Development of an evaluation tool for clinical competence of community service nurses in North West Province, South Africa

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Thesis submitted in fulfilment of the requirements for the degree *Doctor of Philosophy in Nursing Science* at the North-West University

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Co-Promoter: Professor LA Sehularo

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THESIS LAYOUT

This thesis on the **development of an evaluation tool for clinical competence of community service nurses in the North West Province, South Africa** is presented in article format.

The PhD candidate, **Ms Kholofelo Lorraine Matlhaba**, conducted the research and wrote the manuscripts. **Professor Abel Jacobus Pienaar** was my promoter and **Professor Leepile Alfred Sehularo** acted as co-promoter and critical reviewers in the research process. The thesis is presented in the following sequence:

Section One:	Overview of the research
Section Two:	Methodology
Section Three:	Manuscripts

NB: This thesis is formatted according to the North-West University guidelines; however, the manuscripts will be submitted according to the journal's guidelines.

Manuscript One: Professional nurses' perceptions regarding clinical competence of community service nurses (CSNs) in North West Province, South Africa (Submitted to *Curations*).

Manuscript Two: Community service nurses' experiences regarding clinical competence during placement (Published at *Health SA Gesondheid* on 21 October 2019*).*

Manuscript Three: Convergence of the results of the experiences of community service nurses as well as the perceptions of professional nurses regarding the clinical competence of community service nurses during community service (To be submitted to *Internatihonal Journal of African Nursing and Midwifery*).

Manuscript Four: Legislation, regulations and policies that govern Community Service Nurses: A literature review (To be submitted to the *International Journal of African Nursing and Midwifery*).

Manuscript Five: Desk review on assessment tools for clinical competence of newly qualified nurses (To be submitted to *Nursing Education in Practice*).

Manuscript six: Development and validation of a clinical competence evaluation tool (CCET) for community service nurses in North West Province, South Africa (To be submitted to *Health SA Gesondheid).*

Section Four: Conclusions, Contributions, Limitations and Recommendations

DECLARATION

I, Kholofelo Lorraine Matlhaba, declare that this thesis on the **development of an evaluation tool for clinical competence of community service nurses in the North West Province, South Africa** submitted for the degree of Doctor of Philosophy in Nursing Science in the Faculty of Health Sciences at the Mafikeng Campus of the North-West University, is my own work and that all sources and references used in the thesis have been acknowledged accordingly.

Ms K.L. Matlhaba (PhD Candidate) Date

This thesis on the **development of an evaluation tool for clinical competence of community service nurses in the North West Province, South Africa** has been read and approved for submission in article format at the Mafikeng Campus of the North-West University by:

Prof. A.J. Pienaar (Promoter) Date

Prof. L.A. Sehularo (Co-promoter) Date

DEDICATION

This Thesis is dedicated to my late father, Mr Solomon Tikedi Tlabela. Robala ka kgotso Mokone.

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I want to thank the following people for making this research on **the development of an evaluation tool for clinical competence of community service nurses in the North West Province, South Africa** a success:

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ABSTRACT

Introduction and Background: Nurses' ability to demonstrate competence is necessary to meet the requirements of the healthcare organisations. In many countries, measures and initiatives are put in place to prepare newly qualified nurses for their roles as professional nurses. As of 2008, national requirements make it mandatory for nurses who have qualified as a General, Psychiatric and Community and Midwifery nurse to complete a 12-months' community service prior to their registration as professional nurses. During this community service, community service nurses (CSNs) are assigned to different public healthcare facilities. However, since the introduction of this community service, little has been done to evaluate their clinical competence and whilst it is expected of them to be competent practitioners when resuming their duties as professional nurses. It was therefore important for the researcher to think of ways to evaluate their clinical competence during community service, hence the need to develop and validate a clinical competence evaluation tool in North West Province, South Africa.

Research purpose: The purpose of this research was to develop and validate the clinical competence tool to evaluate clinical competence of community service nurses in North West Province, South Africa.

Methodology: An exploratory sequential mixed method research design with multi phases was followed to address the research problem. The design involved three phases, namely, empirical phase, which addressed the problem analysis and planning, information gathering and synthesis, and design; development phase that addresses the development of the tool and the validation phase which addresses the validation of the developed tool, consisting of four sections. In phase one, the researcher started with qualitative design of which the results guided the formulation of quantitative data collection tool.

Phase two and three are comprised of the development and validation of the proposed clinical competence evaluation tool. Information from phase one and its multi stages was used to develop the tool. The developed Clinical Competence Evaluation Tool (CCET) was grounded on Patricia Benner's "From Novice to Expert" model. The tool development process followed the four steps on tool development described by LoBiondo-Wood and

Haber. Experts in nursing education, nursing practice, governance and government as well as labour movements validated the tool. A total number of 10 experts participated in the validation process.

Results: Themes and categories emerged from the qualitative design, which were later converged to guide the questionnaire used for the developed tool. This developed tool consists of five sections. *Section A* consists of six main competencies, 17 domains and 144 items, which were rated on a five-point Likert scale by community service nurses. The six main competencies are as follows: legal practice; ethics and professional practice; operational (unit) management and leadership; contextual clinical and technical competence; therapeutic environment; and quality nursing care.

Sections B – E with semi-structured questions to be completed by the CSN; the peer and the mentor. To measure the tool's reliability and validity, a content validity index (CVI), content validity ratio (CVR) using the experts' validation and the Cronbach alpha was done using the SSPS version 25. 10 experts and 11 CSNs participated in this process respectively.

This tool's CVI has exceeded 0.80 as it is at 0.98, which shows excellent content validity. A higher CVR score indicates greater agreement among experts. The Cronbach's alpha coefficients in the six (6) competencies are all greater than 0.7 and this implies that the tool used for this study was proven to be reliable during the pilot study. All experts and community service nurses indicated that the tool is clear, simple, general, accessible and important.

Conclusion: The results of this research indicate that piloting the developed clinical competence evaluation tool demonstrates adequate reliability and validity for measuring the perceived clinical competence of the community service nurses. This tool was also deemed essential; useful and easy to administer despite the concern regarding the length raised by some experts and the tool was proven to be reliable. Limitations and further recommendations based on the research objectives are discussed.

Keywords: Clinical competence; competencies; community service; community service nurses; evaluation tool; professional nurses; placement

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LIST OF ABBREVIATIONS

ANMC:	Australian Nursing and Midwifery Council
ANMAC:	The Australian Nursing and Midwifery Accreditation Council
CCET:	Clinical Competence Evaluation Tool
CPD:	Continuous Professional Development
CSNs:	Community service nurses
CVR:	Content validity ratio
CVI:	Content validity index
DoH:	Department of Health
ICN	International Council of Nurses
NMBI:	Nursing and Midwifery Board of Ireland
NMC:	Nursing and Midwifery Council
NWP:	North West province
NWDoH:	“North West Department of Health”
PNs:	Professional nurses
SA/ RSA:	South Africa / Republic of South Africa

SONS: School of Nursing Science

FAST: Faculty of Agriculture, Science and Technology

SANC: South African Nursing Council

UK: United Kingdom

USA: United State of America

WHO: World Health Organization

WORDS/ CONCEPTS USED INTERCHANGEABLY

Community service nurse / Comm serves

Patients/ Health care users

Results/ Findings

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1. SECTION ONE: OVERVIEW OF THE STUDY

1.1. Introduction

The World Health Organization (WHO) in their *Global Strategic Directions for strengthening Nursing and Midwifery* (2016-2020:10) posits that to provide required health services there is a continuous necessity not only for quality nursing and midwifery education but also for competent practitioners. Following the expectations of WHO, the National Department of Health (2012:14) acknowledges that "South Africa's predominantly nurse-based healthcare system requires nurses to be clinically competent and have the expertise to manage the country's burden of disease and to meet the health needs of South African (SA) society".

The South African Nursing Council (SANC) under the provision of the Nursing Act (33 of 2005), on the Nursing Education and Training Standards also aims at enabling "nurses to give and support high quality care in the changing environment of the nursing education landscape of South Africa" (Nursing Act 33, 2005:2). Furthermore, Human and Mogotlane (2017:172) assert that the public have the right to expect competent, high quality, ethically safe nursing care from health care professionals.

However, continuing reports on "infant and maternal deaths" as well as "patient suffering and humiliation", alongside what is often considered as "inhumane and poor treatment", a lack of infection control in conjunction with nurses' misconduct, incompetence and uncaring attitudes, project a negative impact of the nursing profession (Ndaba, 2013:3; Oosthuizen & Phil, 2012: 57). According to statistics, the majority of the lawsuits stem from incompetent nurses. The Health System Trust (S.A.) indicate in their statistical report of misconduct cases between March 2012 and October 2016, that throughout all South African provinces including North West Province, from a total number of 121 registered nurses and midwives there were approximately 125 cases of professional misconduct with 32 cases involving poor nursing care, 53 were maternity related and 19 were related to medication. More recently, it has been reported in the media that the Department of Health has paid out a total of R79-million for negligence lawsuits between 2012 and 2017

(Sidimba, 2017:2).

Notwithstanding the high litigation rate, it is therefore a common cause that the clinical competence of newly qualified nurses is put under scrutiny in the health care facilities (Zonke, 2012: 20). A sign of entering the profession unprepared is the inability of these newly qualified nurses to execute delegated tasks despite having undergone community service (Harwood, 2011:13). Hence, it should be considered necessary for all Community Service Nurses (CSNs) to be prepared with the necessary knowledge, skills, attitude, and values to become competent practitioners. Therefore, the researcher aimed to develop and validate an evaluation tool for clinical competence in order to measure the competence of the CSNs.

1.2. Background and Rationale

In many countries around the world it is generally the new and unprepared nurses who are associated with low levels of clinical competence resulting in an inability to implement quality nursing care (Duchscher, 2009:1105; Halfer, 2007:7; Moeti *et al*., 2004:72). This is a worldwide concern and has resulted in governments or the Nursing Education Institutions (NEIs) seeking to introduce measures that would assist with the improvement of newly qualified nurses' competencies. Within the state of California, USA, a registered nurses' residency programme was initiated and implemented in 2009 with the aim of improving the nursing skills of newly registered nurses (Kim *et al.,* 2014:51). In Asia countries like Japan and Indonesia, implemented supporting programmes with the intention to promote the newly qualified nurses' success in acquiring the basic skills and supporting them in coping with their new roles (Ebrahimi *et al.,* 2016: 12; Sari *et al.,* 2017:119). Likewise, in the sub-Saharan Africa, mentoring and preceptorship programmes have been initiated with similar intentions of improving such newly qualified nurses' clinical competences.

South Africa requires that nurses having successfully completed a four-year nursing degree or obtained a nursing diploma (R425) complete a mandatory 12-month period of community service prior to their registration as professional nurses (SANC, 2005:76). The Government Gazette Notice No. 765 published this requirement on 24 August 2007, as

well as providing additional details that would remunerate this category of nurse for their community service at health care facilities. According to Govender, *et al.* (2017:14)" community service for nurses in South Africa was implemented in 2008" while Notice 765 has as its main community service objective "to ensure improved provision of health services to all South African citizens" (Hatcher et al., 2014). The SANC (2007:46) states that improvement will be achieved through the empowerment of young professionals with development of their skill base, and enrichment of knowledge, whilst instilling professional behavioural patterns and critical thinking congruent with such professional development. Currently there is no published literature on how clinical competence of CSNs is achieved and evaluated nor any established known tool that could evaluate clinical competence in different provinces including the NWP. This omission in knowledge encouraged the researcher to carry out research of this nature in South Africa, specifically in the North West Province.

1.3. Problem Statement

In terms of the Act, a "remunerated community service" is mandatory for a period of one year for those newly qualified South African nurses who have met the prescribed requirements and plan to enroll as professional nurses for the first time (SANC, 2007). As stated in Section 40 (3) of the Nursing Act (33 of 2005), this regulation applies to any person "who seeks registration on completing and meeting the requirements prescribed in the Regulations relating to the Approval of and the Minimum Requirements for the Education and Training of a Nurse (General, Psychiatric and Community) and Midwife leading to registration" as published in Government Notice No. 425 of 22 February 1985. Throughout the community service period, newly qualified CSNs are allocated to different disciplines of the public hospitals, where they are required to demonstrate clinical competence through "integration and application of knowledge and skills required to practice safely and ethically in a designated role and setting" (SANC, 2007:46). However, misperceptions and doubts among CSNs and their supervisory professional nurses have been noticed from the existing literature. This is because there is a lack of any clear policy or guidelines pertaining to the CNS's professional role and responsibilities in the health care facilities.

Literature has revealed that blame has fallen amongst the different stakeholders including the SANC due of the omission of any designated scope of practice and job descriptions, specifically designed to address the level of responsibilities for CSNs (Khunou, 2016: 102; Govender, *et al.,* 2015:2). In addition to the previous challenges, CSNs are not mentored during their community services in the health care facilities. The latter was highlighted by studies conducted by Nkoane (2015:53); Tsotetsi, (2012: 52) and Andren and Hammami (2011:12), which revealed that CSNs were at times left alone in the units with no proper orientation, and some experienced some unrealistic expectations with regard to their responsibilities. Despite the robust evidence presented with respect to the challenges faced by CSNs, little is known regarding achievement and evaluation of their (CSNs) clinical competence in all provinces including the North West Province. Therefore, the need to develop and ratify a tool to assess the clinical competence of CSNs in the NWP became an imperative.

1.4. Research Aim

The aim of this research was to develop and validate a clinical competence evaluation tool for CSNs in NWP, SA.

1.5. Research Objectives

Objectives of the study were to:

I. Explore the perceptions of professional nurses (PNs) with respect to CSNs' clinical competence;

II. Explore the experiences of CSNs with regards to clinical competence during their period of community service;

III. Converge the results of the perceptions of PNs and experiences of CSNs on clinical competence of CSNs;

IV. Describe the legislation, regulations and policies that govern clinical

competence in community service;

V. Conduct a desk review on the available clinical competence evaluation tools of newly qualified nurses;

VI. Develop a baseline tool to evaluate clinical competence of the CSNs; and VII. Validate and refine the developed baseline tool.

1.6. Research Questions

These research objectives sort to answer the following research questions

I. What are the perceptions of professional nurses (PNs) with respect to CSNs' clinical competence?

II. What are the experiences of CSNs with regards to clinical competence during their period of community service?

III. How can the results of the perceptions of PNs and experiences of CSNs on clinical competence of CSNs be converged?

IV. What are the legislation, regulations and policies that govern clinical competence in community service?

V. What are the available clinical competence evaluation tools of newly qualified nurses?

VI. Which baseline tool can be developed to evaluate clinical competence of the CSNs?

VII. How can the developed baseline tool be validated and refined?

1.7. Significance of the Research

The research will contribute to the body of knowledge within nursing and further, has the potential to enhance the standard of clinical nursing education, which will have a positive

impact of nursing care quality in NWP. Furthermore, nursing practice will benefit as the results will assist in the development of additional guidelines and policies that will, with the development of job descriptions or scope of practice for CSNs, provide a positive contribution to nursing care quality within South Africa. The North West Department of Health will also benefits from this research, as the results will be shared with policy makers with the department. This will assist in ensuring that necessary measures are put in place to enhance clinical competence of CSNs during their placement in the province. This tool is a baseline instrument to guide CSNs through their tenure. Therefore, they can be used to the fullest in the practice to enhance clinical competence.

Eminent advantages for the nursing profession will arise as gaps were already identified in the clinical educational preparation of professional nurses and areas to be addressed during training which will improve the nurses' level of competence. Different health establishments and NEIs to prepare CSNs for community service can use the results and recommendations of the study.

1.8. Paradigmatic Perspectives

The paradigmatic perspective of this study, which is comprised of meta-theoretical, theoretical assumptions and the central theoretical statement, has guided the study's research decisions.

1.8.1. Meta-Theoretical Assumptions

The researcher's personal views of man and the world in conjunction with Patricia Benner's four metaparadigms in nursing is the base for the meta-theoretical assumptions of this study. Assumptions concerning nursing, human beings, health and environment are discussed below:

- **Nursing:** according to WHO and the ICN (2002), is a profession that "encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities; sick or well in all settings", it seeks to promote health, prevent illness and facilitate the "care of the ill, disabled and dying people" (Human & Mogotlane, 2017:21).

Benner in Alligood (2013:129) describes nursing as “an enabling condition of connection and concern” which reflects a “high level of emotional involvement in the nurse-client relationship”. Further, she views “nursing practice as the care and study of the lived experience of health, illness, and disease and the relationships among these three elements” (Alligood, 2013: 169). In this research, the CSNs underwent the training journey and successfully completed their training under Regulation 425 in order to become professional nurses. Prior to registration as professional nurses with SANC after completing their four-year training, CSNs are expected to complete mandatory remunerated community service for a 12month period. As developing professionals, the CSNs are expected to convert classroom learning into practice to become independent competent nurse practitioners.

- **Human beings:** are living creatures created by God in His image who seeks to perfect themselves through the acts of knowledge seeking, understanding and making meaning of that which surrounds them (Bible, 2000). Benner in Alligood (2013: 129) asserts that a “self-interpreting being, that is, the person, does not come into the world predefined but becomes defined in the course of living a life. A person also has an effortless and non - reflective understanding of the self in the world. The person is viewed as a participant in common meanings”. For the benefit of this research, the CSNs are human beings performing a 12-months’ compulsory community service on completion of their four-year degree or diploma whilst improving their competence with the assistance of their supervisors in the health care facilities by providing efficient and safe quality care for the benefit of South African society.

- **Health:** according to Jassim (2018:1), WHO, in their 1948 constitution, defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or illness”. Benner focuses on the “lived experiences of being healthy and ill”, defining health “as what can be assessed”, whilst well-being is “the human experience of health or wholeness”. Health is described as “not just the absence of disease and illness” (Alligood, 2013:130; Benner & Wrubel, 1989:7). These aspects enable individuals to function independently as people, whilst facilitating interaction with others. A patient’s health is trusted on the CSN for rehabilitation. In this research, clinical competence of CSN who interact with the society (health care users and relatives) during the period of rendering nursing care service was evaluated.

Therefore, the CSN is expected to be in a good state of health to give quality nursing care that will be of benefit to the health of society at large, particularly in the NWP.

- **Environment:** is defined as everything that surrounds an individual or group of people, and can encompass the physical, social, psychological, cultural or spiritual (Smith et al., 2013: 426). Patricia Benner used the term "situation" instead of the term "environment" because, according to Benner and Wrubel (1989:80), "situation implies a social definition and meaningfulness". Phenomenological terms of being situated and situated meaning, are used by her and are defined by "the person's engaged interaction, interpretation and understanding of the situation" (Alligood, 2013:130). In this research, environment refers to the selected health care establishments where CSNs are allocated for the 12-months' period of community service in the NWP.

1.8.2. Theoretical Assumptions

The basis of nursing practice is formed through clinical competence. Matlhaba (2016) points out that SANC, under the provision of Nursing Act (33) of 2005 nursing education and training standards, emphasises the significance of nurses' clinical competence. Benner's (1984) "Novice to Expert Theory" indicates that five proficiency levels are passed through the third of which is competence. SANC's definition of competence is the "combination of knowledge, psychomotor, communication, and decision-making skills that enable an individual to perform a specific task to a level of proficiency". Further, they believe competence development is encouraged through community service.

The theoretical assumptions of this research contain the central theoretical argument as well as conceptual clarification of the major concepts appropriate to the study.

1.8.3. Definition of Key Words

Key words used in the study are competence, community service nurse, experience, newly qualified nurse, perception and professional nurse and are defined as follows:

Competence refers to the ability to assimilate "learned professional attributes including,

but not limited to, knowledge, skills, judgement, values, and beliefs required to practice safely and ethically in a designated role and setting" according to SANC (2005:1). Whereas the Nursing Council of New Zealand (2012:10) defines competence as the

"combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse". The United Kingdom Nursing and Midwifery Council's (NMC) definition of competence as a "set of knowledge, skills and attitudes required to practice safely and effectively without direct supervision" (NMC, 2010:145). Riddle *et al.,* (2016:239) define it as "the array of abilities (knowledge, skills, and attitudes) across multiple domains or aspects of performance in a certain context". In this research, competence refers to a CSN's ability to apply the knowledge, skills, attitudes and values required to practice safely and effectively with direct or indirect supervision during community service placement in NWP**.**

Community Service Nurse (CSN) refers to a remunerated citizen of South Africa who is expected, after completion of training, to fulfil a 12-month period of community service at a public health care facility, prior to being registered as a professional person. In this study, CSN refers to a newly qualified nurse performing a 12-months' compulsory community service at an allocated health care facility in order to meet the registration requirements as a General, Psychiatric and Community and Midwifery nurse (SANC, 2005: 29).

Evaluation tool refers to a "tool utilized in all clinical nursing courses, and include guidelines for use, which are composed of distinct sections" (Eymard et al. 2014:118). In this study, evaluation tool refers to the tool developed to evaluate clinical competence of CSNs during their community service placement. This evaluation tool consists of five distinct sections as well as instructions for its utilization.

Experience refers to the capacity to "generate and recognise regularities, and make predictions based on the observations" (Polit & Beck, 2012:10). The Oxford Dictionary of English (2010: 615) defines experience as "practical contact with and observation of facts or events". In this study, experience refers to the

CSNs' knowledge and experiences gained during their 12-months' community service

period in the health care facilities in NWP.

Newly Qualified Nurse denotes one who has successfully concluded a four-year education and training at an accredited NEI in compliance with the SANC Regulation 425 of 22 February 1985, and has qualified as a General, Psychiatric and Community and Midwifery nurse (SANC, 2005:61). But, for this study, is still required to complete 12months' community service at an allocated health care facility in the NWP.

