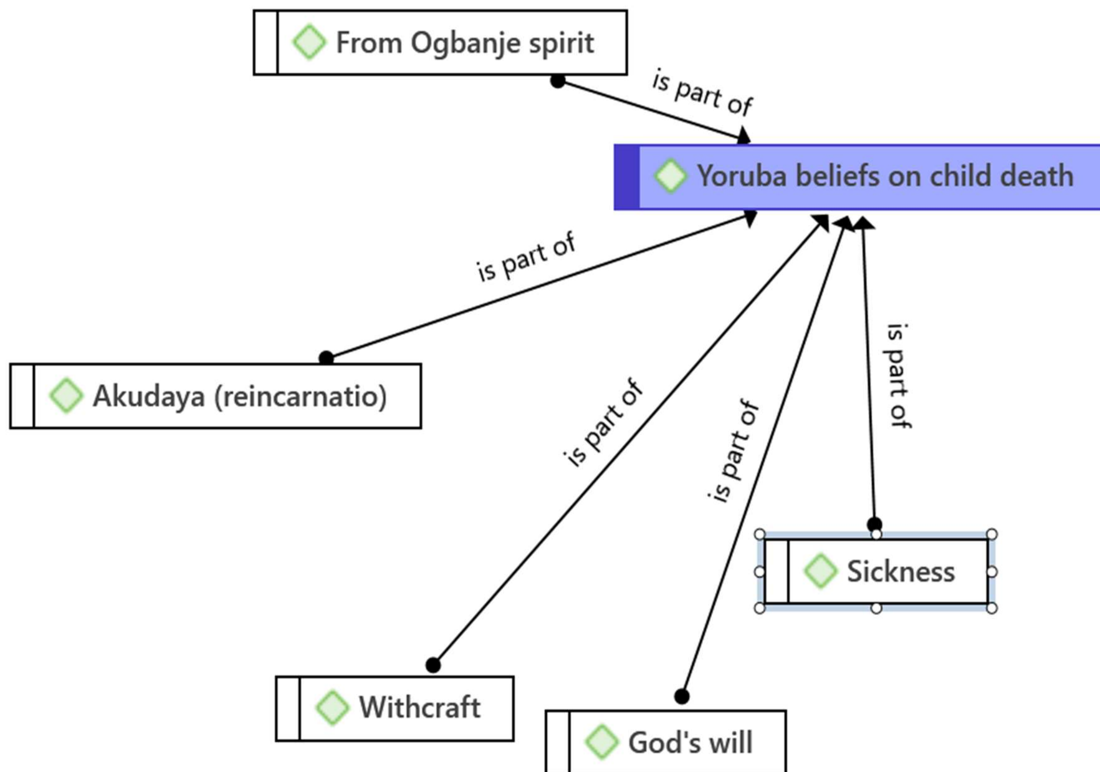

Figure 1: Network showing Yoruba beliefs about child death

In their responses, they said Yoruba believe that the children's death is often caused by supernatural factors like witchcraft, akudaya, death, ogbanje, and promiscuity. The non-Yoruba nurses are very senior nurses as at the time of study, one was a Chief Nursing Officer, the second was a Deputy Director of Nursing. Both of them have worked in the hospital for at least 30 years.

One of the nurses spoke thus:

"Some people believe that when a baby dies at a very young age, it is not from God. It is either some witchcraft or some bad people that actually killed that baby, so there are a lot of mystical beliefs that surround Yoruba, when it comes to Yoruba. It is kind of complex. So, some believe, not all, if a baby, if someone die in their prime, Yoruba people believe that it is only the elderly

> *that are expected to die, you understand. So, whoever die at a very young, won a ni ah iku si da won loro, iku si she kinikan. Not believing that it is actually from God like that" (PART 15 UITH SNO)*

In describing death by akudaya or ogbanje, one of the nurses said,

> *"…There are so many schools of thought, so many beliefs that when it comes to Yoruba people ah. Some people believe there is akudaaya…" (PART 15 UITH SNO).* Another said Ogbanje children are those who die at child birth and they are reborn. The nurse described it thus:

> *"Dying and death. you know this ogbanje people, they believe in, especially when a woman used to have, most of the children that used to die at childbirth. So, once you are having a child that, maybe most of the time you deliver, after delivering, let's say those who their children usually die, they say it's ogbanje. They believe in that o, that it's ogbanje. The child is ogbanje, any child that used to be sick frequently like this sickle cell, they will say it's ogbanje child. But medically we know it's sickle cell. But they will say it is ogbanje. They believe in spiritual children." (PART 19 UITH DDN)*