Perception according to the Oxford Dictionary of English (2010: 1318) refers to the way in which "something is regarded, understood or interpreted". For the benefit of this work, perception will refer to the understanding and interpretation of clinical competence of CSNs through the observation of PNs in NWP health care facilities.

Placement: According to Bigdeli et al. (2015:2), clinical placements play an essential role in the learning process throughout the nursing history and it is the most influential educational component to acquire nursing knowledge and skills. In this study placement refers to allocation of CSNs at a particular health care facility for a 12 month period of community service.

Professional Nurse (PN) denotes a "person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed, and who is capable of assuming responsibilities and accountability" (SANC, 2005:2).

Blackwell's Dictionary of Nursing (2003:459) describes a nurse as "a person who is specially prepared and registered to provide care for the sick, wounded or helpless, as well as those with potential health problem" whilst a professional is defined as related to one's own profession or occupation (2003:541). The Oxford Dictionary of English (2011:1418) defines professional as a person qualified in a profession. For this study, a "professional nurse" is considered to be the nurse registered by the SANC and one who has more than two years' experience post registration. This PN will supervise the CSNs during their community service program in NWP's health care facilities.

1.9. Theoretical Framework

Polit and Beck (2012:729) describe a framework as "the overall conceptual underpinnings

of a study". The theoretical framework that grounds this research emanates from Benner's (1984) work on skills acquisition and will be discussed in detail in the next section (Section Two).

1.10. Research Methodology

Research methodology is described as the processes, procedures, techniques, or a plan used to conduct the specific steps of a study (Polit & Beck, 2012:733). Within research methodology can be the "theory of correct scientific decisions that include the design, setting, sample, methodological limitations, and data collection and analysis techniques in a study". This research followed an exploratory sequential mixed method design, whereby different methods were utilised to meet the set objectives. The research methodology of this study was based on the research tool development process of LoBiondo-Wood and Haber (2010:208). This process is clearly discussed under data collection process in Section Two. Figure 2 below represents the research methodology overview:

Figure 1: Research methodology overview adapted from Polit & Beck (2012:628)

1.11. Research Paradigm

According to De Vos *et al.* (2011:40), the term paradigm originates from the discipline of linguistics, which means “the various forms that a word can take in some languages, according to the declension or conjugation of that word” especially in the natural sciences. Polit and Beck (2012:604) consider that pragmatists place the research problem centrally and then apply all approaches to understand the problem; this can create concern with the applications and the resolutions to the problems. For the benefit of this research, a pragmatic approach was followed as it was considered the paradigm that provided an underlying philosophical structure for carrying out mixed-methods research. The outline this research followed is set out below:

1.12. Section Outline

An outline of the sections in this study is presented below:

Section One: Research Overview

Section one will outline the rationale, problem statement and objectives of the research and also provide the reader with an introduction to the research context and the main concepts employed in the research. Therefore, the reader is given a broader sense of the conceptualisation and purpose of this research in this section.

Section Two: Research Methodology

In this section, the methodological approach of the study is discussed. The objective of the researcher was to develop and validate a clinical competency evaluation tool for CSNs in NWP, South Africa. The researcher used a mixed methods research with exploratory sequential design with multi stages to achieve the objectives of this research. Populations and sampling techniques are discussed according to each stage and are fully described in section 3. Similarly, data collection and analysis were carried out according to each objective.

Section Three: Manuscripts

This section presents the manuscripts, published, accepted or intended to submit to the accredited journals. These manuscripts are prepared according to the research objectives. Respective journal's author guides are included in this section.

Section Four: Conclusions, Contribution, Recommendations, Limitations, and Overall Conclusion

Section Four will provide a conclusion to this research. Additionally, any limitations that were experienced throughout the research, as well as this study's contribution to knowledge and any recommendations for further studies will be discussed. In concluding the research, a summary of Section Four is provided.

1.13. Summary

In this section, the need to conduct this research was highlighted in the introduction and background. The significance of the research was discussed with the research questions clearly outlined. Further, the researcher has described the rationale and objectives of the research, the problem statement, and given a brief discussion of the framework underpinning this research and methodology. An explanation of the concepts used in the title was also specified. Finally, a broad overview of the research was provided in this section. In the next section, the researcher will provide a detailed theoretical framework and methodology discussion in addition to the methods employed to collect and analyse the data.

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2. SECTION TWO: METHODOLOGY

2.1. Introduction

The previous section provided an overview and a brief description of the research methodology. In this section Benner's (1984) "Novice to Expert Model" is elaborated on as the theoretical framework that guided the research.

2.2. Framework Underpinning this Research

The framework underpinning this research is derived from Benner's (1984) stages of competence. Dreyfus and Dreyfus established a five-stage development model of competence that includes novice, advanced beginner, competent, proficient, and expert (Hall-Ellis & Grealy, 2013:589). The first stage of competence is then defined in relationship to the acquisition and development of skills. This model was applied to nursing by Benner (1984) who found similar configurations of skills achievement (Rischel *et al.,* 2007:512).

2.2.1. Levels of Skill Acquisition

The Dreyfus "Model of Skill Acquisition" was adapted by Benner who applied it to nursing practice as can be seen in Figure 2.1 below. The Dreyfus Model (1980:41) hypothesises that in "the development of skill, an individual moves through five levels of proficiency, namely, novice, advanced beginner, competent, proficient, and expert" as cited by Benner (1984:74). Further, the model also maintains that because there is progression through the levels, an individual can reflect changes across three aspects of skill performance as they move from a dependency on abstract principles to the use of concrete experience. The second occurs in the individual's observation of the situation, whereby the situation is no longer perceived as being composed of separate, equal pieces but rather as a whole and which contains certain pertinent components. Finally, the individual moves from being an observer of the situation to one of being an involved performer. In this research, the CSN

after successful completion of a four-year basic training carries out 12-month community service in which they work under professional nurse supervision. Therefore, it will only be on completion of the community service, that the CSN will then be deemed competent to be registered and to practice independently as a professional nurse.

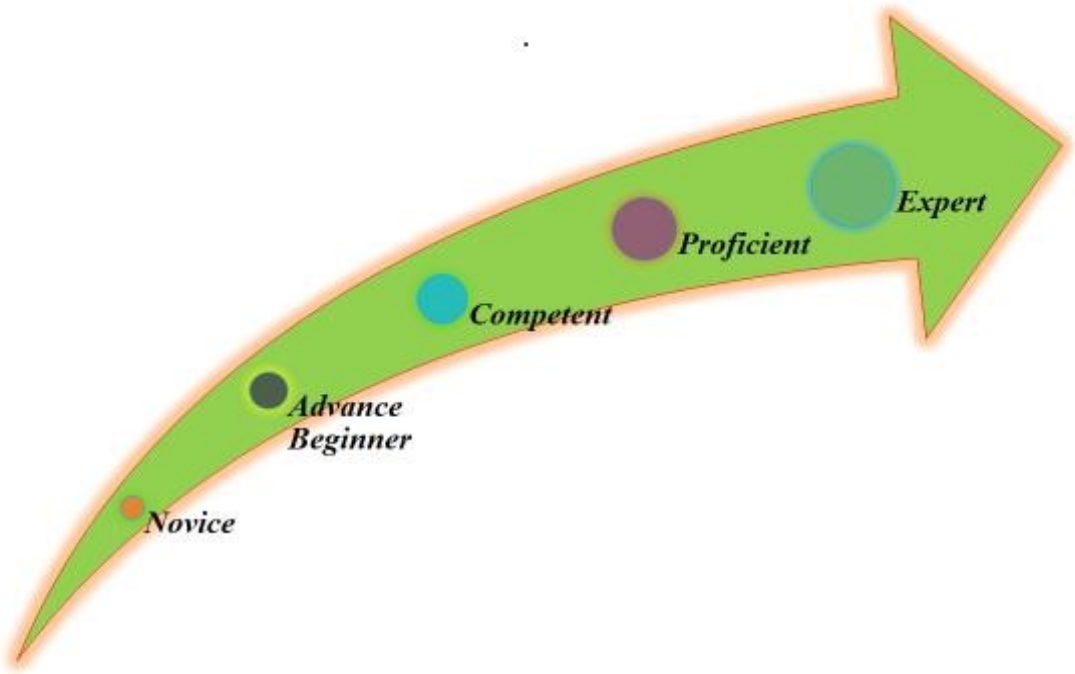

Figure 2: Derived from Dreyfus's Model of Skills Acquisition in (Benner, 1984)

Stage 1: Novice

A novice is defined by Benner (1984:20) as a "beginner with no experience of the situation in which they are expected to perform". As a novice, they will lack confidence to demonstrate safe practice and therefore require continual verbal and physical clues to facilitate their skill development and it is vital that the novice nurse experiences new clinical situations. Benner (1984) also indicates that in order for the novice nurse to recognise characteristics of the patients' conditions without having any situational experience they should be taught about those conditions within objective and assessable parameters. Because novices have limited to no clinical experience they utilise strict rules to govern practice, which results in this becoming limited and inflexible. For the purpose of

this research, the CSN is a novice who is transitioning from being a NEI student nurse to one involved in community service in the clinical area. The CSN still relies on the mentoring and supervision of the qualified nurses to be productive in their allocated tasks.

Stage 2: Advanced Beginner

Benner (1984:22), describes the next level of skill acquisition as an advanced beginner as a nurse “who can demonstrate marginally acceptable performance, one who has coped with enough real situations to note the recurring meaningful situational components that are termed aspects of the situation”, whereby “aspects” are those universal features that need prior familiarity in actual circumstances for recognition. The nurse who is the advanced beginner then develops principles grounded in experience and will begin to use those experiences to guide their actions (Benner, 2001:22). The advanced beginner CSN in this research will be one who is able to accomplish some goals using their own judgement, but still needs supervision for the overall allocated task.

Stage 3: Competent

For Benner (1984) a competent nurse is one who has acquired two to three years’ experience in the same or similar working environments and that such competence develops when the nurse starts planning their actions in terms of future goals. Therefore, for the competent nurse, their plans no longer include all aspects but are rather grounded on those that are important for the situation. A plan for the competent nurse then “establishes perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem” (Benner, 1984:26). It is that planning which is this skill level’s characteristic and one that enables the efficiency and preparedness of the competent nurse (Benner, 2001:22). In this research a competent CSN refers to one who is able to achieve the majority of tasks through their own judgement.

Stage 4: Proficient

Benner (1984:27) believes that “perception is not thought out but ‘presents itself’ centred upon experience and current events”, and therefore it is central to the proficient nurse who observes situations wholly instead of in terms of aspects. This is the level at which the nurse comprehends more holistically, and hence there is improvement in decision-making (Benner, 2001:28). From their experiences, the proficient nurse has become aware of those events that can typically be expected in clinical situations and is knowledgeable on how plans can be modified to respond to these events. A proficient CSN in this research would be the CSN who is able to accept full responsibility and accountability for their own work, and has the capability to assist others.

Stage 5: The Expert

The ultimate level achievable within the skill acquisition model is the expert who is described by Benner (1984) as a nurse who has a profound connection and deep situational understanding. The analytic principle is no longer relied upon as the expert nurse now utilises an instinctive comprehension of situations to determine actions. In this stage, performance is more flexible and also highly proficient. The expert CSN in this research refers to the CSN who is able to take responsibility, able to go an extra mile, go beyond existing standards and create his or her own interpretations.

2.2.2. Relation of Major Components

Benner (1984:3) emphasises that for expertise to develop, nurses need to be exposed to those situations where the “clinician tests and refines propositions hypotheses, and principle-based expectations in actual practice situations. Experience is therefore a requisite for expertise”. Less experienced nurses require support and mentoring from experienced nurses and it is through explanations of higher clinical judgment that new opportunities are provided for those with less experience and which may assist their shift to a higher level of skills performance (Benner, 1984). Notwithstanding, it should not be forgotten that expertise is situational, therefore not everyone can be an expert in every

situation as differing levels of skill acquisition are dependent on experience acquired in the same or similar clinical situations (Brykczynski, 2010). As transition to higher levels of skills performance is effected, a more comprehensive approach will be used in practice. The situation is viewed holistically through the lens of past real life situations, and the expert nurse is then able to identify the problem without contemplation of inappropriate decisions. Conversely, the less experienced nurse often depends on conscious, careful and critical problem-solving (Benner, 1984).

The varying descriptions of levels of skill acquisition as outlined by Benner have been beneficial for the continuing articulation of fixed knowledge in advanced nursing practice, which is used for the development and reinforcement of competence (Brykczynski, 2010). From these statements the researcher believes that developing a clinical competence evaluation tool will positively influence the development and improvement of CSNs' clinical competence in NWP, South Africa.

2.3. Research Methodology

A brief description of the research methodology has been given in Section One. In this section, the researcher has elaborated on the research process followed in Figure Three with an associated discussion:

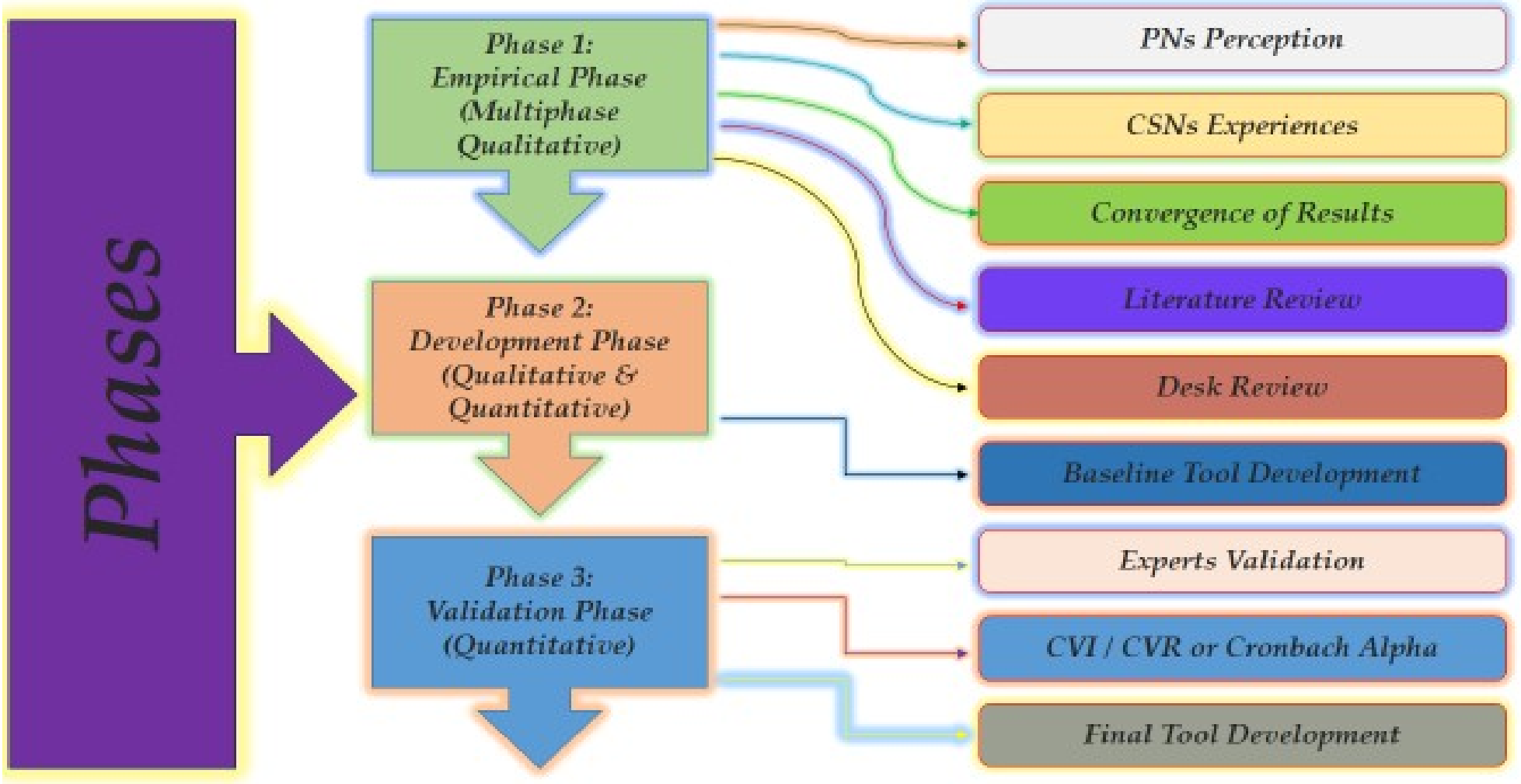

Figure 3: Research process: Exploratory sequential mixed methods with multiphase design Source: (Matlhaba, Pienaar & Sehularo, 2019)

2.3.1.1. Research Design

This research utilised a mixed method with multiphase. Polit and Beck (2012:734) describe mixed methods research as “research in which both qualitative and quantitative data are collected, analysed, and integrated in a single study or a longitudinal program of inquiry”. According to Creswell (2014:266), the justification for a mixed method research is that both qualitative and quantitative research collectively delivers an improved and stronger understanding of a research problem or issue than if either research approach was applied on its own.

2.3.1.2. Exploratory Sequential Mixed-Methods Design

An exploratory sequential mixed methods design with multiphase was followed in this research. Polit and Beck (2012:727) define exploratory design as a sequential mixed method design in qualitative data collected in the first and second phases; quantitative data was collected in the third phase based on the initial in-depth exploration. According to Creswell and Creswell (2018:248), exploratory sequential mixed methods is a “mixed methods strategy that involves a three-phase research” during which a researcher initially collects qualitative data and analyses it, then designs a quantitative feature based on the qualitative results and finally tests that quantitative feature. Therefore, the rationale for utilising an exploratory sequential mixed methods design is explained by the fact that the researcher wanted to first collect data using focus groups and existing literature, analyse the results, and then later develop and validate the tool to evaluate clinical competence of CSNs during placement (Creswell & Creswell, 2018: 224).

2.3.1.3. Multiphase methods

This research consists of three phases as indicated in Figure 1 of Section One, namely: Phase One: Empirical phase, Phase Two: Development phase and Phase Three: Validation phase. This research, incorporated a mix of both qualitative and quantitative methods within the research objectives, data collection, data analysis, and interpretation

(Creswell & Creswell 2018:249) (Refer to Table 2.1 on the multiphase of this study).

Table 1: Research Multiphase Methodology Overview (Matlhaba, Pienaar & Sehularo, 2019)

Phase	Component	Objectives:	Population	Sampling method	Data collection	Data analysis
Phase One: Empirical phase	Qualitative	Explore the perceptions of PNs regarding the clinical competence of CSNs	PNs	Purposive sampling	FGDs, semi-structured questions	Interpretive analysis-four steps according to Pienaar (2017:91)
		Explore the experiences of CSNs with regards to clinical competence during their period of community service	CSNs	Cluster sampling	FGDs, semi-structured questions	Interpretive analysis-four steps according to Pienaar (2017:91)

		Converge the results of the perceptions of PNs and experiences of CSNs on clinical competence of CSNs	PNs & CSNs	Purposive sampling	World café	Interpretive analysis-four steps according

						to Pienaar (2017:91)
		Describe legislation, regulations and policies that govern clinical competence in community service program	legislations, regulations and policies	Purposive sampling	Literature review	Interpretive analysis-four steps according to Pienaar (2017:91)
		Conduct a desk review on the available clinical competence evaluation tools of newly qualified nurses	Clinical competence evaluation tools	Purposive sampling	Desk review	Interpretive analysis-four steps according to Pienaar (2017:91)
Phase Two: Development phase	Qualitative	Develop a baseline clinical evaluation tool	LoBiondo-Wood & Haber (2010:208) four steps of tool development		Semi-structured tool	Interpretive analysis-four steps according to Pienaar (2017:91)

Phase Three: Validation	Quantitative	Validate the developed tool	Experts validation	Baseline tool	SPSS version 25
			CVR, CVI & Cronbach Alpha	Baseline tool	SPSS version 25
		Refine and finalise the tool for evaluating clinical competence of CSNs	LoBiondo-Wood & Haber (2010:208) four steps of tool development	Final tool (CCET)	SPSS version 25

2.3.2. Phase One: (Empirical Phase)

In this phase, data was collected in five stages (Refer to the Table 2.1 above on objectives of each stage).

2.3.2.1. Population

Population refers to “characters, objects or elements that meet an inclusion criterion in a particular world” (Burns & Grove, 2009:42). Brink *et al.,* (2012:131) as well as Polit and Beck (2012:738) agree and define a population as a “collection of objects, events or individuals” with the same mutual “characteristics that the researcher is interested in studying” or the collective of all “cases that conform to some designed set of conditions”. The target population in this research were the CSNs and the PNs where the CSNs were allocated in the NWP.

2.3.2.2. Sample

Brink *et al.,* (2012:131) define a sample as a “portion of population targeted and selected for participation in a research study”. Polit and Beck, (2012:275) believe that sampling should lessen representatives of the nominated population and permit generalisation to be as accurate as possible. Description of the sample is given in the next section:

- **Sampling Techniques**

Sampling is a process of selecting a group of people, events or behaviour for participation a research study which is about to be conducted (Brink *et al*., 2012:132). The confirmation is that in sampling, a representative part of the entire population is selected (Polit and Beck, 2012:742). Cluster and nonprobability purposive sampling techniques were used in this research.

- **Cluster sampling technique**

Levy and Lemeshow (2008) stipulate that there are two reasons for choosing cluster sampling over other sampling methods; namely, when a sampling frame for the whole population is not available and when the observed population is dispersed geographically. According to Creswell and Creswell (2018:150), cluster sampling is “ideal when it is impossible or impractical to compile a list of the elements composing the population”. Frey (2018:298) posits that cluster sampling can reduce travel cost for in-person data collection by using geographically concentrated clusters when a more dispersed population would be expensive to survey. In this research, CSNs are allocated within four regions of NWP. Therefore, cluster sampling was deemed suitable for this study as it allowed the researcher to obtain data from a concentrated population of CSNs across the four regions of the province and resultantly, was more economical.

- **Purposive sampling technique**

The researcher used a purposive sampling technique to instinctively select participants according to what was considered representative of the population (Brink *et al*., 2012:141). According to Polit and Beck (2012: 517), purposive samples consist of characteristics based on a particular quality that will benefit the study. In this study, professional nurses were purposively sampled as they are in constant supervision of the CSNs during their community service in identified hospitals. The literature review conducted was purposively sampled to describe legislation, regulations and policies that govern clinical competence in community service and desk review to explore the existing clinical competence evaluation tools for newly graduate nurses.

- **Sample size in qualitative component**

Brink *et al.,* (2012: 143) maintain “sample size does not influence the importance or quality of the study” and further that “there are no guidelines in determining sample size in qualitative research”. De Vos *et al.* (2011:391) also indicate that the qualitative researcher will not typically be aware of the potential number of participants involved in advance of the research; therefore, the sample size may fluctuate during the period of research. In qualitative research, sample size is determined by data saturation. In such a situation

sampling will continue until a saturation point is reached whereby there is no further production of new information (Creswell, 2014:189). Data was collected in this study until such a point whereby no new information was emerging from either the professional nurses or the CSNs after the third focus group discussion.

The inclusion criteria used to select participants of this study is as follows:

- PNs employed full-time at the selected hospitals where the CSNs are allocated for community service in NWP. PNs, in this case, had two years or more experience after SANC registration as professional nurses. These professional nurses directly supervise the CSNs during community service placement.
- CSNs with degree or diploma nursing qualification (R425) currently performing their community service in the selected hospitals in NWP.

2.3.2.3. Setting

A study setting is considered the physical site or environment where and within which a research study is conducted (Polit & Beck, 2012:743). A neutral venue was selected for data collection to minimise any potential bias and influences, therefore, the venue selected had to be one that was comfortable and accessible and where the participants felt relaxed and was without any expected behaviours (Polit & Beck, 2012:743). This study was carried out at NWP public health care facilities at which the CSNs were located their community service and where PNs were employed that could supervise those CSNs.

2.3.2.4. Data Collection

Exploratory sequential data collection processes were followed in this study. Data collection of this study was carried out in two phases with the sequential mixed methods approach being completed over the period of two years. The data collection protocol was designed to allow. qualitative results to provide insights on the implementation of the community services program through semi-structured interviews and an existing literature study. The insight led to development of a clinical competence evaluation tool that was validated using experts and later piloted by the CSNs themselves. More information on the

data collection methods employed in this study is given in specific manuscripts in Section Three.

2.3.2.5. Data Analysis

Pienaar's (2017:19) four steps of data analysis as indicated below were followed for interpretive analysis in the qualitative phase

Step 1: Data collection and analysis of the data occurred simultaneously with basic concepts being derived from the spoken word. Both an audio recorder to record the spoken words and field notes to record observed actions that took place during data collection were used by the researcher.

Step 2: Concepts that emerged were separated and those that were similar or related were linked together by the researcher.

Step 3: The researcher instinctively deducted, converged and/or discovered new concepts, themes or clusters (insights/discoveries). This occurred through the intuitive deduction of the researcher as additional information emerged during data collection.

Step 4: The researcher then built the storyline or pattern to form a process and a generic framework for African-unique context.

Data in the quantitative descriptive phase was analysed using descriptive statistics utilising frequency and cross-tabulation tables and various types of graphs by means of the "Statistical Package for the Social Sciences (SPSS) version 25 software" for the quantitative phase. Polit & Beck (2012:366 & 379) indicate that this software is used to "conduct statistical analysis regarding validity and reliability of the measuring instruments, descriptive statistics, Cronbach's alpha, factor analysis, and Pearson's correlation coefficients".

2.3.3. Phase Two (Development phase)

In this phase, a clinical competence evaluation tool was developed using the results from phase One.

2.3.3.1. Tool Development Process

The four steps of tool development proposed by LoBiondo-Wood and Haber (2010:208) were followed. These steps are discussed in details in manuscript 6 (Development and validation of the CCET) in Section Three. The tool was developed as an effective tool that had been tested for reliability and validity and that can be used by others in alternate research studies as a proven, trustworthy tool to evaluate clinical competence (Polit & Beck, 2012: 268). The tool consists of sections A to E. Within Section A being the competencies, domains and items the CSN is evaluated upon using the rating scale of 1 (novice) to 5 (expert); Section B being the CSN self-evaluation; Section C being the peer-evaluation; Section D, the mentor-evaluation and Section E been the self-learning assessment during first six months of community service. To test the reliability of this tool, the researcher hand delivered the tool to participants as the researcher intended a group administration technique (Polit & Beck, 2012:311).

Figure 4 represents the steps on tool development followed as described by LoBiondo-Wood and Haber (2010:208).

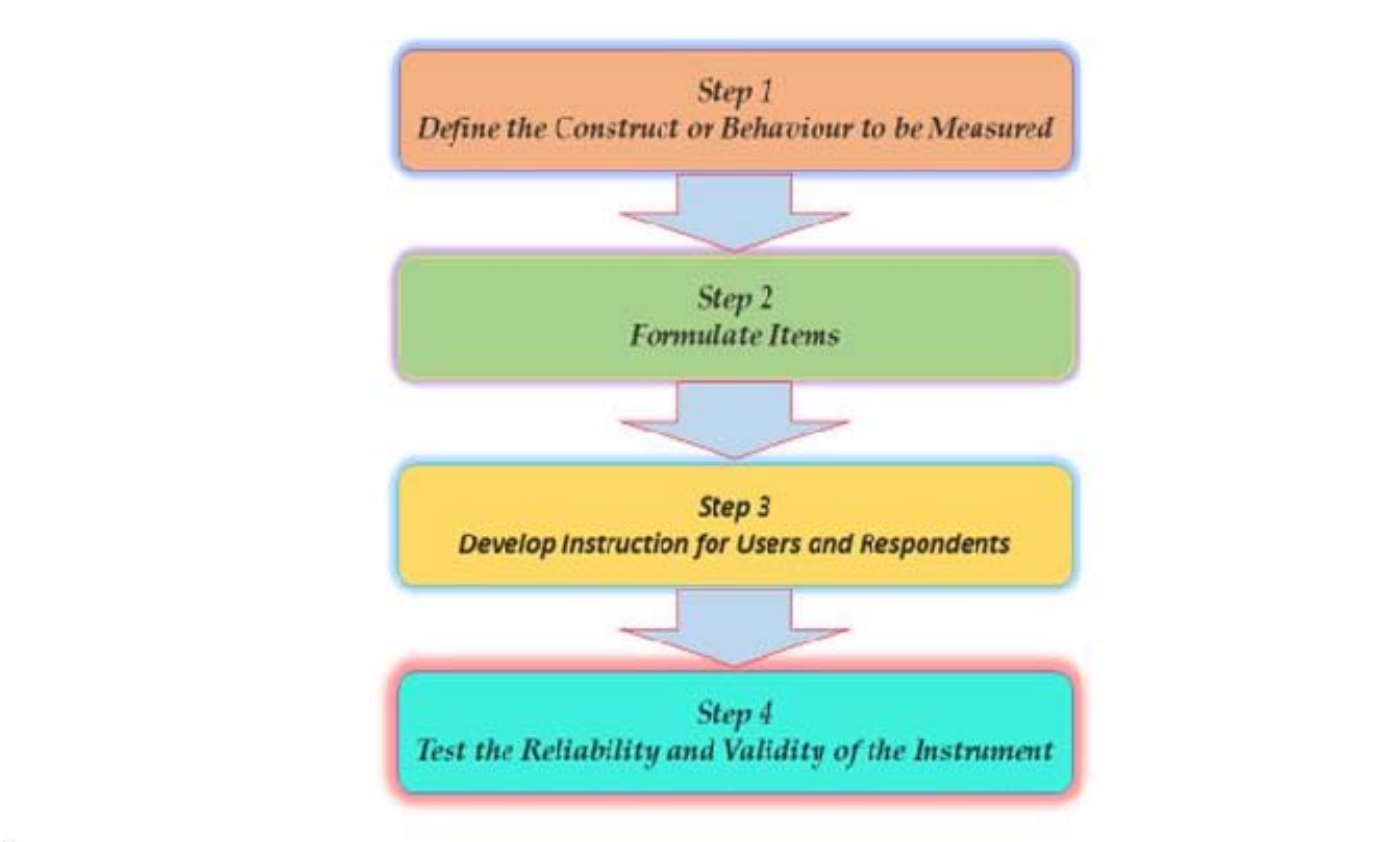

Figure 4: Research tool development process (LoBiondo-Wood & Haber, 2010:208)

2.3.3.2. Crystallisation of the Qualitative Results

It is during the multiple stages where the trustworthiness of the qualitative phase was ensured through crystallisation. Crystallisation is the process where several investigators, sources and methods are used to compare the results with one another (Maree, 2016). Maree and Van der Westhuizen, (2007:40) consider that crystallisation is the "process that gives a complex and more deepened understanding of the phenomenon". Further, Nieuwenhuis (2007:81) indicates that "crystallisation aims at allowing the researcher to shift from viewing things in a fixed and rigid manner". When the researcher used data acquired from participants using the focus group discussions and the world-café methods, results crystallisation transpired in this research. To gain more insight from these methods of data collection, a more considered understanding of the observations of the PNs and the CSNs' experiences with respect to clinical competence during community service placement was established.

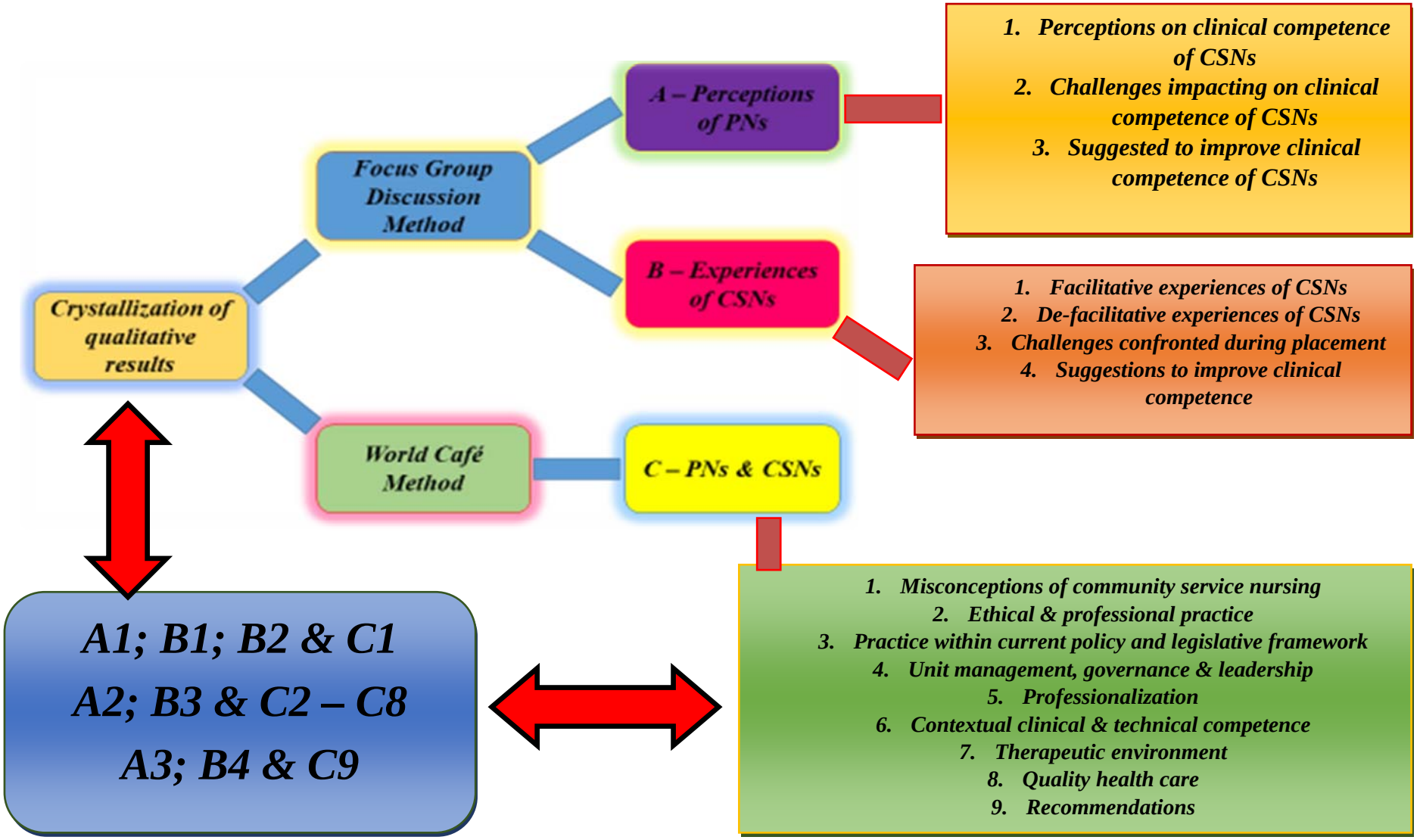

Figure 5: Crystallisation of the qualitative results. Source: (Matlhaba, Pienaar & Sehularo, 2019)

2.4. Quality Measures

Quality measures were ensured according to the three phases of this mixed method research study; the empirical phase; the development phase and the validation phase.

2.4.1. Measures of Trustworthiness (Phase One and Two)

Triangulation is a quality measure used within qualitative research that translates as a method utilised to increase the validity and trustworthiness of research. To ensure triangulation, the researcher employed different data sources of information (Creswell & Creswell, 2018:200). Furthermore, trustworthiness in this study was ensured whereby the participants and existing literature were the main sources of information. The following strategies were checked to ensure trustworthiness (Creswell & Creswell, 2018:201):

- Data was accurately and completely documented;
- Transcripts were verified to ensure that they contained no obvious mistakes through use of the coding system;
- Co-coding was carried out and approved by the study promoters; and
- Triangulation of different sources of data was achieved by using different data sources of information.

In phases 1 and 2 of this study, the quality criteria framework proposed by Lincoln and Guba in 1984 as stipulated in Polit and Beck (2012:584) ensured measures of trustworthiness; these criteria are fully discussed in the different manuscripts in Section Three.

Phase Three (Validation phase)

In the validation phase, both the validity and the reliability of the developed tool had

to be established and ensured. The content validity index (CVI) and content validity ratio (CVR) were achieved and validity was ensured through use of experts' validation. Cronbach's alpha was employed for evaluation of the internal consistency of the develop tool (Polit & Beck, 2012:333). The validity and reliability process took place between June and October 2019. A brief discussion below presents the process that was followed:

2.4.1.1. Validity

Validity refers to the "degree to which an instrument measures what it is supposed to be measuring" (Brink *et al.,* 2012:218), and Burns and Grove (2009:191) describe validity as "the extent to which the results can be generalised beyond the sample used in the study". Validity entails both internal and external validity with Polit & Beck (2012: 251) indicating that internal validity refers to the "ability of the research tool to measure what it is intended to measure" whereas external validity relates to the "degree of generalisation of the results to the population" scrutinised. In this study, face, content and benchmark validity were confirmed by submitting a developed tool to the experts, the statistician and the study promoters for scrutiny.

Tahadoost (2016:30) proposes that it is recommendable to apply content validity whilst the new instrument is being developed. According to Lewis *et al.,* (1995) and Boudreau *et al.,* (2001, cited in Tahadoost 2016:30), content validity involves "evaluation of a new tool in order to ensure inclusion of all essential items and elimination of those undesirable to; a particular construct domain". In this study, the process to ascertain content validity involved evaluation of the developed tool by experts. Although the experts were located in differing geographical areas, but they still retained a similar speciality of interest, the nursing profession (Gilbert & Prion, 2016:530).

The following steps, as adapted from Tahadoost (2016:30), were followed to apply content validity:

- Related items emerged from the empirical phase of this study.
    - A content validity tool was generated in which the experts were requested to rate each item as either “essential”, “useful” or “not necessary”.
    - The tool was evaluated by experts in the same field of the research (refer to Figure 6).
    - The content validity ratio (CVR) and content validity index (CVI) was then calculated for each item through use of Lawshe’s (1975) method.
    - Although in this study, no items were eliminated, any that were deemed not significant at the critical level would have been eliminated. .
    - The generation of a refined tool.

Figure 6 depicts a brief description of the experts who participated in the validation process. A full discussion on the selection process of the experts is illustrated in Section 3, Manuscript 6.

Figure 6: Experts validation process (Matlhaba, Pienaar & Pienaar, 2019)

2.4.1.2. Reliability

Reliability refers to the level of consistency and dependability with which a research instrument measures the specific attributes it is designed to measure (Polit & Beck, 2012:331). Creswell (2005) proposes that the reliability of a study can be ascertained if the results of a study are close to the original if the study is administered repeatedly for the same time period to similar candidates used in the original study. Therefore, for the results of this study to be reliable, similar results would be obtained if the study were to be replicated by other researchers using the same method. Internal consistency was determined to ensure that items in the tool measured the clinical competence of CSNs (Cronbach, 1951:363).

2.5. Ethical considerations

Table 2 represents the ethical measures ensured in this study:

Table 2: Ethical considerations (Matlhaba, Pienaar & Sehularo, 2019)

Ethical considerations	Ethical principles	Applications
1. Ethical Clearance	Ethical certificate and permissions	The School of Nursing Science Research Proposal Committee first approved research proposal. Ethical clearance was obtained from NWU Faculty of Agriculture, Science and Technology "Health Science Ethics Committee" (NWU – 00230-18-A9) and Provincial Department of Health Research Committee. Permission was sought and granted by the NWP facilities in which the study was conducted.
2. Ethical Principles For the study's duration, Brink *et al.'s* (2012:34-38) three fundamental ethical principles were ensured.	Principle of Beneficence	The well-being of the participants was secured at all times. Participants were protected from any harm or discomfort. Even though this study did not involve harmful intervention to participants, there was no manipulation of participants.
	Principle of Justice	During this study, participants' right to fair selection and treatment was ensured. Participants' cultural values as well as time agreed upon between the researcher and participants were respected. There were no incentives for participants and they were made aware before the data collection process commenced.

3. Participants rights	Rights to privacy, confidentiality and anonymity	The right to privacy, confidentiality and anonymity was ensured. Confidentiality was maintained, as the collected data was only made available to the research team. Care was taken to ensure that the privacy and anonymity of the participants and their identities were protected; the researcher used identity codes to identify the participants during data collection.
	Rights to Informed Consent	Participants received detailed consent with sufficient information about the research, and were informed about their rights to participate voluntarily or to decline any participation. A written informed consent form was signed prior to participation. Participants who declined to give written consent were excluded from the study participation.

2.6. Summary

In this section, the theoretical framework underpinning the study was described as well as an overview of the research methodology that was followed when conducting the study. The following section includes the presentation of results in the form of published and unpublished manuscripts submitted to peer-reviewed and accredited journals. Figure 7 gives a brief summary of the manuscripts to follow in the next section. It must be noted that although the university guidelines were used to format the manuscripts, journal publication guidelines were adhered to during submission and publishing.

Figure 7: Published & unpublished manuscripts (Matlhaba, Pienaar & Sehularo, 2019)

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3. SECTION THREE: MANUSCRIPTS

Introduction

The previous section elucidated the methodology followed in this research and provided a detailed account of the research designs applied in the various phases. This section presents the six manuscripts produced in this study. It must be noted that this thesis is formatted according to the North-West University guidelines; however, the manuscripts will be submitted according to the journal's guidelines which are presented at the beginning of each manuscript. It must be further noted that all the tables and figure numbering are based on each manuscript. Listed below are the manuscript titles and the journal published or to be submitted at.

Manuscript One: Professional nurses' perceptions regarding clinical competence of community service nurses (CSNs) in North West Province, South Africa (Submitted to *Curations*).

Manuscript Two: Community service nurses' experiences regarding clinical competence during placement (Published at *Health SA Gesondheid* on 21 October 2019*).*

Manuscript Three: Convergence of the results of the experiences of community service nurses as well as the perceptions of professional nurses regarding the clinical competence of community service nurses during community service (To be submitted to *International Journal of African Nursing and Midwifery*).

Manuscript Four: Legislation, regulations and policies that govern Community Service Nurses: A literature review (To be submitted to the *International Journal of African Nursing and Midwifery*).

Manuscript Five: Desk review on assessment tools for clinical competence of newly qualified nurses (To be submitted to *Nursing Education in Practice*).

Manuscript six: Development and validation of a clinical competence evaluation tool (CCET) for community service nurses in North West Province, South Africa (To be submitted to *Health SA Gesondheid).*

Manuscript One

Manuscript One:

Professional nurses' perceptions regarding clinical competence of community service nurses (CSNs) in North West Province, South Africa (Submitted to *Curations*).

Journal Link for Manuscript One

https://curationis.org.za/index.php/curationis

Professional nurses' perceptions regarding clinical competence of community service nurses in North West Province, South Africa

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Abstract

Background: Regulation 425 dictates that South African, nurses who have successfully completed their training are required to perform 12-months' community service before obtaining registration as professional nurses. This strategy was devised by the government to retain newly qualified health professionals within the country. The premise is that community service provides opportunities for the new graduate nurses to develop skills and acquire critical knowledge necessary for their professional development. Professional nurses' perceptions of the clinical competence of community service nurses cannot be overlooked in this respect.

Aim: The aim of the study was to explore professional nurses' perceptions of the competence of community service nurses in North West Province, South Africa.