Sometimes, death was simply an inevitable situation that is subject to the will of God. It is not always explicable. One of the nurses described it as

> *"Amuwa Oloun ni, /it is an act of God/ that means it's God that owns life. He's the one that takes life, it's not from anybody." (PART 20 UITH DDN). "Yoruba say, there is an adage that says Kosi eni to w'aye yi ti o ni lo /there is no one that comes to this world that will not leave it/ So we have that belief that one day we come to this world, and one day one will leave definitely." (PART 16 UITH CNO)*

Participants mentioned that in grieving children's death they sympathised with the parents of the deceased, prayed, and preached to the parents. They expressed understanding of inevitability of death.

> *"It's a normal thing you know, but it's not, erm, death is a normal thing that everybody tend to die one day, but we don't pray to die younger, okay? But if it happens, you take it as a destiny, that's how God destined it, okay?" (PART 12 UITH PNO)*

Reaction to Child's Death

The participants described their immediate emotional reaction to a child's death, ranging from bitterness to introspection:

> *"Bitterness now. Because we don't pray for such to happen. And when it happens, it is not a good thing sha." (PART 4 CSH CNO).*

> *"Hmmm, my first thought, if I managed this patient very well, my first thought is, where have I gone wrong? You know it's a team work. If they provide everything and the baby now died, did anybody see the patient? Did anybody give the medication wrongly? That stuff. But if they were not able to provide, but ahah, maybe because you did not give this, that's why. Then another one, the condition they brought that child determines. If the child is paper white, of course you don't expect magic. If the child is breathless, you don't expect… So it depends on the condition they brought that child" (PART 2 CSH PNO).*

> *"When a patient dies, what comes to my mind is there are some certain things that come to my mind like, especially in this NICU. What comes to my mind is, oh, where the child was birthed, you understand, their negligence. The patient's ignorance too. Maybe if she has an idea of what to use, what she shouldn't have used, ehnehn, prompt medical care, maybe if she had, maybe of she was knowledgeable enough to*

have sought proper medical care and all that, maybe the child wouldn't have come this way. That is that on the part of the parents. Then on we the medical, let's talk about, there rare somethings I think about that, oh, maybe if we have advanced to this level, maybe if there was provision of a normal radiant warmer, normal CPAP and all that, maybe I could, ehnehn, maybe the child wouldn't have ehnehn. That's the part of facility. Then I would now think of we the healthcare providers that oh, maybe if we had been observant enough, maybe if we had seen this earlier, maybe if we have, we have followed that holistic part, maybe this child would have made it. Those are the things I think about." (PART 8 UITH NO).

Coping Strategies Learned from Superiors on First Experience of Death as a Nurse

Following the first death of a child experienced by the nurses, their superiors were not as emotionally expressive as the younger nurses. However, they were rather empathetic towards the mothers. They also showed understanding towards junior nursing officers who couldn't manage their emotions.

"No. You know as a professional, you need to at least display some professionalism when you are discharging your service to your patient. The only thing they did was that seeing me, because I was so attached to the child; so seeing me breaking down at that level, I was excused. They were intended to, I was the only one with them on duty, I was supposed to do the last office. So they only excused me out and avoid me doing the last office. They took it upon themselves to do the last office because I was shaking. I don't know where the thing, coming near to the corpse, I don't know where that shaking spirit was coming from. So, they just asked me out, excused me from doing it, and they did it. "(PART 17 UITH NO)

Coping Techniques Adopted by Nurses

In order to deal with the ordeal, the nurses said they often remind themselves that they had tried their best for the child and that helps them to live with the grief (Figure 3).

One of them described it in this way,

"I will know that, yes, I've tried my best. That's the first. Have I tried my best? I've tried, aha, omo yi, opada ku na. at least we've tried our best. But if to say maybe the child don't have money, no, you know there's some cases that there will be no drug, nothing you can do. There are some hopeless, even though you did everything, he's going to die. But I will just know that ah, I will be satisfied with my mind that, in fact I tried my best." (PART 13 UITH ACNO).

After that, they try to forget about the incident because there was nothing, they could do about it after having done their best and that it was simply God's timing.