Method: The study was conducted at three public hospitals in the North West Province using a qualitative, exploratory and descriptive design. Through purposive sampling, fifteen professional nurses who supervise community service nurses participated in the study Pienaar's four steps of thematic analysis was used to analyse the data collected from the three focus group discussions using semi-structured questions, all of which were recorded and transcribed for analysis.

Results: Three themes emerged: perceptions of clinical competence, challenges influencing clinical competence and suggestions to improve clinical competence.

Conclusion: Participants perceive that the majority of community service nurses are competent and capable of working independently but still require supervision and mentorship to refine their competence. Numerous challenges that affected the community service nurses' ability to provide quality health care were identified and recommendations were made for improvements.

Keywords: Clinical competence, Community service nurse, Perceptions & Professional nurse

Introduction

Clinical competence of community service nurses (CSNs) is dependent upon the supervision and mentoring received during their placement in the healthcare facilities. Increased scrutiny has been focused on the roles of all stakeholders, particularly the professional nurses (PNs) who are involved in the development of the CSNs knowledge and skills and who are expected to provide necessary support throughout the 12-months' period of community service. This pre-empts the question to what degree does community service have impact on nurses' preparedness for the real working environment and the reality of dealing with the high prevalence of disease in the country. Therefore, exploring perceptions of the PNs will be of great assistance in the development of a tool to evaluate clinical competence of CSNs in the NWP.

Background

Chapter 3 of the Constitution (1996) of the Republic of South Africa (RSA) states that the "government is constituted as national, provincial and local spheres which are distinctive, interdependent and interrelated" (Constitution of the Republic of South Africa, 1996: ss40-41). Further, that the principle of co-operative government and intergovernmental relations specifies that the government must "secure the wellbeing of the people of the Republic" Constitution of the Republic of South Africa, 1996: ss40-41). These principles served as a basis for the introduction of community service in South Africa (SA), whereby all health professionals are expected to perform community service.

Community service refers to the mandatory service that health professional are required to perform at public health care facilities after successful conclusion of their training, prior to registration as professional practitioners (Karamchand & Kistnasamy, 2017). Frehywot *et al*. (2010:364) define community service for health professionals as a "law or policy" of a particular country, that regulates "the compulsory deployment and retention of a health professional in an underserved or rural area of that country for a certain period of time". In South Africa, the initial group amongst health

professionals required to perform community service were the medical doctors in 1998 (South Africa Department of Health, 2006). The second group were dentists in 2000 followed by pharmacists in 2001. Other health professionals excluding nurses followed in 2003 (South Africa Department of Health, 2006). The Nursing Bill was published as the Nursing Act (33 of 2005) and community service for nurses was implemented in 2008 (SANC, 2007).

The policy regarding community service is clarified in section 40 of the Nursing Act (33 of 2005) and in the *Regulations Relating to Performance of Community Service* published as Government Notice No. 765 of 24 August 2005. The primary objective of this proposal was to ensure the equitable distribution of health workers, especially for rural and underserved populations. In addition to providing a service, the intention of community service is designed to provide CSNs with opportunities to develop skills, knowledge, experience and clinical competence. Further, the hope is that such community service also encourages CSNs to continue in public service, in particular in those rural and underserved areas (Hatcher *et al*. 2014). Therefore, recently qualified South African nurses are obliged to complete a one-year community service at any of the designated government health care facility (SANC 2007).

During the 12-months of community service, all CSNs work under the direct and indirect supervision of Professional Nurses (PNs). The suggestion from the literature is that for these CSNs to gain independence, professional support, approval and supervision is needed. From the onset, it is expected that CSNs have the necessary skills that enable them to render professional and quality care within the clinical arena (Snell & Daniel, 2014). In the literature, this is referred to as competence and within the South African context, competence is defined as a cluster of “related knowledge, skills, attitudes and values” which empowers an individual to effectively deliver career development services (Department of Higher Education & Training, 2015). In this study, clinical competence refers to the CSN's ability to integrate theory into practice by demonstrating knowledge, judgment and skill to render quality patient care (Hansen-Salie & Martin, 2014).

Clinical competence can be improved if effective supervision and mentoring is received during placement in healthcare facilities such as clinics and hospitals

(Motala & Van Wyk, 2016). There has been increased scrutiny into the roles of stakeholders, including PNs involved in the development of expert knowledge and skills of CSNs, as these PNs are expected to provide such support throughout the 12-months period of community service. The question that must then be asked is if compulsory community service has an impact on CSNs' preparedness for the working environment and the reality of managing the high burden of disease in South Africa.

Several studies, including those of Tsotesti (2012); Roziers *et al.* (2014) Nkoane (2015); Zaayman (2016) and Govender *et al*. (2017), have been conducted since the requirement of community service for nurses, but their focus was on the lived experiences of CSNs and the support they require during placement. Snell and

Daniels (2014) study encompassed the PNs' perceptions regarding CSN's clinical competence, which compared the clinical competence between degree and diploma graduate nurses in the Western Cape. However, very little is known on how PNs perceive CSNs' clinical competence in the NWP. The researcher identified a need to conduct a qualitative study that would explore and describe the PNs' perceptions of the clinical competence of CSNs during their placement. This study provides some insight and into these perceptions and identifies perceived problems that require improvement. This data could be then used by the researcher towards developing a tool to evaluate clinical competence of CSNs in the NWP.

Aim of the study

The aim is to examine the perceptions of registered professional nurses with respect to the clinical competence of CSNs they supervised in selected North West Province hospitals.

Methodology

Research setting

The study was conducted at three North West Province public hospitals within, South Africa.

Research design

A qualitative, exploratory, descriptive and contextual research design was adopted for this study. According to Creswell and Creswell (2018) and Creswell (2014), qualitative research is a way of "exploring and understanding the meanings individuals or groups ascribe to a social or human problem". Creswell (2013) asserts that a qualitative research design centres on the viewpoints, meanings and various personal opinions within the participants 'context, and presents a complex, holistic picture. For this study, the researcher aimed to acquire cognizance of professional nurses' recognition of the clinical competence of CSNs during their placement.

Population and sampling method

The target population in this study were professional nurses in 3 selected NWP hospitals. The inclusion criteria were PNs with 2 or more years of experience after registering with SANC and were directly responsible for supervising CSNs at the hospitals in NWP. The exclusion criteria included all operational managers since they only have indirect supervision of CSNs.

Burns and Grove (2009), define a population as all "the components, including characters, objects or elements that meet certain criteria for inclusion in a particular world". For the benefit of this study, a purposive sampling method was used to select participants who were subjectively selected by the researcher as those she considered to be typical of the population (Brink *et al.,* 2012). According to Creswell and Creswell (2018), , researchers use purposive sampling to select individuals who

will aid understanding of the research problem and the research question. Therefore, the researcher deliberately recruited participants' who could best provide perceptions on the competence of CSNs (De Vos *et al.*, 2011).

Instrumentation for data collection

Focus Group Discussions (FGDs) with semi-structured, open questions were carried out to elicit participants' perceptions regarding clinical competence of CSNs and to increase the trustworthiness of the results (Creswell & Creswell, 2018). Both digital recordings and field notes were taken to record and capture verbal and non-verbal cues during the FGDs. Participants were asked the following two central questions:

"What are your perceptions regarding clinical competence of CSNs?"

"What suggestions do you have for improving clinical competence of CSNs during their placement?"

Data collection process

Data was collected through the medium of Focus Group Discussions (FGDs), with the first author conducted all three of the FGDs. Each FGD group of five participants respectively were conducted in the study, with the discussions lasting between 30 and 60 minutes each. FGDs are defined as "carefully planned discussions that take advantage of group dynamics for accessing to rich information, in an efficient way" (Polit & Beck 2012:589). According to Masadeh (2012), FGDs can be used to explore the participants' opinions and views related to the topic of interest, which cannot be explained statistically.

The researcher's theoretical and any past personal knowledge was put aside to allow full attention to be given to the perceptions of the PNs (De Vos *et al.*, 2011). This was achieved by excising any previous knowledge or experiences that could influence the perceptions of the PNs. The researcher conducted all FGDs until the point of data saturation was reached, meaning no new information was forthcoming (Creswell,

2014). This occurred after the third FGDs where no fresh insights emerged (Creswell & Creswell, 2018).

Data analysis

Authors 1 and 3 analysed data from the transcripts independently following Pienaar's four steps of data analysis (Pienaar, 2017). The steps are as follows:

Step 1: There was simultaneous data collection and analysis, with basic concepts being derived from the spoken word. The researcher made use of an audio recorder to record the spoken word and took field notes to record observed actions took place during data collection. Concepts were built from the participants' spoken words.

Step 2: Concepts that emerged were separated and those that were similar or related were linked together by the researcher..

Step 3: New concepts, themes or clusters (insights) were identified through the intuitive deduction of the researcher as additional information emerged during the data collection process..

Step 4: The researcher built the storyline pattern to form a process and a generic framework for a unique African context. The first and third author held a consensus discussion to confirm the final themes.

Measures of trustworthiness

To ensure trustworthiness, the researcher discarded any preconceived ideas regarding the PNs' perceptions and followed the criteria suggested by Lincoln and Guba (1985) [cited in Polit and Beck (2008) and Brink *et al.* (2012)]. As an experienced qualitative researcher, I conducted the FGDs to ensure credibility, furthermore, a qualified independent qualitative researcher analysed the data independently and verified the research findings to ensure credibility of the analyses. Dependability was guaranteed through the detailed explanation of the research method and the suitability of the methodological applications. Audio recordings were

used from which an independent transcriber transcribed the raw data and the researcher validating the transcripts. Furthermore, existing literature was used for literature control. Transferability was ensured by purposively selecting participants based on their knowledge of the perceptions regarding the clinical competence of CSNs. Confirmability was achieved by ensuring credibility and transferability.

Ethical considerations

Ethical clearance for this study was granted by the North-West University Faculty of Agriculture, Science and Technology “Health Science Ethics Committee” (NWU-00230-18-A9), the “North West Department of Health” (DoH) and the three selected NWP hospitals. Participation in the study was on a voluntary basis. The objective of the study and the participants’ roles in data collection was explained by the researcher. The participants were advised that participation was voluntary and that they had the right to opt out of the interview at any stage without providing explanation and without penalties being imposed on them for withdrawing. After the explanation, the informed consent forms were signed by those willing to participate, which gave the researcher permission to continue with data collection. Anonymity was observed and respected through all stages of this research and the participants’ identities were protected by the use of card numbers as their identity codes. During participation, fairness was ensured and all participants shared their perceptions without any judgment or coercion.

Discussion of results

There were a total of 15 PNs who participated in the study, which included 2 males and 13 females, all of whom supervised CSNs working in different wards of the selected NWP hospitals. Twelve of the PNs had completed a four-year training following a diploma programme from nursing colleges and 3 had followed a degree programme from a recognised university. Seven of the participants had experienced

community service themselves in different provinces of South Africa. Participants represented a single racial group, (Black), with age ranges of 28 to 61 years, and between 2 to 38 years of work experience post-registration as professional nurses with SANC. Table 1 depicts the themes and sub-themes that emerged from data analyses.

Table 1: Themes and sub-themes (Matlhaba, Pienaar & Sehularo, 2019)

Themes	Sub-themes
1. Perceptions on clinical competence of CSNs	1.1 Perceived to be competent
	1.2. Requires minimum supervision
	1.3. Trusted with responsibilities
2. Challenges impacting on clinical competence of CSNs	2.1. Unprofessional conduct
	2.2. Unclarified roles leading to role confusion
	2.3. Fear of taking responsibilities
	2.4. Failure to communication
	2.5. Negative attitudes towards colleagues
	2.6. Supervisors' negative attitudes towards CSNs
	2.7. Shortage of staff leading to poor or insufficient supervision

3. Suggestions to improve clinical competence of	3.1. Improve supervision and provide continuous guidance, feedback and support
CSNs	3.2. Provide continuous in-service trainings 3.3. Encourage peer teaching 3.4. Improve attitudes towards CSNs

Theme 1: Perceptions on clinical competence of CSNs

Sub-themes for this theme are discussed below and supported by existing literature for literature control.

Sub-theme 1.1: Perceived to be competent

The majority of participants perceived the CSNs competent with knowledge and skills. One participant said:

"…. they are competent even when we teach, they show responsibility"

This study's results are in correlation with the results of a study conducted by Snell and Daniels (2014) in the Western Cape Province. Their study revealed that professional nurses perceived CSNs with degree and diploma qualification equally competent with knowledge and skills despite some minimal difference in attitudes.

Sub-theme 1.2: Requires minimum supervision

The majority of participants mentioned that most of CSNs required minimum supervision. To support this statement, one participant said

"…they need less guidance. Most of them they have the confidence, 'cause of usual they are based where there are no supervision, from my experience"

The results of this study were in contrast with several studies contacted in South Africa including that of Nkoane (2015); Thopola, Kgole and Mamogobo, (2013); Khunou (2016); Makau (2016); Tsotetsi (2012) and Ndaba (2013). The majority of participants in these studied reported that the CSNs need efficient supervision as they displayed minimum confidence and knowledge with allocated tasks.

Sub-theme 1.3: Trusted with responsibilities

Participants also mentioned that the CSNs displayed high levels of commitment and could be trusted with responsibilities given to them. This is what one participant said

"There are instances where the commserves were left to lead to the shift. That's what I'm saying, in high care, we are working two/two. So, you will be with a commserve and you'll be four professional nurse per shift with two staff nurses. So, somehow, during the course of time, we let them lead the shift."

These results contrasted with Makua's (2016) results whereby some participants reported a lack of faith in the education and training of newly qualified professional nurses who were performing community service. The qualifications and range that the newly qualified professional nurses should be able to manage were doubted by some participants in that study.

Theme 2: Challenges impacting on clinical competence of CSNs

Sub-themes for this theme are discussed below.

Sub-theme 2.1: Unprofessional conduct

Some incidents of unprofessional conducts were observed by PNs during CSNs placement. Participants mentioned that this conducts are of distractions and might a hinder to patients care. One participant said:

> *"The way they wear their uniform, it's …… if you expose your body, being a nurse, I think that contributes negatively to the care of patients, and, if you nurse people, having some things like … the headset devices in your ears, how are you going to have effective communication with patient"*

Kieft, de Brouwer, Francke and Delnoij (2014) in the Netherlands reported that nurses require applicable knowledge of the nursing profession including those social skills that create a trusting and caring relationship with patients. Those skills include "correct behaviour and attitude, composure, making time for patients, listening and having empathy as essential nursing competencies" (Kieft *et al*., 2014:4). Therefore, from this study, behaviour and conduct of the CSNs were deemed to be not acceptable as it might have negative impact on patient care.

Sub-theme 2.2: Unclarified roles leading to role confusion

The majority of participants mentioned that there were some unclarified roles due to lack of scope of practice and job descriptions for CSNs that led to confusion. One participant said

"…commserves when they come, they are a little bit confused because their role as CSNs is not clarified clearly from even the governing body. Mostly, when they come, they don't know if they are professional nurses or what they are because, from Nursing Council, they don't explain it clearly."

This study results concurred with few studies conducted in different provinces since the implementation of community service for nurses. This includes the studies of Shezi (2014); Khunou (2016); Govender, *et al.*, (2015) and Kruse (2011).

Sub-theme 2.3: Fear of taking responsibilities

Some participants stated that some CSNs displayed some fear and not confidence when they are expected to take on tasks including allocation or delegation of duties to those who they felt had more experience due to their length of service . One participant said

"The challenge that they face sometimes is that those people have been there for quite a long time, that competent commserves. They fear to delegate and do almost everything on their own without asking help."

This study's results concurred with those established in a study from England conducted by Magnusson, Allan, Horton, Johnson, Evans and Ball (2017) in. The study reported that the act of delegation was actually avoided by many newly qualified nurses because of a lack of confidence. Due to the greater experience of the healthcare assistants, they felt that their instructions and advice was unwarranted.

Sub-theme 2.4: Failure to communications

Some participants mentioned that poor communication skills from the CSNs were the main challenge observed during supervision of CSNs. Some participants said:

"…they don't want to ask. And, when you show them, guys, you are not doing this, no they know, and they are too stubborn for me, and then they don't want to be corrected"

This study's results concurred with the results from a qualitative study conducted in Iran. Ebrahimi, Hassankhani, Negarandeh, Azizi and Gillespie (2015) reported that lack of communication was one of the impediments raised by licence nurses as a barrier for their support in clinical settings.

Sub-theme 2.5: Negative attitudes towards colleagues

Some participants mentioned that some CSNs displayed some negative attitudes towards their supervisors especially those who trained through the Bridging courses (R683). One participant said

". they have that attitude of undermining the other professional nurses, especially those who don't have bars. They regard themselves as being higher, the level, to us"

This study's results concurred with the outcomes of another from the same province conducted in by Khunou in 2016, which that the mentoring of CSNs was negatively influenced because of their lack of respect and poor attitudes.

Sub-theme 2.6: Supervisors' negative attitudes towards CSNs

Some participants mentioned that their attitudes towards CSNs were not acceptable and that had a negative impact on CSNs performance and competence. One participant said

> *"So, the treatment that we also give to them is not right. And we also 'premed' each other……So, already also, us, we are having attitudes towards them without giving them a chance"*

These results concurred with the results of Walker, Earl, Costa and Cuddihy, (2013). The study reported that unit managers identified occurrence of unacceptable behaviours experienced nurses displayed towards new graduate nurses. Similar results were reported in the study conducted by Baumberger-Henry (2012). Baumberger-Henry reported that some uncooperative behaviours including turning backs when new nurses were asking questions or needed assistance by the experienced nurses prevented new graduate nurses to gain acceptance in the units.

Sub-theme 2.7: Shortage of staff leading to poor or insufficient supervision

Staff shortages were an issue raised by all of the study participants. Many indicated that they have reported the matter to those in charge such as the operational managers, but little was achieved as they are constantly advised that there are no more available nursing posts. One participant said:

> *"You won't say anything. When you report it to your manager, the OPM, saying that there a shortage, then they will tell you there's nothing we can do. The hospital has no post so that we can have*

more staff. So, it will be rectified in some years or sometime, that's all they say."

These results were also confirmed in study Ibrahimi *et al*.'s study of 2015. Participants in this study reported that the head nurse was unable to object about the staff shortages to the matron or the hospital authorities despite the increase workload of the experienced nurses, which in turn negatively affected the supervision of new graduate nurses. Ibrahimi *et al*. (2015) stated that hospital managers' inability to maintain acceptable numbers of nursing staff, which was based in deficient management, created an obstacle to support of new graduated nurses.

Theme 3: Suggestions to improve clinical competence of CSNs

Sub-themes for this theme with the support of existing literature are discussed below.

Sub-theme 3.1: Improve supervision and provide continuous guidance, feedback and support

In the main, the participants suggested that it was necessary to enhance supervision and to include the provision of continuous guidance, feedback and support in order to improve clinical competence of CSNs. Some participants said:

"for competence to them is to make use of a little bit time that you'll be having, to let them work with us, close to us, time and again, immediately when you've had that little time, so that we show them…because I think they are still under supervision, they still have to learn"

"I think I'm just going to add like in special areas like maternity, there they need supervision. They are trying we have to be there for them."

The results of this study are supported by the conclusions reached by Gardiner and Sheen, (2016), who concluded that the transitions of graduate nurses are inclined to be positive when they felt welcomed and supported by the existing nursing team. They further stressed the importance and value of consistent and truthful feedback execution of duties and progress particularly in the first few months.

Sub-theme 3.2. Provide continuous in-service trainings

The majority of participants suggested that CSNs be offered continuous in-service trainings to improve their clinical competence. One participant said

"I think that's where they going to improve. Communication, information, we can give them in-service training every day."

This study results supported results from the study by Makua, (2016) in which participants stated that the experienced nurses taught the newly qualified professional nurses as the learning opportunities arose whilst working by in addition to attendance of nurses in-service programmes.

Sub-theme 3.3: Encourage peer teachings

Majority of participants suggested that peer teachings be encouraged among CSNs to improve their clinical competence. One participant said

"The ones that are more competent, they can teach them. Even them, as CSNs, they can communicate and give others more information, if they know more about it"

Peer teaching and learning is encouraged by most of the literature in nursing education. This results concurred with the result of Pålsson, Mårtensson, Swenne, Ädel, and Engström (2017), whose results revealed improved levels of perceived self-efficacy was evidenced in those nursing students who had been given opportunities to learn during clinical practice education with a peer had. Furthermore, the study reported that nursing students saw their potential capacity for performance of nursing tasks and related competencies as being related to their ability to identify and analyse patients' care needs.

Sub-theme 3.4: Improve attitudes towards CSNs

Some participants suggested that supervisors need to improve their attitudes towards CSNs in order to assist them to grow professionally. One participant said

"So, to ensure that these commserves neh they are competent enough, I think rona [us] as seniors we should work on our attitude. Our attitude can help them to improve, to grow to be like …to perform well in communication and professional behaviour."

The results of this study are in agreement with those of a study administered in Limpopo province by Thopola *et al.* (2013) where it was reported that there was a

need for stakeholders to professionally support CSNs. The researchers recommended that for relevant stakeholders to enable CSNs to provide better quality nursing and midwifery care, it was important that a more positive and resourceful environment were created for them. It is therefore believed that from this study results, improved attitudes of PNs will contribute positively to the competence of CSNs.

Conclusion

This study focussed on investigating and elaborating on professional nurses' perceptions of the clinical competence of CSNs in the NWP. Three main themes emerged from the study, which included perceptions regarding clinical competence, challenges affecting clinical competence and suggestions of clinical competence improvement of the CSNs during their secondment. Important information has been contributed to the body of knowledge in the nursing education and clinical practice from the results of this qualitative study, which might not have been achieved if alternate approaches had been employed. The results of this manuscript have then been utilised to develop a tool to evaluate clinical competence of CSN in the NWP, South Africa.

Recommendations

Interested parties such as health care facilities, the regulatory body that is SANC and the NEIs can make use of this study's results to improve clinical competence of CSNs by developing scope of practice and job description for these nurses. The hospitals should use them to improve clinical competence of CSNs by developing effective support systems that include proper orientation programs, in-service trainings and workshops, and mentoring programs. PNs should use these results to improve their communication skills and their teaching roles as well as their attitudes towards the CSNs. CSNs must use these results to improve their communication skills which will result in a having a positive impact on their supervision.

Limitations

Limitation of this study was that it mainly focused on only three particular NWP hospitals, which may have decreased the chances of the generalisability of results. Similar studies can be conducted throughout the other provinces and the subsequent results from different settings can be then compared. Nevertheless, study findings may be applicable in the other provinces.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

K.L.M. was responsible for collection and analysis of data and drafting the manuscript. L.A.S. was responsible for data analyses and proof reading of the

manuscript, A.J.P. made conceptual contributions in the whole manuscript. All authors contributed in finalisation of the manuscript.

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Manuscript Two

Manuscript Two:

Community service nurses' experiences regarding clinical competence during placement (Published at *Health SA Gesondheid* on 21 October 2019*).*

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Community service nurses' experiences regarding clinical competence during placement

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Abstract

Background: In South Africa, it is mandatory for nurses who have qualified as a nurse (General, Psychiatric and Community) and midwife leading to registration in Government Gazette Notice No R425 of 22 February 1985 to perform compulsory 12-months community service after completion of training at a Nursing Education Institution. The community service affords new graduate nurses the opportunity to improve their clinical skills and knowledge while nurturing professional behavioural patterns and critical thinking consistent with the profession.

Aim: The aim of the study was to explore the experiences of community service nurses regarding clinical competence during their placement in three selected hospitals.

Method: This study followed a qualitative, exploratory, descriptive, and contextual research design. A cluster sampling technique was used and 17 community service nurses participated in the study. Three focus group discussions framed by semi-structured questions were conducted with five to six participants per group. All discussions were recorded using a digital voice recorder and transcribed. Data were analysed using Pienaar's four steps of qualitative thematic analysis.

Results: Four themes emerged from this study: facilitative experiences, defacilitative experiences, challenges confronted during placement and suggestions to improve clinical competence.

Conclusion: Clinical competence of community service nurses could be improved if all the stakeholders, including professional nurses and community service nurses themselves, hospital management and the regulatory body, the South African Nursing Council, collaborate. More importantly, the findings of this study were used to develop a clinical competence evaluation tool in the North West Province, South Africa.

Keywords: Clinical competence; community service; community service nurse; experiences

Introduction and background

In many countries around the world, new nurses are associated with under preparedness and a low level of clinical competence, which lead to their inability to perform quality nursing care (Duchscher, 2009). This is a concern around the world where either the nursing education institutions (NEIs) or the government resorts to introducing measures that seek to improve the competencies of newly qualified nurses (Duchscher, 2009). According to Andre and Barnes (2010), many hospitals offer a 12-month non-compulsory graduate nurse programme designed to support and build the confidence and competence of graduate nurses as they develop professionally. This is perceived to assist and support graduate nurses in their transition into the working environment (Andre & Barnes, 2010). In the United States, The Institute of Medicine (IOM) (2011) has determined that nursing graduates need to enhance competencies in the basic areas of nursing care. Institute of Medicine suggests that to ensure that its members are well prepared, the profession should institute residency training for nurses (IOM 2011). Furthermore, according to Theisen and Sandau (2013), many health organisations use orientation programmes or nurse residency programmes to ensure that new graduates are both confident and competent.

In the Republic of South Africa (RSA), it is mandatory for nurses to complete a 12month period of community service after successful completion of a four-year nursing degree or nursing diploma education (R425) before they can be registered as professional nurses (general, psychiatric or community) and midwifery (South African Nursing Council [SANC] 2005). This requirement has been published in the Government Gazette Notice No. 765 of 24 August 2007 and further details remunerated community service for this category of nurses at the health care facilities. Community service for nurses in the RSA was implemented in 2008 (Govender, Brysiewick & Bhengu, 2017). According to the Department of Health (2006), the process of community service affords young South African health professionals with the opportunity to develop skills, acquire knowledge, behaviour patterns, and critical thinking that will assist them in their professional development.

Competence is defined as the constellation of abilities, including knowledge, skills and attitudes across multiple domains of performance in a certain context (Riddle, Beker & Sapp, 2016). Furthermore, Kubin and Fogg (2010) describe competence as the ability to perform tasks according to defined expectations. According to HansenSalie and Martin (2014), clinical competence is the ability of newly qualified nurses to integrate theory into practice and to render quality patient care. In this study, clinical competence refers to the abilities of the community service nurses (CSNs) to work competently in providing quality nursing care to the patient under their care during community service period. In the North West Province (NWP) of South Africa, like other provinces, CSNs perform their 12-month community service in allocated health care facilities such as clinics and hospitals under the supervision of experienced professional nurses in order to obtain and improve their clinical experience (SANC 2007). As newly qualified nurses, CSNs require the supervision and support of experienced professional nurses to enhance their clinical competence which would ensure seamless transitioning into the working environment as professional nurses after completion of the mandatory community service (Makhakhe, 2010).

CSNs' preparedness and readiness to enter the working environment has been questioned for various reasons. This is evident in several studies conducted and reported on CSNs' clinical competence since the implementation of community service for nurses in 2008 in the RSA. A qualitative study conducted by Shezi (2014) in Kwa-Zulu-Natal Province revealed that not all CSNs were fully competent and independent to allow them to practice autonomously during their community service.

Shezi (2014) further reports that CSNs' competence developed in the period of community service was significantly influenced by the clinical supervision provided by experienced registered nurses who assisted with continued development of skills in clinical practice. In a comparison study conducted in the Western Cape by Snell and Daniels (2014), professional nurses perceived the CSNs who had completed a diploma in nursing programme to be more competent than nurses with university degrees. In addition, the study conducted by Khunou (2016) in the NWP revealed that nursing service managers perceived CSNs as lacking in practical skills,

professional responsibility, and these CSNs were unable to exhibit basic practical skills. The same sentiments are shared by Makua (2016) whose study reported that operational nurse managers perceived newly qualified nurses as lacking in clinical competence during community service (Makua, 2016).

In a qualitative study conducted by Netshisaulu and Maputle (2018) in Limpopo Province, it was identified that despite the expectations of experienced midwives, new graduate midwives placed for community service lacked a sense of independence and commitment to patient care and could not perform delegated duties with respect to ward coverage. This lack of independence and commitment was seen to have an impact on the increased workload and frustration by the experienced midwives supervising CSNs (Netshisaulu & Maputle, 2018). Therefore, experiences of CSNs in the NWP regarding their clinical competence during placement needed to be investigated. The findings and recommendations of this study could assist to improve the experiences of CSNs regarding their clinical competence during placement in NWP, South Africa.

Theoretical perspective

This study followed the point of competence development stages by theorist Patricia Benner (2001). Clinical competence forms the basis of nursing practice. In its nursing education and training standards under the provision of Nursing Act (33 of 2005), SANC emphasises the importance of clinical competence among nurses.

According to Benner's Novice to Expert Theory (Benner 2001), a person passes through five levels of proficiency, with the third level being competence, which SANC defines as a combination of knowledge, psychomotor, communication, and decisionmaking skills that enable an individual to perform a specific task at a level of proficiency. It is believed that community service encourages competence development for nurses (SANC 2007).

Methods

Research setting

The research setting for this study was three selected hospitals in NWP, South Africa. One of the three hospitals is a district level 1 and the other two hospitals are regional level 2. These hospitals were selected based on the availability of CSNs for focus group discussions (FGDs).

Research design

This study utilised a qualitative, exploratory, descriptive, and contextual qualitative research design (Creswell 2014) aimed at gaining an in-depth understanding of CSNs' experiences during community service placement.

Sampling method

A cluster sampling method was used to select participants for this study. Cluster sampling technique is used when the elements of a population are spread over a wide geographical area (Creswell & Creswell, 2018). According to De Vos et al. (2011), cluster sampling is employed when economic considerations and cluster criteria are significant for the study. In this study, CSNs are placed across all the four regions of the NWP which made it impossible for the researcher to extend the study across the entire population (Babbie, 2015). Therefore, three hospitals were selected with one FGD each. Inclusion criterion for this study was the CSNs who were performing their community service at the selected hospitals. CSNs who completed their community service but awaiting registration by SANC were excluded in this study.

Instrumentation for data collection

The FGDs were framed by semi-structured questions to reach an informed understanding of the participants' lived experiences and to increase the credibility of the findings (Creswell & Creswell 2018). The interviews were audio-recorded. The interview guide was self-developed, pretested and narrowed to two central questions with possible probes. The questions are as follows:

- What are your experiences regarding clinical competence during your placement as a CSN?
- What suggestions do you have for improving clinical competence of CSNs during placement?

Data collection process

Data were collected through FGDs. The latter are a research technique used to collect data through group interaction (De Vos *et al.,* 2011). Data were collected between September and November 2018. Three FGDs with 17 CSNs (two groups with six and one group of five) informed this study. The first author conducted all the FGDs. Data were collected in each FGD until saturation was reached (Creswell & Creswell 2018). These FGDs were conducted during working hours when participants were on duty as arranged with the nursing service managers of the selected hospitals. The researcher, being a former nurse lecturer at one of the NEIs in the province, ensured that all personal knowledge and theoretical knowledge were bracketed so that full attention could be given to investigating the clinical competencies and challenges experienced by CSNs (De Vos *et al.,* 2011). This was achieved by attempting to withhold all prior knowledge and past experiences, which would contaminate the studied phenomenon (Polit & Beck, 2012).

Data analysis

All FGDs were recorded and transcribed. Data from the transcripts were analysed independently by the first and third authors following Pienaar's four steps of qualitative thematic analysis (Pienaar 2017). The steps are set out as follows:

Step 1: Data collection and analysis occur simultaneously. Basic concepts are derived from the spoken words. The researcher used a recorder to record spoken words and take field notes.

Step 2: Group similar concepts together. Constantly, as the concepts emerge, the researcher separated and categorised related concepts together.

Step 3: The researcher intuitively deduced, converged and identified new concepts, themes or clusters (insights).

Step 4: Build the storyline or pattern to form a process and a generic framework for an African unique context. A discussion was held by the first and third author to verify the final themes and reach consensus on the veracity and authenticity of the themes and patterns.

Measures of trustworthiness

Trustworthiness of the results was ensured by following the criteria suggested by Creswell and Creswell (2018). Credibility was ensured because the FGDs were conducted by the researcher herself, who is experienced in conducting FGDs. Credibility was also ensured by checking the reliability of coding with a qualified researcher who analysed the data and checked for patterns (Creswell & Creswell, 2018). Furthermore, dependability was ensured by selecting a solid description of the research methods and the appropriateness of the methodological applications. A digital recorder was used and an independent transcriber transcribed raw data and the researcher validated the transcripts. To ensure transferability, the researcher generated thick descriptions of the setting, process of data collection, analysis methods and results. Existing literature was used to confirm or dismiss the

perceptions, and a dense description of the results was done to enhance comparison with other similar settings. Lastly, conformability was ensured by an inquiry audit, in which the identified themes and sub-themes were scrutinised by an experienced independent coder.

Ethical considerations

The scientific committee of the School of Nursing Science (SONS), Faculty of Agriculture, Science and Technology (FAST) Health Science Ethics Committee (HSEC) of the North-West University first approved this study. The North West Department of Health and the three selected hospitals in the NWP, South Africa, also granted ethical clearance for this study. Informed consent was obtained from the CSNs after a thorough explanation of what was expected of them during their voluntary participation in the study. CSNs were offered the choice to participate in this study, and they were informed that they could withdraw from participating without penalty. The study posed minimal risk as CSNs may experience discomfort or emotions when talking about their experiences. The identity of all CSNs was safeguarded by using card numbers as identity codes. Discussion of results was done in such a way that CSNs cannot be identified because of the use of identity codes. Fairness was ensured during participation as all participants were given opportunity to express their experiences without bias or coercion of the researcher. The study would be of indirect benefit to participants, as their contribution to the developed tool will be of benefit to the future CSNs in the province.

Demarcation and description of the sample

Three FGDs were conducted with CSNs at the three selected hospitals in NWP. All of these CSNs were allocated at the three selected hospitals for their community service. Two FGDs consist of six CSNs and one FGD consists of five CSNs. Table 1 reflects the hospitals and its classification involved in the study, the number of CSNs per hospital, age, gender, race, and the qualification obtained.

Table 1: Description of the sample for focus group discussions (Matlhaba, Pienaar & Sehularo, 2019).

	Hospital A (District Level 1)	Hospital B (Regional Level 2)	Hospital C (Regional Level 2)
Age ranges	22 – 29 = 3 30 – 39 = 1 40 – 49 = 2	26 – 29 = 2 30 – 39 = 2 40 – 49 = 1	23 – 29 = 2 30 – 39 = 3 40 – 49 = 1
Gender	4 females and 2 males	3 females and 2 males	4 females and 2 male
Race	4 black people and 2 white people	5 black people	4 black people and 2 white people
Qualification obtained	4 Degrees and 2 Diplomas	3 Diplomas and 2 Degrees	4 Diplomas and 2 Degrees
Province of training	5 North West and 1 KwaZulu-Natal	5 North West	6 North West

Source: (Matlhaba, Pienaar & Sehularo, 2019)

Presentation and discussion of results

Table 2 provides a summary of the themes and sub-themes, and discussions with literature control follows:

Table 2: Themes and sub-themes (Matlhaba, Pienaar & Sehularo, 2019)

Themes	Sub-themes
1. Facilitative experiences of CSNs	1.1. Improved clinical competence
	1.2. Effective teamwork among staff members
	1.3. Supportive nursing staff and other health professionals
	1.4. Constructive orientation and supervision
2. De-facilitative experiences of CSNs	2.1. Unrealistic expectations
	2.2. Incompetent to perform basic nursing procedures
	2.3. Undesirable attitudes from some permanently employed staff
	2.4. Lack of interest in specific ward/department (maternity)
3. Challenges confronted during	3.1. Shortage of human and material resources
	3.2. Unavailability of a job description or scope of

placement	practice
	3.3. Inconsistent rotation and allocation period per ward
4. Suggestions to improve clinical competence	4.1. Sufficient allocation period per ward
	4.2. Need for adequate human and material resources
	4.3. Effective communication including feedback from CSNs

Source: Authors (Matlhaba, Pienaar & Sehularo, 2019)

Theme 1: Facilitative experiences of CSNs

Facilitative experiences of CSNs emerged as the first theme in this study. The subthemes are discussed in the next sections with supporting verbatim statements from the participants whom are referred to as 'commserves'. The results are considered and discussed in relation to the literature.

Sub-theme 1.1: Improved clinical competence

Several participants mentioned that community service is beneficial to them. To support this finding, one of the participants said:

"…because I was put into the deep end, I had to learn to swim, now I am a good swimmer in that ward, now they don't want to lose me…[laughs]". (FGD1/P4/female/33 years old)

The results of this study concur with those of Govender et al. (2017) and Zaayman (2016) that community services were perceived positively by participants as they provided them with the opportunity to gain knowledge and develop requisite skills. These studies indicated that despite other challenges observed, CSNs felt confident and were able to adapt and work under pressure.

Sub-theme 1.2: Effective teamwork among staff members

Some of the participants felt that effective teamwork among staff members helped them as CSNs. For example, one of the participants said:

"I think it depends on people that you are exposed to 'cause' [because], in our shift, seriously, we are working very well; we collaborate very well with the staff members there".
(FGD1/P5/male/24 years old)

These results contrast with those of Parker et al. (2014) and Saghafi, Hardy and Hillege (2012). These studies reported that graduate nurses experienced stress from interactions with other nurses. Participants in these studies perceived other professional nurses as distant, unavailable and disinterested in helping them.

Sub-theme 1.3: Supportive nursing staff and other health professionals

From this study, it was evident that support received by CSNs from the nursing staff and doctors had a positive impact on their daily practice. This finding is supported by the following quotations: One participant said:

"Even the assistant nurses, you just go to them and ask them…listen here help me with this or help me with that… I just had to go to the staff nurses and they showed me". (FGD2/P5/female/27 years old)

To support this sub-theme, another participant said:

"The doctors, in most wards, they are so nice. We're actually supposed to learn from the sisters, but it's fine doctors are teaching us". (FGD3/P5/female/23 years old)

The study results concur with other studies conducted outside NWP. These studies include Roziers, Kyriacos and Ramugondo (2014); Zaayman (2016) in Western Cape Province and Govender et al. (2017) in Kwa-Zulu-Natal. These studies revealed that despite the challenges experienced during placement of CSNs, the amount of support CSNs received assisted them in transitioning through the process of professional development.

Sub-theme 1.4: Constructive orientation and supervision

With regard to supervision and orientation, the majority of participants mentioned that they received orientation programmes, which assisted them in the day-to-day routines of the wards. One of the participants noted:

"At least they taught me how to do the doctor's rounds, they orientated me very well, to do other stuff, what is it they expected from a commserve". (FGD3/P4/female/26 years old)

This submission is in contrast with the results of the study by Kruse (2011) where lack of orientation and induction programmes prior to commencing duty was identified as a huge cause of anxiety and discord among CSNs.

Theme 2: De-facilitative experiences of CSNs

De-facilitative experiences of CSNs were the second theme that emerged from the findings of this study. Participants mentioned some negative experiences during their placement for community service. These experiences were perceived as having a negative impact on their ability to function and perform their tasks as expected by those who are supervising them.

Sub-theme 2.1: Unrealistic expectations

Participants reported that most of their managers and professional nurses displayed some unfair treatment and unrealistic expectations. This might be attributed to the unavailability of a job description and scope of practice for this group of nurses as mentioned in existing literature. To support this experience of unrealistic expectations, one of the participants mentioned:

> *"I was the only sister, for the whole weekend, for 36 patients. It was expected of me to run the ward. I called the matron and I said to her I can't do this, I'm a commserve". (FGD3/P5/female/23 years old)*

In a different study, Wilkes (2009) argues and recommends that supervisor and supervisee's roles and responsibilities should be defined at the beginning of the placement to give realistic expectations and minimise misunderstandings and mistrust.

Sub-theme 2.2: Incompetent to perform basic nursing procedures

The majority of participants raised concerns regarding their incompetence with basic nursing procedures. Some of the participants said:

"There's an intercostal drain, and I don't even know how to handle this patient with an IC drain. (FGD1/P4/ female/ 33 years old)

Sometimes I ask myself what if this patient reacts during blood transfusion, I don't know what to do, who to call". (FGD2/P5/ female /27 years old)

According to Brown and Crookes (2016), nurses' competence levels directly affect their ability to provide precise care for their patients. This study found that the majority of participants felt they were incompetent in basic nursing procedures, which made it difficult for them to render quality care for the patients. This observation concurs with those in the study conducted by Shezi (2014) showing that not all CSNs were fully competent and independent to practice autonomously during their community service.

Sub-theme 2.3: Undesirable attitudes from some permanently employed staff

Some participants mentioned that they have experienced instances of negative attitudes from some permanently employed staff members, especially the professional nurses. One participant said:

"But there's a bad attitude…coming from the permanent employees who were here before you; they are having this attitude like…they

don't want working with commserves". (FGD3/P1/male/29 years old)

According to Chaiklin (2011), attitudes are defined as a mental positioning with regard to a fact or state or a feeling or emotion towards an object. These results concur with studies conducted by Khunou (2016), Makua (2016) and Tsotetsi (2012), revealing that CSNs experienced some negative attitudes and feelings of unacceptance from their seniors during community service.

Sub-theme 2.4. Lack of interest in specific wards or departments (specifically maternity)

Some of the participants mentioned that they would prefer that they be allocated to departments or wards where they are having interests in working at after completion of their community service. These participants mentioned that being allocated to a ward where one does not have an interest generates a negative attitude and lays blemish on their competence. Some participants said:

"I'm not competent with maternity. It is just that I'm not competent with maternity". (FGD3/P3/female/30 years old)

"I agree with you absolutely because I am so depressed working in maternity". (FGD3/P5/ female/ 23 years old)

In the study of Ross and Clifford (2002), the participants suggested specific changes that could potentially be useful to nurse educationists regarding the selection of clinical placement during the training of nurses. These authors articulated that being able to choose their final placement area of specialisation would have been particularly beneficial, especially if this was an area they wanted to work in once qualified. In the case of this study, CSNs had no choice but to work wherever they have been allocated. Despite the good intentions of allocating CSNs to different wards for the benefit of being exposed to different clinical experiences, some

participants felt it was unjust for them to be allocated to areas where they have no interest at all, specifically the maternity ward.

Theme 3: Challenges faced by CSNs during placement

All participants were faced with challenges that are not new to the specific cohort of CSNs in this study. These challenges were mentioned by participants in several studies conducted at the different provinces of the RSA.

Sub-theme 3.1: Shortage of human and material resources

Many of the participants from the three FGDs mentioned shortage of human and material resources as a major challenge influencing negatively on their competence.

One participant said:

> *"Like you have to do what you have to do with what you have, and doing a dressing without a sterile pack, it's not correct, but you have to do it because that dressing has to be done". (FGD1/P1/ female/ 22 years old)*

These study results replicate those of Thopola, Kgole and Mamogobo (2013), showing that participants perceived shortage of human and material resources as their greatest challenge during community service and had a negative impact on the provision of quality of nursing care.