"You know that we have a lot of things. Once a patient is gone, it's gone o. They are many. So, it's only when we talk ehn, like this intussusception case now. But at times I will, even if they, once they leave the, they are discharged, some I don't remember them, it is them that will remember me, mummy I was the one that you took care of" (PART 14 UITH DDN)

"What I will say is Why? What happened? What is wrong? Why did this baby die? Then you will now look for the reason why this baby die, is it negligence? Or either negligence or that is the will of God because if you did not take care of the child you are supposed to take care of, and the baby dies, you will feel it may be due to my own negligence. But if you try all what you are supposed to do as a nurse, and the baby dies, that's the will of God." (PART 19 UITH DDN)

Among the responses of the nurses was also that they cope by trying to encourage the parents. Counselling the parents help to ensure that they cope with the grief they just experience.

"That one has helped me a lot. When you know that a child is maybe terminal case, you just know that you attend to them when they call, you attend to them. In fact, you even go to them. We have many cases like that. You go to them, you play with them, anything you have you give it to them, keep on encouraging." (PART 13 UITH ACNO

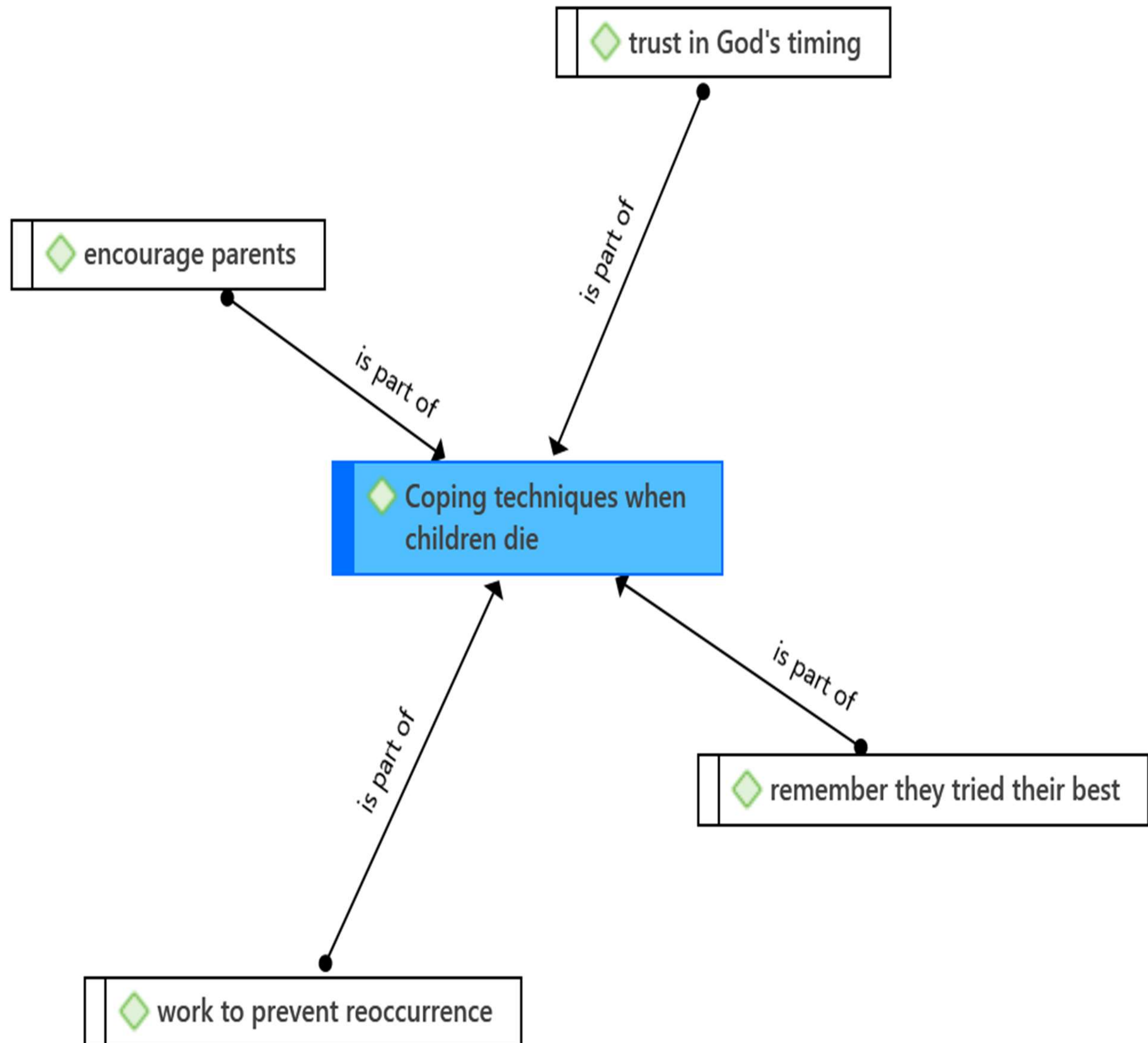

Figure 2: Network showing coping techniques when children die

Discussion

The study's aim was to describe the influence of the Yoruba culture on the lived experiences of clinical nurses following death of paediatric patients, and describe their adopted coping strategies to reduce the emotional effect of the patient's death on them. Four themes were identified; Cultural and religious beliefs and practices about a child's death, reactions to a child's death, coping strategies learned on the first experience of death as a nurse, and coping techniques adopted. A common thing all themes had was the odious nature of a child's death has a negative effect on the psyche of the nurses.

Nigerians are usually expressive in their grief, as a show of compassion and solidarity. This is similar to what obtains in Western societies, where health professionals expressing their emotions is a show of care and compassion (Chew et al., 2021). In this study, however, the nurses have learnt, particularly after their first experience of a paediatric patient's death, not to show their emotions, but to be professional in their demeanour. Therefore, they conceal their grief, which culturally is not acceptable. Some of those who cry do so privately away from the ward. This may be due to what they have been taught during clinical postings as students, as some of them noted that their superiors encouraged them not to grieve in front of their patients, but rather face the work at hand. Quite a number of them have applied this to their professional lives and have developed a professional mien or face as suggested by Meller (2018), who noted that nurses temporarily put on their "Nurse face" when coping with death on the ward.