Sub-theme 3.2: Unavailability of a job description or scope of practice

All participants highlighted the confusion caused by unavailability of a job description or scope of practice. This was perceived as a challenge as it was difficult for CSNs to know exactly what is expected of them in undertaking their daily duties. One participant mentioned:

> *"…and, because you don't have any scope of practice, but you are a nurse. Whether the scope of practice, whether there's something written, but you are a nurse". (FGD1/P4/female/33 years old).*

The results of this study confirm that of Govender et al. (2017). The results of these researchers revealed that CSNs find themselves holding 'double' titles, depending on the situation at their respective facilities, where at times CSNs were considered as being 'students', while on the other hand they were considered as replacements for registered nurse shortages (Govender et al. 2017). It is evident that the hospitals should work closely with their human resource departments to develop specific job descriptions for CSNs to minimise this confusion.

Sub-theme 3.3: Inconsistent rotation and allocation period per ward

Most of the participants in all FGDs displayed feelings of dissatisfaction owing to insufficient allocation period per discipline or inconsistent rotations to different wards or disciplines. This was identified as a disadvantage because this negatively affected the seasoning of clinical competence among participants. Some participants said:

"So, you are competent now for six months in one ward, and now you are PN next year, and I know nothing about theatre. I'm not competent, never got the experience in my commserve". (FGD1/P3/female/34 years old)

Adequate and logical rotation during placement provides the opportunities to experience different wards or disciplines. The study conducted by Aggar et al. (2018) in Australia revealed that graduate nurses reported their preference for rotation at commencement of their transition programme. The study also reported that graduates rated clinical rotations as very important during their 12-months transition period (Aggar et al. 2018).

Theme 4: Suggestions for improving clinical competence

Some participants suggested that several issues should be taken into account in order to improve comprehensive clinical competence of CSNs. The sub-themes and verbatim quotations from participants are as follows:

Sub-theme 4.1: Sufficient allocation per ward

Some participants suggested that the allocation period per ward must be comprehensive enough to allow CSNs exposure to most of the wards during placement. One participant said:

"So, I think they should at least maybe give two/two for the whole year so that you can get enough experience and then decide at the end of the year where do you want to work". (FGD3/P4/female/26 years old)

These findings concur with those of Ndaba (2013) in Tshwane District where participants felt they were allocated to the busiest areas for most of the duration of community service. They felt they were disadvantaged in their professional development because their allocation was limited only to particular disciplines like medical and surgical rather than the essential exposure to a variety of other disciplines such as maternity, geriatrics and paediatrics.

Sub-theme 4.2: Need for adequate human and material resources

Participants also suggested that the provision of adequate human and material resources ought to be considered if the comprehensive objectives of community service should be achieved. One participant said:

> *"More staff are needed in the ward so that, if the other sister is busy with the rounds, the other sister must be busy with you on medication, to help you". (FGD3/P2/male/28 years old)*

The results of this study support the recommendation by Thopola et al. (2013), that the Department of Health should address challenges of shortage of staff and material resources in order to improve the quality of nursing and midwifery care.

Sub-theme 4.3: Effective communication, including feedback from CSNs

Participants also suggested that there should be effective communication that includes regular ward meetings and feedback as a strategy to improve clinical competence which would lead to achieving the objectives of community service.

Some participants said:

"I do think they should get feedback from us before the end of the year, so that they know what we are experiencing so that they can correct such if there are any things that need to be corrected". (FGD3/P4/ female/26 years)

These results support the statement from Goodwin-Esola, Deelay and Powell (2009) who noted that constructive feedback during transition period creates awareness in one's ability in different areas and enables the novice to succeed in role transition. Similarly, Saghafi et al. (2012) show that graduate nurses reported feedback as important in boosting their confidence. Furthermore, Marks-Maran et al. (2013) found that feedback enhances learning and is essential to support graduate nurses in identifying how their performance is perceived.

Limitations

This study focused on only three selected hospitals in NWP. This means that the results of this study cannot be generalised to other hospitals in the province or country. However, similar studies could be conducted in other hospitals and primary health care settings where CSNs are allocated for their clinical service and in other provinces of the country in order to compare the results from different settings. However, study results could be applied in other provinces.

Recommendations derived from the positive experiences of CSNs

The study revealed that CSNs have facilitative experiences during their placement. It is recommended that facilities continue to improve on facilitative clinical competence experiences of CSNs by developing and implementing contextual transition

programmes to orientate, supervise and support CSNs as well as encouraging peer collaborative learning and effective teamwork among staff members including CSNs.

Recommendations derived from challenges encountered during placement

It is necessary for hospitals to develop proper orientation programmes and have mentors for CSNs as definitive strategies to provide support and improve clinical competence. It is also important for PNs to set realistic expectations when they have allocated CSNs in their departments. Rotation or allocation per ward is important as this provides broad exposure for CSNs, with opportunities to experience different wards. Employment of adequate personnel and availability of human and material resources ensure the effectiveness of community service and such should be integrated in the community service menu for CSNs. It is recommended that there must be a definitive job description and scope of practice for CSNs from the SANC that would inform decisions on delegation of duties for CSNs, thereby preventing the current role confusion and uncertainties with respect to their supervision.

Recommendations for improved clinical competence

It is recommended that, for the clinical competence of CSNs to improve, CSNs need to be allocated adequate periods of clinical experience in each major clinical setting and ensure effective communication among all stakeholders. In tandem, hospital management need to ensure adequate human and material resources. It is also imperative that there must be a continuous professional development programme in

place for CSNs during their placement to reinforce and refine their clinical competence, particularly in basic nursing procedures.

Conclusions

Clinical competence of CSNs could be improved through effective collaboration among all stakeholders including the hospital management, professional nurses, CSNs, and the SANC. From this study, despite the positive and facilitative experiences, CSNs had de-facilitative experiences and challenges that have a negative impact on their development and improvement of clinical competence. Many of the challenges reported by participants are consistent with those reported in the literature. There is a variety of programmes or strategies in place in preparation of the new graduate nurses enter the working environment well prepared and emerge as competent practitioners. However, from this study, most of the challenges raised are owing to the evident negative impact of shortage of human and material resources that impedes the effectiveness of community service. Suggestions were made in the hope that they would be considered to improve the clinical competence of CSNs. The results of this qualitative study contribute to the body of knowledge regarding clinical competence of CSNs during their placement.

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Competing interests

The authors declare that they have no financial or personal relationships which may have inappropriately influenced them in writing this article.

Authors' contributions

K.L.M. was responsible for collection and analysis of data and drafting the manuscript. L.A.S. was responsible for data analyses and proof reading of the manuscript, A.J.P. made conceptual contributions in the whole manuscript.

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Manuscript Three

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Convergence of the results of the experiences of community service nurses as well as the perceptions of professional nurses regarding the clinical competence of community service nurses during community service

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Abstract

Introduction and background: The transition from student to newly qualified nurse can be difficult when not well prepared for the real world. The expectation is that the newly qualified nurses should reflect competency across a wide range of skills. In order to acquire and improve on the necessary skills, many countries opted to introduce and implement strategies to prepare them for their professional roles. In South Africa, the newly qualified nurse is required to perform an obligatory12months' community service as mandated by the Regulation as promulgated by the Minister of Health.

Objective: The objective of the study was to report the convergence of the results of the experiences of community service nurses as well as the perceptions of professional nurses regarding the clinical competence of community service nurses during community service.

Method: This was a qualitative explorative, descriptive and contextual study. Purposive sampling was used to recruit twenty-one participants. The World Café method was used to collect data. Participants were also requested to rate their level of competence following Benner's levels of competence. Data were analysed following Pienaar's four steps of qualitative thematic analysis.

Results: Four main themes were identified, namely (1) Ethos and professional practice, (2) Unit management, governance and leadership, (3) Contextual clinical and technical competence, (4) Recommendations on improving clinical competence of community service nurses.

Conclusion: The World Café method allowed for real conversations around mutual topics of interest and the rich data collected is a true reflection of the participants' perceptions and experiences. These results will contribute to the development of a tool to evaluate clinical competence of CSNs in NWP, SA.

Key words: Convergence; community service; community service nurses; professional nurses; World café

Introduction and background

The transition from student status to newly qualified nurse can be stressful because of the adjustments to a new role, which requires a combination of knowledge and skills (Edwards, Hawker, Carrier & Rees, 2011). This is owing to the feeling of being inadequately prepared, lack of confidence, and the feelings of incompetence (Baxley, Ibitayo & Bond 2016). To overcome this, many countries have resorted to the introduction and implementation of methods to improve clinical capabilities of new graduate nurses. In South Africa, the National Department of Health (NDoH) introduced community service for health professionals in 1998 (SANDoH, 2006). The primary objective of community service is to enhance quality healthcare access for South Africans, more especially in previously under-resourced areas. Young professionals are afforded opportunities, through this process, to develop their skills, establish behaviour patterns and critical thinking and acquire knowledge that assists with their professional development (NDoH, 2006). In 2008, the Nursing Bill was promulgated into the Nursing Act (33 of 2005) and as a result community service for nurses was effected (SANC, 2007). The directive stipulates that nurses must complete a mandatory 12-month period community service after successful completion of the four years' nursing degree or nursing diploma training (R425) prior to their registration as professional nurses (general, psychiatric, or community) and midwifery (SANC, 2011). Since the implementation of this mandatory community service, numerous researchers have established that CSNs lack competence, yet there is currently no tool available that informs the evaluation of this competence. It is this gap in the knowledge that has prompted the researcher to carry out such a study in NWP, South Africa. This research paper forms part of the original study, which aims to develop a tool to evaluate clinical competence of CSNs in NWP, South Africa.

Definition of competence

Competence during the Florence Nightingale era was associated with the qualities of the character and skills of a nurse (Adu-Gyamfi & Brenya, 2016). Since then, there has been debate on the definition of the two interchangeably used concepts competence and competency. Wilkinson (2013) provided definitions of the two concepts, defining competency as "the set of behaviour patterns needed to perform the given task" whereas competence is seen as "the capacity of individuals to perform the given task". South African Nursing Council (SANC) defines competence as the "ability of a practitioner to integrate the professional attributes including, but not limited to, knowledge, skills, judgement, values and beliefs, required to perform as a professional nurse in all situations and practice settings" (SANC, 2011). Therefore, for the benefit of this study, clinical competence is defined as the "ability to function under the legal scope, which includes the application of knowledge, psychomotor skills and ability to adequately manage the demands that clinical nursing require" (SANC, 2011).

Frameworks underpinning this study

The concept of a development model of competence was constructed by Benner (1984) and contains five levels of competence. Those levels include novice, advanced beginner, competent, proficient, and expect, which were fully elaborated on in the previous section; Section Two (Methodology).

Objective

The objective of this study was to report the convergence of the results of the experiences of community service nurses and the perceptions of professional nurses with respect to the clinical competence of community service nurses during their community service placements in NWP, South Africa.

Methods

Research design

This study used a qualitative, exploratory, descriptive and contextual research design through the use of World Café method, to gain a greater comprehension of PNs' perceptions and CSNs' experiences regarding clinical competence for the period of their placement.

Research setting

The study was administered at the two NWP public hospitals in, South Africa.

Population and sampling method

A purposive sampling technique was used in this study to determine subjectively, participants based on a considered population representation (Brink, *et al*., 2012). According to Polit and Beck (2012), purposive samples consist of characteristics based on a particular quality that will benefit the study. Therefore, 21 participants attended the World Café. The participants consisted of 12 PNs and nine (9) CSNs. Two (2) research assistants facilitated the process.

Data collection process

The World Café method was selected for data collection. This method was developed as a brainstorming tool with the aim of creating concepts and explanations about a particular topic (van Wyngaarden, Leech & Coetzee, 2018). According to Brown and Isaacs (2005), and cited by Froneman, du Plessis and Koen (2015:3) the World Café method is a "synchronous network of conversations for

leading collaborative dialogue, where knowledge is shared; and possibilities for action in groups of all sizes around questions that matter is created". This method was deemed appropriate for this study as a volume of rich data could be assimilated within a limited period, which prompted ideas and comments from the PNs, and CSNs on specific topics in a form of questions asked. All of the participants were actively encouraged to take part in the study.

In applying the World Café principle, an open room was arranged in a manner similar to a café setup in. Four tables with 3 – 4 participants per table convened during data collection with paper and coloured markers provided to answer to the questions posed. The participants rotated across all the tables. One participant remained at the table to welcome the new group and to facilitate their discussions, add to their ideas and capture the responses on the provided paper. Refreshments were served during the process in order to capture the essence of a café. The process lasted between 15 to 20 minutes; the following discussion questions were posed during the data collection process to prompt the World Café discussions:

- Which competencies are needed for the CSNs to be regarded as competent practitioners?
- Which competencies are achieved during community service placement? **(Use rating scale A and motivate)**
- Which competencies are still lacking?
- How can the competence challenges be bridged?

Each table had one participant who was the host. At the close of each round, the host remained at that table whilst the other participants moved to the next table. The host greeted the new group, shared information from the previous group, allowing the new group to familiarise themselves with the written ideas, and add the new ideas. This process carried on until each group of participants had rotated around all of the tables and answered all the questions. After the rotation, a final discussion

session took place where all of the participants reflected on the overall process, explained and confirmed their results and ideas written down on the papers. During the final discussion session, the final discussion was recorded using an audio recorder in addition to field notes being taken. All data were then transcribed.

Data analysis

Data from the World café were analysed by the second author and the research assistants following Pienaar's four steps of qualitative thematic analysis (Pienaar, 2017). The steps are as follows:

Step 1: Data collection and analysis of the data occurred simultaneously with basic concepts being derived from the spoken words. An audio recorder for the spoken words and field notes were used by the researcher.

Step 2: Concepts that emerged were separated and categorised and those that were similar or related were linked together by the researcher.

Step 3: The researcher intuitively deducted, converged and/or discovered new concepts, themes or clusters (insights or discoveries). This occurred through the intuitive deduction of the researcher as additional information emerged during the process of data collection.

Step 4: Built the storyline or pattern to form a process and a generic framework for African unique context. The first and third author held a consensus discussion to confirm the final themes.

Measures to ensure trustworthiness

The following criteria for trustworthiness were ensured, namely: credibility, transferability, dependability, and confirmability (Creswell & Creswell, 2018). The "truth-value" was ensured by the researcher procuring the perceptions and experiences as experienced and understood by the participants, which replicated the trustworthiness of the results. Credibility was confirmed in the final discussion, which

gave the participants opportunities to review the collected data and provide feedback to each other. Further, the entire process was recorded. In contrast, Lincoln & Guba (1985) consider that “transferability is reached if the study is one in which the findings are relevant in other contexts”. To ensure transferability, data presentation is done in a descriptive manner, which makes it possible for other researchers to make a comparison if necessary. An independent coder checked the descriptions of each category and the transcripts relevant to those categories. This was ensured through a research assistants’ feedback session, which provided them with the chance to discuss the ideas and comments indicated on the posters, and to verify and clarify the data collected. Confirmability was ensured when the data obtained and the link between the interpretation of results and actual events was supported by the results, conclusions and recommendations. The results could not be generalised, but the research process particularly data collection is discussed in detail so that any alternate application of this research in a similar context will be possible. Therefore, multiple data collection methods were used to integrate the results to ensure reliability and existing literature used for literature control.

Ethical considerations

The “Scientific Committee of the School of Nursing Science” (SONS) as well as the

“Faculty of Agriculture, Science and Technology” (FAST) ““Health Science Ethics Committee”” (FAST-HSEC) of North-West University initially gave approval for this study. The “North-West University Research Ethics Committee” (NWU-00230-18-A9), the “North West Department of Health” (NWDoH) and the two selected NWP hospitals in, South Africa, granted ethical clearance for this study. Informed consent to participate was obtained before the commencement of the process after an explanation as to what is expected from them. All participants were advised that involvement was voluntary and that they had the right to opt out of the interviews at any stage without providing any explanation and without incurring any penalties, after which they gave their informed consent. Anonymity was observed and respected through all stages and identities were protected by the use of cards

numbers as their identity codes. During participation, fairness was ensured and all participants had opportunities to state their experiences without any judgement or intimidation

Results

The convergence of the results is illustrated on the Figure 1:

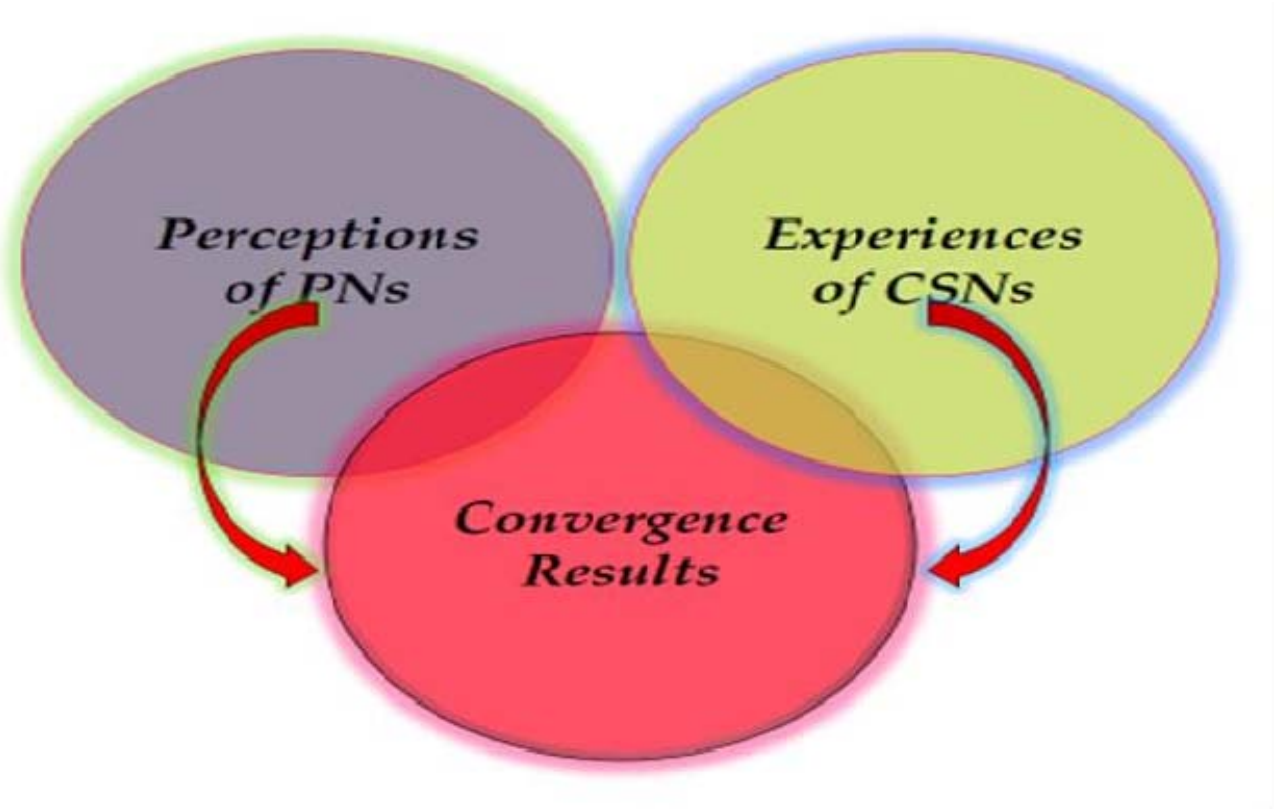

Figure 1. Convergence of the results from perceptions of PNs and experiences of CSN regarding clinical competence during community service in the NWP, SA (Matlhaba, Pienaar & Sehularo, 2019).

Each group was asked to rate their perceived level of competence since the commencement of their community service using the five levels of competence by Benner (1984)

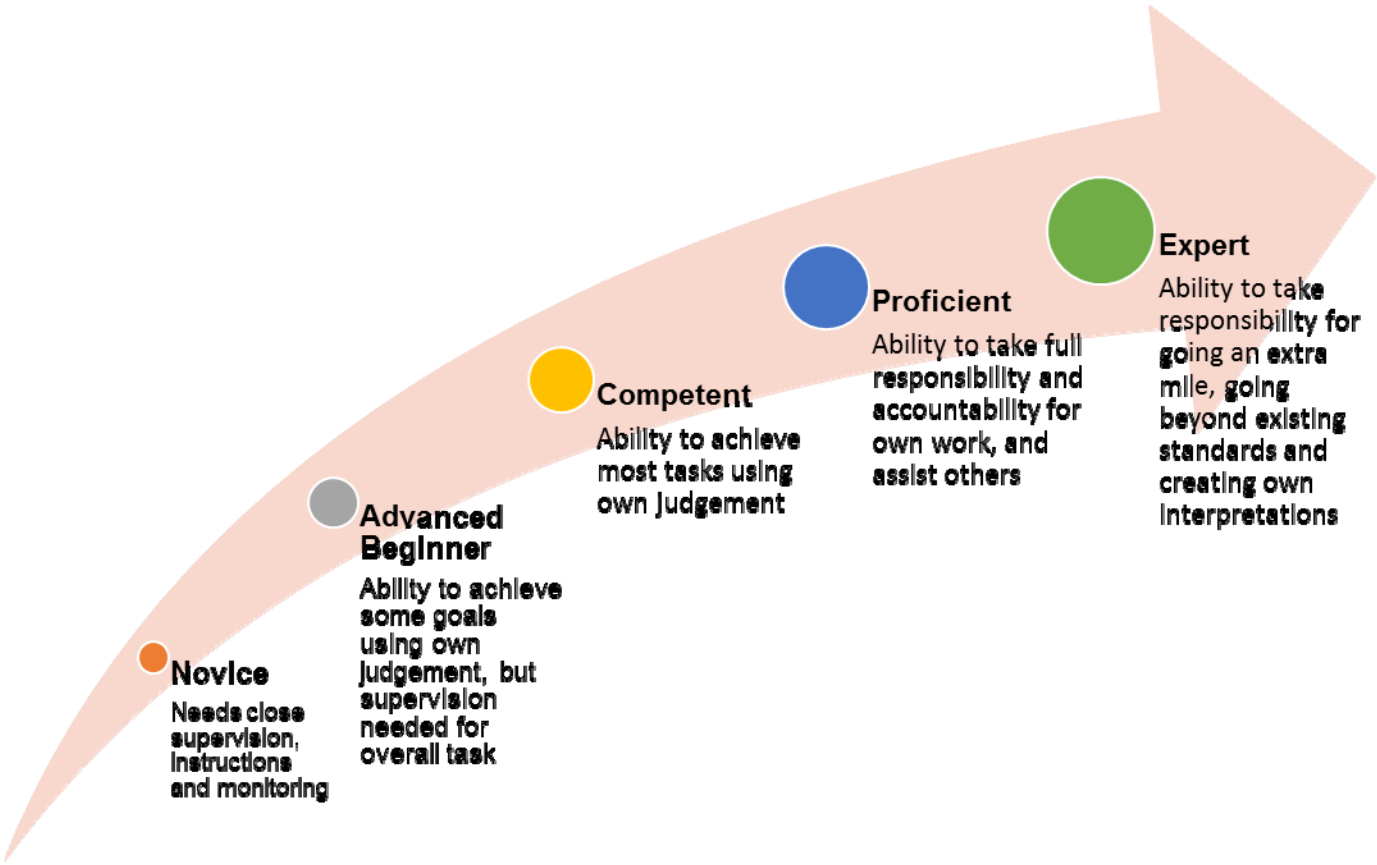

Figure 2. Adapted from Benner's levels of competence (Benner, 1984)

Table 1: CSNs competence levels (Use rating scale A and Motivation) (Matlhaba, Pienaar & Sehularo, 2019); Group A

Themes	**Categories**	**CSN**		**PNs**	
		Competence level rating	Motivation	Competence level rating	Motivation
1. Ethos and professional practice	Ethical & professional conduct	2 – Advanced beginner	I don't have much exposure with regards to ethics	1- Novice	They do not uphold to the professional and ethical conducts of nursing. They are resistant to adhere to uniform, no telephone etiquette
2. Unit management, governance & leadership	Unit administration	3 - Competent	I had day-to-day exposure of the wards and what is expected to run the	2 – Advanced beginner	Application of different management skills and personnel management and

			ward.		communication skills
	Governance & leadership	3 - Competent	I am able to take leadership and assist junior students and personnel which are not well	2 – Advance beginner	Do not take responsibility. They cannot lead
3. Contextual clinical and technical competence	Medical/ Surgical Nursing	3 - Competent	I have knowledge as I worked there during my studies and I can carry out tasks and run the	3 - Competent	They [CSNs] are competent but still need minimal supervision

			unit.		
	Midwifery Nursing	2 – Advanced beginner	Able to apply maternity guidelines to manage patient	1 – Novice	Some still need intense supervision
	Operating theatre	1 - Novice	Never worked there.	1 – Novice	Exposure is limited in their training and the area is highly specialised with a lot of risks

Table 2: CSNs competence levels (Use rating scale A and Motivation) (Matlhaba, Pienaar & Sehularo, 2019); Group B

Themes		**CSN**	**-**	**PNs**	**-**
		Competence level rating	Motivation	Competence level rating	Motivation
1. Ethos & professional practice	Ethical & professional conduct	2 – Advanced beginner	Not really clued up much on ethical principles in nursing.	2 – Advanced beginner	Their behavior must still improve
2. Unit management, governance & leadership	Unit administration	2 – Advanced beginner	Have not had much chance to “run” a unit but I have been trained on how to.	3 - Competent	Ability to manage the ward under indirect supervision

	Governance & leadership	1 - Novice	Never came across a situation where I have to lead people.	1 – Novice	Not enough exposure to lead in the unit

3. Contextual clinical and technical competence	Medical/ Surgical Nursing	3 - Competent	I've worked this unit most of my training, I can handle them pretty well by myself.	3 - Competent	With multiple conditions, some appear less often than others, they [CSN] are competent.
	Midwifery Nursing	3 - Competent	I can manage a pregnant woman from antenatal care to puerperium (sp.).	2 – advanced beginner	Due to limited exposure, supervision is still necessary in the working environment.

	Psychiatric/ Mental health Nursing	2 – Advanced beginner	I still need supervision on almost everything am doing	2 – Advanced beginner	Certain situations they [CSNs] have not come across. So supervision is really needed.
	Operating theatre	2 – Advanced beginner	I did not have enough clinical exposure.	2 – Advanced beginner	Not allocated in theatre unit for enough hours.

Discussion of the results

Themes are introduced and discussed, and a relevant literature control from existing literature is provided as evidence.

Theme 1: Ethos and professional practice

The International Council of Nurses (ICN) adopted in 1953 the first international code of ethics for nurses, since when various ethics codes have been adopted by other nursing and midwifery regulatory bodies by the (ICN, 2006). The Nursing and Midwifery Board of Ireland (2014: 2), indicates that the aim of the code of professional conduct and ethics is to "guide nurses and midwives in their day-to-day practice and help them to understand their professional responsibilities in caring for patients in a safe, ethical and effective way". SANC (2013) asserts that the code of ethics is the "cornerstone of ethical decision-making and aimed to inform nursing practitioners and the public of the following ethical and moral principles applicable to nursing practitioners in the performance of their duties" (SANC, 2013). According to SANC, the nursing code of ethics in South Africa regulates all nursing practitioners with respect to their "duties towards individuals, families, groups, and communities" which will be executed out with the necessary regard for human rights (SANC, 2013). SANC goes on to further stipulate that the "persons in the care of every nursing practitioner must be able to trust such Nursing Practitioner with their health and wellbeing" (SANC, 2013).

Epstein and Turner (2015:3) highlight that an "effective ethical code for nursing practice must provide guidance on managing ethical problems that arise at the societal level, the organisational level, and the clinical level". Therefore, it is the ethical code that summarises ethical behaviour for the nursing profession and guides decision making when those barriers that prevent fulfilment of their professional obligations are encountered. (Zahedi, Sanjari, Aala *et al.,* 2013). It is the responsibility of the nurse to provide highquality care for patients under their purview (Clarke & Donaldson, 2008).

In this study, participants reported that ethos and practice form the basis of the nursing profession. These results were in support of the results by Dehghani, Mosalanejad and Dehghan-Nayeri (2015) in Iran. Their qualitative study revealed that the majority of nurses highlighted professional ethics and accountability as being the important characteristics that provided the base for the ethical context background in healthcare settings (Dehghani *et al.,* 2015). Therefore, it was of outmost important that the CSNs uphold the ethical and professional conduct of the nursing profession. However, CSNs from both hospitals indicated that they had little or not much clued up with the ethics or professional conducts. This was supported by the PNs who stated that CSNs do not uphold to the ethical and professional conduct of the nursing profession particularly with regard to the nursing etiquette. Similar results from reviewed literature with regard to interpersonal and communication skills revealed that newly qualified nurses faced with the inability to communicate effectively with the multi-disciplinary team members (Phillips, Esterman, Smith & Kenny, 2013; Baldwin, Bentley, Langtree & Mills, 2014 and Phillips, Esterman & Kenny, 2015). In this study, participants mentioned that CSNs are facing challenges when they are supposed to communicate and express themselves with the other multidisciplinary team members or when answering the telephones. The outcome of this study also concurred with the results of a study conducted by Ortiz (2016) in the United States of America (USA), which revealed that many challenging experiences with respect to team member communication were described by new graduates nurses (Ortiz, 2016).

In this study, the fact that CSNs revealed that they had limited knowledge of ethics was seen to be a concern as this could also affect their responsibilities with regard to patient's advocacy. In their reflection paper, Tomaschewski-Barlem, Lunardi, Barlem *et al.,* (2017) posit that the nurse-patient relationship, effective communication, and the recognition of patients' needs, are essential for effective advocacy practice. They further maintain that the establishment of a proper relationship with patients enables nurses to understand more broadly the patients' real needs and become more efficacious when defending the patients' desires and interests.

When considering the upholding of values and principles, including the Batho-pele principles and patient rights charter, this study's results were in contrast with those of

the several Iranian studies conducted on nurses and student nurses' awareness of patients' rights, including that of Parsapour, Mohamad, Malek *et al.,* (2009) and Nejad, Jamaloddin, Abotalebi *et al.,* (2011). These studies reported that participants were knowledgeable and aware of patients' rights. From the present study, it was evident that CSNs lacked knowledge of ethics and professional conduct. Therefore, it is vital for the units to develop some ethics and professional conduct in-service trainings for the CSNs to ensure that their onus of responsibility to provide high-quality care for patients is foregrounded.

Theme 2: Unit management, governance and leadership

Participants reported that some CSNs had the ability to manage the unit with minimal supervision. However, the majority of PNs were in disagreement as some CSNs mentioned that they have never been in the situation where they led or managed the unit, and thus they were not confident with their leadership skills. These results concurred with those of several studies contacted in different provinces of South Africa where CSNs where unable to manage conflicts, and expressed reluctance to take the lead, particularly with delegation of duties and other managerial responsibilities (Ndaba & Nkozi, 2015; Roziers, Kyriacos & Ramugondo, 2014).

Theme 3: Contextual clinical and technical competence

Walker, Earl, Costa and Cuddihy (2013) established that new graduate nurses work in challenging health care environments with unfamiliar technologies, work shift hours, have heavy patient loads, and have to deal with patient safety issues. However, they are often unable to integrate what they have learned with the realities of practice (Welding, 2011). In this study, participants reported that contextual clinical and technical competence was not satisfactory and this competence was dependent on the duration of time spent in specifically allocated units. It was also reported that some CSNs still need basic procedure supervision and that there is a lack of adequate exposure during their training days. The conclusions of a study carried out

in Australia by Parker, Giles, Lantry and McMillan in 2014 further corroborate the results of this study. Their study reported that it was found that new graduate nurses require more support than is given and also suggested that the performance of new nurses is negatively affected when they find themselves in unfamiliar workplaces.

Theme 4: Recommendations for improving clinical competence

Provide clear job descriptions (Scope of Practice) for CSNs/ roles among the multidisciplinary team

Globally, it is advised that “nurses practice within the limits of their training”, education and competence and “within their scope of practice” (Kumaran & Carney, 2014:2). Different nursing regulatory bodies and boards prescribe the scope of practice which designate the activities to be performed according to the different nursing qualifications (Australian Nursing and Midwifery Council, 2006; Canadian Nurses Association, 2006; American Nurses Association, 2010; Singapore Nursing Board, 2012). In South Africa, although the regulatory body – SANC – prescribes a nursing scope of practice there has been a lack of availability of this scope for CSNs that has resulted in many of the health care facilities used for community of practice being confused and unsure as to what exactly the CSNs’ roles are within the multidisciplinary team. In the studies conducted on community service for South African nurses by Govender, Brysiewicz, and Bhengu, (2015) and Khunou, (2016) it was reported that SANC were blamed for the lack of any scope of practice and job descriptions that explicitly deal with the extent of responsibilities for CSNs. The same sentiments were observed in this current study. Therefore, participants recommended that provision of a clear scope of practice and job descriptions for CSNs be made that would clarify their role amongst the multidisciplinary teams.

Extension or adjustment of community service nursing to six months' internship and six-month community service nursing or two years' community service.

Several studies advocate for a one-year nurse internships or residencies as an alternative process for the integration of new graduates into practice. The intention is to expose newly qualified nurses to different hospital units through rotations, shifts and improvement of their skills (Al-Dossary *et al.,* 2014). In this study, the participants made the recommendation that community service nursing be either extended or adjusted to accommodate six months' internship and six-month community service nursing or two years' community service nursing. Participants believe that this will create greater exposure to majority of the units for the CSNs and this will afford them the opportunity to become independent and competent practitioners who are better prepared to assume the role of professional nurses.

Support measures including induction and orientation

To aid transition many of the graduate nurses' programmes commence with orientation and include working with a senior nurse prior to the newly graduate nurses being given a full workload of patients and associated accountability, liability and responsibility for patient care (Andre and Barnes, 2010). Makhakhe (2011) agrees that newly qualified nurses need support during that transition period of student nurses to professional nurse to enhance their competence. In the study conducted by Saintsing, Gibson and Pennington (2011), newly graduated nurses indicated minimal support and a lack of those learning opportunities that were supervised throughout the graduate nurse programme which was seen as a concern as lack of support during skills performance dramatically increase errors possibilities. In the study conducted by Tsotetsi (2012) in Gauteng Province, SA, it was reported that newly qualified professional nurses' orientation during their community service differed from institution-to-institution, and at times, some CSNs received no orientation at all. From the results of the study presented in this research paper, it is recommended that a proper support system in the form of induction and orientation

be initiated to guide the community service nurse into the world of unit management and control of patient well-being.

Continuous professional development

According to Khan, Khan and Khan (2011), in order for the organisation to achieve productivity and retain employees, it is important to ensure provision of career development training and job satisfaction as this will be of long-term benefit. Furthermore, Chaghari, Saffari, Ebadi *et al.,* (2017) concur that training is an essential factor which contributes to the greater efficiency of the staff development and successfulness of the organisation and it will lead to internal promotions, staff development and positive results of organisational plans. The authors further stated that owing to the practical nature of the nursing profession, empowering education could enable occupational tasks and the achievement of greater capabilities of professional skills among the nurses (Chaghari *et al.,* (2017). In this present study, participants recommended that the CSNs clinical competence would be improved and maintained through continuous professional development and in-service trainings during community service placement.

Limitations of the study

The researchers acknowledge that this qualitative research is limited to only two NWP hospitals in South Africa and that the results cannot be generalised. However, this article delivers important information and confirmations that can be considered by both CSNs and PNs as well as other stakeholders including hospital management and NWDoH for measures to improve clinical competence of CSNs during their community service placements. Furthermore, the results of this article will be used to develop a tool to evaluate clinical competence of CSNs in the NWP.

Recommendations

Founded on the outcomes of this research paper, the following recommendations are made:

- There is a dire need to improve the ethical and professional conduct of the CSNs. Strategies for this include in-service trainings and workshops on topics related to ethical and professional practice to be incorporated into teachings of personnel at each unit. This should be reinforced on rotation of CSNs to new units.
- Orientation and induction programmes must provide relevant information and focus on ensuring competencies in the specific unit where the CSN is currently assigned.
- Effective supervision and mentorship programme at different units.
- Allocation and rotation period for CSNs must carried out in a manner that includes the majority of the disciplines. This will assist CSNs with exposure opportunities in all the disciplines. Providing the CSNs with the opportunities to take charge of the unit through the delegation of unit management duties will boost their confidence in unit management and leadership.

Conclusion

To report convergence of the results that occurred because of similarities identified in the outcomes of the World Café on the perceptions of professional nurses and CSNs experiences regarding clinical competence during community service placement. Utilisation of the World Café method allowed for real conversations concerning mutual topics of interest and the rich data collected is an accurate expression of the participants' perceptions and experiences. All participants fully participated in the data analysis therefore authenticating the results, as this is a form of member checking. The World Café yielded meaningful data that will contribute to the development of a tool to evaluate clinical competence of CSNs in the NWP, SA.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Author contributions

K.L.M. was responsible for finalisation of data analysis and writing the manuscript. L.A.S. was responsible for conceptualization and proof reading of the manuscript, A.J.P. finalised the data collection, made conceptual contributions to the whole manuscript.

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Legislation, regulations and policies that govern Community Service for Nurses: A literature review

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Abstract

Background: Existing literature reports that many countries have introduced different retainment and recruitment strategies with the intention of mitigating the shortage of healthcare professionals and to retain those who are trained within these countries. However, it is also noted that several factors can influence the effectiveness of this programmes.

Objective: The objective of this article is to elucidate the legislation, policies and regulations governing the clinical competence of community service.

Methodology: Online databases, relevant websites and reference lists of selected literature were searched to establish studies on compulsory rural service programme. Themes were analysed using the adapted Pienaar's steps of data analysis.

Results: Themes were derived from research studies conducted on community service. Five (5) themes and 16 sub-themes developed through the analysis of existing data based on the results of cited studies. Each theme and sub-theme is discussed separately and supported by references from literature.

Recommendations: It is recommended that objectives of the community service can be achieved by having all stakeholders on board as well as introducing clear policies and regulations especially at the provincial and institutional level.

Keywords: Community service; community service nurse; Legislation; Policy; Regulation

Introduction

This article discusses literature pertaining to the origin and the objectives of community service, related legislation, other international regulatory bodies' perspectives on requirements for registration as well as international perspectives on community service. Data for this article were extracted from several research studies conducted on community service for health professional in South Africa and internationally.

Although many countries including South Africa have opted for different strategies to deal with health care professionals postgraduates, there has limited examination of legislation, policies and regulations governing the competence of these health care professionals. As observed in many countries, commitments deal with the shortage of health care professionals using differing retention and recruitment strategies including compulsory community service. A review of legislation, policies and regulations and its impact on clinical competence would contribute to existing knowledge around this initiative. The purpose of this article is to set out the legislation, policies and framework governing the clinical competence of community service and to propose areas that could bear further examination in order to support the nursing profession and the vital role it plays during the placement of CSNs in their community service period.

Objective

The objective of the study was to describe the legislation, policies and regulations governing the clinical competence of community service.

Problem statement

Community service for nurses was implemented in South Africa in 2008, and since then there have been some noticed challenges that appear to have a negative influence on the effectiveness of the programme. These challenges are both

administrative and functional and have been observed across the majority of the provinces in the country. It is evident from the existing literature that there is a gap between legislation, policy and the regulations governing community service for nurses and practice in South Africa. This has prompted the researcher to provide readers with evidence as well as to proffer recommendations to mitigate this knowledge gap. The article sought to describe the legislation, policy and regulation governing nursing community service in South Africa. The results from this article will contribute to filling both policy and gaps in strategies to improve community service for nurses in South Africa that will be of benefit to all stakeholders.

Methods

This article is based purely on existing literature on legislation, regulations and policies relating to CSNs. No new data were collected or analysed and no participants were involved in the literature discussed in this article. Therefore, the article references literature and official documents related to community service. Concept clarification, interpretation and critical analysis were done which led to the development and defence of the argument. Several relevant documents, articles and theses published in both national and international journals were acquired using the following search engines; Science direct, Pub Med, Google Scholar and Medline. Articles on community service initiatives were identified using such keys words as *legislations, regulation, policies, compulsory community service, community service practitioners, community service officers, recruitment and retention of community health practitioners in rural and remote arears*. Articles on community service studies published between 2005 and 2017 that were written in English were used. The reason for the above-mentioned years is that community service for health professionals in South Africa was only introduced in 1998 and little research was conducted in the subsequent years after its introduction.

Defining the concept ‘community service’

The concept of community service has been put into practice for the health sciences as a compulsory requirement for health care professional graduates in South Africa. Community service is defined as “voluntary work intended to help people in a particular area” (en.oxforddictionaries.com). McBride, Pritzker, Daftary, and Tang (2006) define community service as an “organised period of substantial engagement and contribution to local, national or world community, recognised and valued by society, with minimal monetary cost to the participant”. SANC defines community service nurse or practitioner as “any person who is a citizen of South Africa intending to register for the first time as a professional nurse in terms of the Act, as having met the prescribed requirements to qualify as such”, who is performing remunerated community service for a period of one year (SANC, 2005). Therefore, South Africa requires student nurses who complete their training, to do community service 12 months.

Legislation regarding Community Service

The following discussion indicates the legislative framework that influences the community service. Health professional law differs according to different countries. The international NGOs including the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM) have released universal standards to guide the development and implemented nursing and midwifery legislation and regulation. In South Africa (SA), the former Minister of Health, Dr Aaron Motsoaledi, published regulations proposed by SANC in the Government Gazette. Together with the Nursing Act (33 of 2005), these regulations contain the legally enforceable policies of the Council (Government Gazette, 2006). These regulations are discussed in the following paragraphs.

The Constitution of South Africa

Chapter 3 of the Constitution (1996) of the Republic of South Africa (RSA) states that the "government that is constituted shall have as national, provincial and local spheres which are distinctive, interdependent and interrelated" (Constitution of the Republic of South Africa, 1996: ss40-41). Further, that the principle of co-operative government and intergovernmental relations specifies that the government must "secure the well-being of the people of the Republic" (s 41 (1) (Constitution of the Republic of South Africa, 1996: ss40-41b). These principles served as a basis for the introduction of community service in South Africa (SA), whereby all health professionals, including nurses, are expected to perform community service prior to registration by their professional bodies and being allowed to practice. This is based on the objectives of the community service, "to ensure equitable distribution of health workers with an emphasis on rural and underserved populations; to provide health professionals with the opportunity to develop skills and experience to improve their professional development; and to enable and to encourage community service professionals to remain in public service, particularly in rural and underserved areas" (Hatcher, Onah, Kornik, Peacocke, & Reid, 2014; Reid, 2002). However, it seems that most of the health professionals such as nurses do not want to work in "rural and underserved areas".

The National Health Act No. 61 of 2003

The South African National Health Act (an obligation to care) (Act 61, 2003), links the national health system to a common aspiration to "actively promote and improve health within national guidelines, norms and standards". The Act acknowledges the requirements imposed by the Constitution of RSA and other laws relating to health services that include the promotion of observance to norms and standards for the training and human resources for health and identification of national health goals and priorities and monitoring of the advancement of their application (Constitution, 1996).

The policy regarding Community Service

The policy regarding community service is explained in section 40 of the Nursing Act (33 of 2005) and in the Regulations Relating to Performance of Community Service published in Government Notice No. 765 of 24 August 2005.