Though the adopted Abrahamic religions (Christianity and Islam) advocate acceptance of God's will when a child dies, the Yoruba culture believes that it is an anomaly for a child to die. In the event of death, nurses are expected to provide comfort to the child's family, however, based on the responses of the respondents, it can be deduced that the contradictions of the religion and Yoruba culture can confuse the nurses on how to react to a child's death and comfort the grieving parents. This is in tandem with Faronbi et al. (2021), who observed that an inability of nurses to provide comfort to the dying patient's family can leave the nurses feeling inadequate and helpless.

The common coping strategy adopted by the nurses was to work harder. This could be as a result of feelings of guilt and regret following introspection on the child's death. Regret has to been to be common among nurses whose patients have died, and such nurses work even harder to reduce the regret felt when a child dies (Ma et al., 2021).

Study Limitations: The study had 21 participants from 2 hospitals. Both hospitals do not have an end-of-life care policy/protocol for paediatric patients, the nurses still strive to provide some form of end-of-life care for the children who require it. There is an acute shortage of trained, registered paediatric nurses, particularly in the lower cadres, due to the high rate of relocation of nurses to other countries. Most of the non-paediatric trained nurses have spent at least a year in their respective units, but intend to go on for a paediatric nursing training programme in the nearest future. Hence, they were purposively selected to join the study based on their experience in the units. Another limitation faced was the nurses were mostly from the Yoruba tribe. On the other hand, their religious beliefs differed as they were either Christians or Muslims, and this was used to select the participants.

Conclusions and Implications for Future Research: In conclusion, nurses truly feel the loss of their patients; however, they cannot openly grieve because it is deemed unprofessional. This may make them burdened with negative emotions. Work is a major coping mechanism for nurses. Culture plays a strong role in how nurses perceive dying and death, and how they respond to these events, but rather than making it easier to respond, it further complicates their ability to empathise with and comfort the parents because of conflicting ideologies of death.

Nurses should have regular psycho-therapy sessions to properly explore their feelings and emotions concerning a child's death, while newly employed nurses and nursing students should be taught appropriate coping strategies

before they are sent on ward postings and are exposed to dying patients. Guidelines should be formulated on how to handle dying children and their family members.

Linking Evidence to Action

- Education on end-of-life care can reduce feelings of guilt and helplessness.
- Developing coping strategies can help prevent burnout due to overwork, since work is a prevalent coping strategy.
- End-of-life care should be individualised to give sense of accomplishment.
- Psychotherapy should be available for nurses who regularly provide end-of-life care.

Acknowledgement: The authors acknowledged the authority of the teaching hospital where the data were collected. The surgical patients that participated in this study and the statistician are hereby appreciated.

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