- “Section 40 (1) of the Nursing Act, 2005 states that, A person who is a citizen of South Africa intending to register for the first time to practice in a profession in a prescribed category must perform remunerated community service for a period of one year at a public health facility”.
- “Regulation 2.1 of the Regulations Relating to Performance of Community Service stipulates that “any person who is a citizen of South Africa intending to register for the first time as a professional nurse in terms of the Act, as having met the prescribed requirements to qualify as such, must perform remunerated community service for a period of one year”.
- “As a transitional provision, regulation 8(a) of the Regulations Relating to Performance of Community Service states that, these regulations are applicable to any person who seeks registration on completing and meeting the requirements prescribed in the Regulations Relating to the Approval of and the Minimum.
- Requirements for the Education and Training of a Nurse (General, Psychiatric and Community) and Midwife Leading to Registration published in Government Notice No. R.425 of 22 February 1985, or any subsequent regulation made to replace it” (SANC, 2005).

Regulation regarding Community Service in nursing

It is widely accepted that the objective of professional regulation is to assign standards that guarantee the proficiency of practising health care professionals, including nurses and midwives. This professional regulation is presented in the form of the Nursing Act, which has established a “regulatory body or council and authorises it to issue regulations about nursing education and practice”. The nursing

councils have common regulatory objectives that include accreditation of nursing education institutions, registration and licensing of nurses and midwives, execution of continuing education requirements, description of scopes of practice, and execution of professional codes of conduct (Blaauw *et al.,* 2014). Furthermore, the Nursing and Midwifery Acts aim to ensure the provision of quality nursing and midwifery services to protect the public from harm, as well as to advance the professions (Blaauw *et al.,* 2014).

International perspectives regarding regulatory structure

Despite the differences in nursing education programmes, regulation of the nursing profession contrast from country to country. Although, many have had statutory nursing regulation in place for years that safeguards safe and competent nursing employees, there are still some countries that do not have any regulations, rules, or other nursing regulatory structures. Some countries, have established nursing regulations, as a form of law or as additional guidelines, but due to differing reasons, no mechanism has been established to provide a legal framework for nursing as an autonomous regulated profession (ICN, 2009). Other countries including Denmark, Ireland and Taiwan have governmental bodies that determine the basic nursing competencies but no regulatory authority (ICN 2009). Conversely, other countries like South Africa have regulatory structures such as SANC that regulate the nursing profession.

The International Council of Nurses (ICN)

The ICN is a “federation of non-political and self-governing national associations” which was founded in 1899 (Mathews, 2012:5). South Africa like other countries is a member of ICN as it provides a framework for the standards of conduct. The ICN, according to Catallo *et al.* (2014), describes the “goal of influencing health policy as a core organisational mandate”. It also describes its “strategic planning activities through a publicly available plan. Nursing, health and social policy are clearly

articulated as part of this strategic plan, including the identification of policy trends, defining opportunities to be politically active and administering press releases and fact sheets declaring ICN's position and the role it plays in influencing health and social policy". According to WHO, there is an urgent need for countries to repeatedly review and strengthen their regulations pertaining to health professionals including nurses and midwives to guarantee the provision of their optimum contribution to the community they serve.

Canadian Nursing Association (CNA)

In Canada, the provincial or territory government has been granted the responsibility for the legislation that enables the regulatory framework of the nursing profession (Robinson & Griffith, 2007). Unlike other countries, the regulation governing the nursing profession in Canada is achieved through self-regulatory mechanisms according to the different provinces or territories (Schiller, 2015:95). According to the CNA, self-regulation is the ability of a profession to control its admission standards and requirements as well as the norms for its practice (CNA, 2007:2). Therefore, each province has its own particular enabling legislation which operates in different ways whereby other provinces has one law that is solely nursing-specific to regulate the profession (Schiller, 2015:96). The following enabling legislation is elected by different provinces or territory, namely, The Registered Nurses Act, 1988; The Health Professions Act, Nurses (Registered) and Nurse Practitioners Regulation and the Regulated Health Professions Act, 1991; Alberta, 2005; Health Professional Act, 232 of 2005; Ontario, 1991; Health Professional Act, 18 of 1991. From these different regulations, some provinces or territories have created one law that is solely nursing-specific to regulate the profession, whereas others have created a combined health professional legislation particularly for nursing practice (Schiller, 2015:96).

The Indonesian National Nurses Association (INNA)

The Indonesian National Nurses Association is the national nurses' association in Indonesia and its objectives are to "increase and develop knowledge skills, dignity and professional ethics" of the nurses (Suba & Scruth, 2015:256). The association's main functions are to "unify, foster, develop and supervise nursing in Indonesia" (Indonesian, 2014; Nursing Act, 38 of 2014). Unlike other countries, the Nursing Council in Indonesia is still to be established which will form part of the Indonesian Healthcare Professionals Council. The Nursing Collegium, once established, will "improve the quality of the nursing practice and provide legal protection for nurses" (Suba & Scruth, 2015:256).

The Australian Nursing and Midwifery Accreditation Council (ANMAC)

The Australian Nursing and Midwifery Accreditation Council are responsible for the protection of the health and safety of the Australian community through warranting a "high national standard of nursing and midwifery education through certification of educational programs in nursing and midwifery" (Wang 2016:2). After completion of nursing training from an accredited training institution, nurses and midwives are "qualified to register with the Nursing and Midwifery Board of Australia and are bound by the professional code of conduct to practice safe competent health care across the domains of nursing practice" (ANMCA, 2016).

The Indian Nursing Council (INC)

According to literature, the first country to ratify a nursing council was India in 1947, with the Act being amended in 1996. The Indian Nursing Council (INC) is a regulatory body and as such is the only national legislation directly linked to Indian nursing practice in India that is promulgated in adherence to the Indian Nursing Council Act of 1996. The Council offers criterion for the control of nursing education and registration (Shafer & Yuen-Heung, 2012). Furthermore, the Council has

complete independence to establish and ratify rules and regulations, while other acts delegate rule-making authority amongst other councils and one or more of the legislative bodies. The INC consults with the International Council of Nurses for those matters that relate to the nursing code of conduct.

The Nursing Council of Thailand

The Nursing Council of Thailand was established under the Royal decree of Professional Nursing and Midwifery Act, B.E. 2528 (1985) (ICN, 2009). The council answers to the Minister of Public Health and is responsible for the monitoring of the conduct of those “licensed nurses, midwives or nurse-midwives according to the professional code of ethics”. Additionally it provides consultation and recommendations to government for the “advancement of nursing, midwives, and towards the achievement of comprehensive health care” (ICN, 2009).

The South African Nursing Council (SANC)

Section 2 of the Nursing Act 33 of 2005 established SANC in South Africa, and as such is a surrogate organisation and is the regulating body for the setting of standards of practice and education for nurse practitioners in South Africa. A few of its essential roles are the enforcement of nursing practice standards, inquiry into public complaints against nurse practitioners and the support and aid of its professional fellows. SANC’s vision is given as "excellence in professionalism and advocacy for the health care users" although its mission statement is "to serve and protect health care users by regulating the nursing profession" (SANC, 2006). As the registering authority for nurse practitioners, SANC “informs nursing practice through legal frameworks and the code of conduct for nurse practitioners by receiving its authority from the legislation”, further its overall role as the Regulatory body of the profession is "the oversight, monitoring and control of nurses based on principles, guidelines and regulations deemed important by the profession" (SANC, 2006).

The Nursing Act (33 of 2005) indicates that the objectives of SANC are as follows:

- “to serve and protect the public in matters involving health services generally and nursing services in particular; perform its functions in the best interests of the public and following national health policy as determined by the Minister; promote the provision of nursing services that comply with universal norms and values to the inhabitants of the Republic; establish, improve, control conditions, standards and quality of nursing education and training within the ambit of this Act and any other applicable law; promote and maintain liaison and communication with all stakeholders regarding nursing standards, and in particular standards of nursing education and training and professional conduct and practice in and outside the Republic; advise the Minister on the amendment or adaptation of this Act regarding matters about nursing be transparent and accountable to the public in achieving its objectives and in performing its functions; and uphold and maintain professional and ethical standards within nursing (SANC, 2005).

Section 40 of the Nursing Act (33 of 2005) pertains to community service for and has the following three objectives:

- “ensure equitable distribution of health workers with an emphasis on rural and under-served populations;
- provide community service nurses (CSNs) with the opportunity to develop skills and experience to improve their clinical competence; and
- to enable and encourage CSNs to remain in public service, particularly in rural and underserved areas” (Mchunu, 2006:49; Hatcher, Onah, Kornik, Peacocke & Reid, 2014:4).

All these nursing regulatory structures are affiliated to ICN, and there are supportive mechanisms or principles set up that have an influence in policies and regulations that guide the nursing professional practice.

International perspectives on requirements for registration

The government agency responsible for health is able to track and monitor health care professionals through its administrative process of nurse registration. Registration in several countries, such as the UK, is regarded as official recognition given by the professional regulatory body that a person has completed all educational requirements and is now able to work as a nurse. In others licensure by examination is necessary and the process of registration by the regulatory body signals that the nurse has successfully completed training and completed all the requirements to be registered with the official body (Nichols, Davis & Richards, 2011: 575). In most countries including South Africa, registration must be maintained by initial and constant payment of fees.

In other countries, a nurse's education is only considered complete once stipulated service requirements are met after which a license is granted. In Egypt, Eritrea and Israel nurses are required to perform military service before their training is deemed complete are they can be registered as nurses. Such programme requirements are considered as a citizenship responsibility and military service is regarded as a repayment for the student nurse's public education funding (Nichols *et al.,* 2011: 576).

International perspectives on community service programmes

Many countries across the world are facing serious shortages, and enormous inequalities with respect to professional health care access between remote, rural, and urban areas. Many of these countries have considered an array of strategies in an attempt to mitigate these problems, including "compulsory service requirements, bonding schemes, human resource management, improved pay and conditions, greater investment in facilities and equipment, and greater career development opportunities" (WHO, 2017:220). Programmes such as compulsory service programmes mandate that the health care professionals remains within the country or relocate for a specified period to rural or remote areas prior to registration of practice being granted (ibid). These programmes usually commence after a specified

training period and the practitioners are compelled to complete the programme before registration by their respective professional bodies (Frehywot, Mullan, Payne & Ross, 2010: 365).

Indonesia

In Indonesia, health professionals such as “doctors, dentists and midwives were previously required to work as contract staff during a period of compulsory service which ranged from six months to three years, depending on the remoteness of the location”. This was amended in 2007 and became a voluntary commitment, however many new graduates consider this a popular alternative because of the financial incentives and the minimal duration of the contract period. An additional Special Assignment Programme was introduced in 2009 which was intended to tackle specific strategic shortages in including “nurses, nutritionists and public health workers”, particularly in “specific underserved areas” (Indonesia, 2014; Nursing Act, 38 of 2014).

Thailand

Thailand's mandatory health service system has been in existence for several decades now with the primary objective of maintaining the health of the rural workforce (Wiwanitkit, 2011:1583). WHO (2017:222). indicates , Thailand has had a policy of compulsory rural service for early-career health workers graduating from government-funded professional schools for more than four decades Health professional professionals such as doctors and nurses commit to a rural service contract prior beginning their training in a public medical or nursing school (Pagaiya & Noree, 2009:8). After graduation, health workers are mandated to undertake service in such provinces experiencing a shortage of health worker (Pagaiya & Noree, 2009:11). This mandatory service can range from three to 12 years dependent on the scheme they are committed to

Australia

Australia is one of the countries that have introduced a bonding scheme for health professionals as a way of recruitment and retaining strategy. Bonding schemes are those that stipulate that health professionals who have received state-funded scholarships during their training be required to undertake certain public service obligations after graduation (Frehywot *et al.,* 2010:365). Australia requires that those who have received medical education government support be required to carry out a contracted number of years of public service, often in rural hospitals, prior to issue of a billing number. A billing number is required in Australia to receive payment from their national health care system (Australia, Health Insurance Act, 42 of 1974).

Nigeria

In Nigeria, the NYSC was established in 1973 and this is known to be the joint second longest-standing national programme in sub-Saharan Africa (Arubayi, 2015:22). A oneyear compulsory community service programme for graduates was introduced and implemented for all graduates including nurses and other health professionals (Kotzee & Couper, 2006:3). The main objective of this programme is to achieve national agreement through the mobilisation of new graduates to areas of need in Nigeria (Awofesa, 2010: 6). The National Youth Service Corps (NYSC) programme assigns all tertiary institutions' health care professional graduates to a mandatory period of service for one year in rural and remote areas (Awofesa, 2010: 6). The certificate of completion of this compulsory service is a prerequisite for employment or postgraduate studies.

South Africa

In South Africa, graduates of the nursing programmes, both degree and diploma are required to complete a 12-months' community service prior to their registration which allows them to practice as professional nurses. The graduate is allocated at the

approved health care facility for a period of 12-months uninterrupted community service (SANC, 2010).

Data extraction

Data collection for this literature review was carried out through the extraction of relevant research studies from the selected sample studies. This allowed the researcher to ascertain which data were most suitable for responding to the objective of the thesis. The following table indicates the number of studies the researcher used in preparation of this article. The selected articles contain information related to legislation, regulations and policies that govern clinical competence in community service. The tables below depict data extraction evidence, themes and sub-themes from extracted data, media reports, as well as literature control evidence.

Table 1: Data extraction evidence (Matlhaba, Pienaar & Sehularo, 2019)

Authors	**Title / Topic**	**Design**	**Results**
Omole, Maricnconitz & Ogubanjo (2005)	*"Perceptions of hospital managers regarding the impact of doctors' community service".*	A qualitative study – focus group discussions	"Community service has improved health services delivery, alleviated work pressure, and improved the image of hospital managers. In addition, it has provided a constant supply of manpower, and increased the utilisation of health services in the community. The negative perceptions identified included a lack of experience and skills, poor relationships with the rural health team, lack of support structures for community service doctors, poor continuity of care, and budgetary constraints" (Omole, Maricnconitz & Ogubanjo, 2005:55).

Khan (2009)	*"Perceptions of and attitudes to the compulsory community service programme for*	An observational cross sectional study with a descriptive and analytical component. This included a self-	"At the onset 50% indicated that they would work in public sector in the future and that proportion declined to 35% by exit. Even fewer 24% said they would work in rural areas in future. Only 16% said they would stay at the same institutions after community

	therapists in KwaZuluNatal, 2005".	administered questionnaire before and after compulsory community service.	service…However, therapists working in the urban areas were more likely to stay in the same institution". (Khan, 2009:i)

Makua (2016)	*"Induction and professional development support of newly qualified professional nurses during community service in South Africa".*	Mixed methods design of concurrent triangulation approach.	"The qualitative findings confirmed the quantitative findings. Findings were lack of professional development support in some public health institutions, informal, non-comprehensive support were given, shortage of experienced professional nurses, reluctance by some professional nurses and operational nurse managers to supervise newly qualified nurses, and increased workload due to shortage of experienced professional nurses in public health institutions. Inadequate clinical skills, poor discipline and lack of professionalism in newly qualified professional nurses also played a part" (Makua, 2016)

Tsotetsi (2012)	*"Experiences and support of the newlyqualified four-year trained professional nurses placed for remunerated community service in Gauteng Province"*	A qualitative, exploratory, descriptive and contextual study.	"CSNs reported mixed experiences such as feeling good and bad during community service placement. The majority of participants reported that remunerated community service placement is risky and it requires one to take chances. Furthermore, participants referred to remunerated community service placement as a scary venture at first but eventually they mastered practical activities. Support received by CSNs varied from adequate, inadequate, incidental and lack of support. CSNs reported bad staff attitudes, severe staff shortage and that they were subjected to adverse events and low salaries". (Tsotetsi, 2012:v)

Maseko, *Erasmus, Di Rago, Hooper, O'Reilly* (2014)	*"Factors that influence choice of placement for community service among occupational therapists in South Africa".*	A cross-sectional, descriptive, quantitative study	"The results indicated that majority of the participants agreed with the statement that family contact; proximity to home and exposure/experience gained during undergraduate studies were influential to the choice of placements for community service. Urban placements were more favoured over rural placements. Financial incentives were found to have minimal influence on the

			selection of rural placements. Experiences during undergraduate studies, including perceptions and opinions of students towards their university supervisors, and even work more so their clinical supervisors were found to have a significant influence on choice of placement" (Maseko *et al.,*2014) .

Kruse (2011)	*"Retaining community service nurses in the Western-Cape public health sector".*	Qualitative study	"The results of the study suggested that an extremely complex interplay between intrinsic and extrinsic motivators in influencing the decision of whether or not to remain employed in the public health sector. It was further evident that most of the factors were strongly self-centred, largely geared at personal reward and recognition. These results is in agreement with literature published by Manion (2009) who supports the thinking that generation representative of Generation X and Y have a strong need for personal achievement and reward. These findings merit further discussion on whether the permanent multi-disciplinary team at hospitals understand the influential role that they have on the complex task of retaining CSNs in the public

			health service. Furthermore, 92% of CSNs highlighted the need for mandatory orientation and induction programmes in each ward prior to commencing duty. This was identified as a huge cause of anxiety and discord".
Govender, Brysiewicz & Bhengu (2015)	*"Perceptions of newly-qualified nurses performing compulsory community service in KwaZulu-Natal".*	Quantitative survey design	"Community nurse practitioners (CNPs) have a positive attitude towards compulsory community service (CCS) and perceive themselves as being well prepared for the year of community service in terms of knowledge, skills, and ability to administer nursing care. They identified positive benefits of the year of community service. The concerns raised were limited orientation and support and a few CNPs experienced problems of acceptance by the nurses with whom they work" (Govender et al., 2015).

Ndaba (2013)	*"Lived experiences of newly qualified professional nurses doing community*	Qualitative descriptive, interpretative phenomenological	"Findings revealed that the newly qualified professional nurses were in a state of reality shock demonstrated by challenges such as shortage of human and material resources, overcrowding, lack of support and placement

	service in Midwifery section in one Gauteng Hospital"	research	of Midwifery Nursing Science in the curriculum has impacted negatively on midwives registration as professional nurse" (Ndaba, 2013).

Nkoane (2015)	*"Community service nurses' experiences regarding health care service at Tshwane District Public hospital"*	A qualitative study followed an interpretive phenomenological analysis approach	"The study revealed that the health care service rendered at the hospital studied is substandard. CSNs reported several challenges experienced during their placement in the hospital under study. Lack of human and material resources, supervision and support contributed to hindrance of smooth, acquisition of their clinical skills and experience. These challenges resulted in the psychological and emotional drain of the participants" (Nkoane, 2015).
Shezi (2014)	*"The needs of community service nurses with regard to supervision and clinical*	A qualitative exploratory, descriptive and contextual study	"The CSNs appeared to be in desperate need of clinical supervisors to guide, couch, support and be a role model to them. CSNs needed to develop confidence, competence, independence and critical thinking skills during the community service practice. In reality, not all

	accompaniment ".		CSNs were fully competent and independent to practice autonomously during their community service, though some acquired all of above-mentioned skill. However, it stood to a reason that competence developed in the period of community service and was influenced by clinical supervision from experienced registered nurses, who assisted with continued development of skills in clinical practice" (Shezi, 2014).
Snell and Daniels (2014)	*"Perceptions of nurses regarding professional competence clinical community practitioners of degree and diploma service programmes from offered in the Western Cape ".*	A quantitative, descriptive, crosssectional design	"The results show that professional nurses perceived the CSPs who had completed a diploma nursing programme to be more competent than the nurses with degrees" (Snell and Daniels, 2014).

Govender, Brysiewicz &	*"Pre-licensure experiences of nurses*	A qualitative	"The community service nurse practitioners did not a clear understanding of the objectives of compulsory

Bhengu (2017)	*performing compulsory community service in KwaZulu Natal, South Africa: A qualitative study".*	approach	community service policy and expressed their frustrations with poor remunerations and delays with SANC registrations. They experienced role confusion and were given huge responsibilities that were challenging for them. In spite of these negative aspects, they seem to have taken the role as professional nurses with enthusiasm. The initial months of the CCS year were seen as developmental for them and they took on challenges of working under pressure with a positive spirit" (Govender *et al.,* 2017).

Wranz (2011)	*"Compulsory Community Service for speech-language and Hearing Therapy Professionals. Readiness, Reality and Readjustment".*	A approach qualitative	"Results suggested that speech-language and hearing therapists perceived themselves to have the required knowledge, but not necessarily adequate skills to perform compulsory community service. Suggestions to include additional curriculum content were made. All professionals agreed that a positive contribution was made during compulsory community service, but concerns about the shortage of speech-language and hearing therapy services, absence of mentors and supervision, inadequate budgets, amenities and
			resources were identified. Readjustment must involve adaptation from all stakeholders to ensure that compulsory community service honours its original objectives" (Wranz, 2011).

Zaayman (2016)	*"Professional nurse's experiences of their community service placement at a secondary academic hospital in the Western Cape".*	A qualitative research and an exploratory and descriptive research design.	"Results revealed that the community service year was experienced as difficult as it required the community service practitioners to apply new knowledge and take a higher level of responsibility in practice. The undergraduate nursing programme was perceived as not preparing them for the responsibility of the community service practitioner. However, transition from student to community service practitioner was experienced as positive as they developed positive relationships with staff that supported them through the process while they developed professionally" (Zaayman, 2016).

Table 2: Themes from data extraction (Matlhaba, Pienaar & Sehularo, 2019)

Themes	Sub-themes	References
Benefits of community service	Improved health service delivery, alleviated work pressure and constant supply of manpower Increased utilization of the health service by the community Positive attitude towards and benefits of compulsory community service (CCS)	Govender *et al,* 2017 Omole *et al.,* 2005 Wranz 2011 Zaayman 2016
Ineffective systems and support structures	Lack of structures and systems to support the community service; Inadequate/ lack of knowledge, skill and experience acquisition; Unavailability of Scope of Practice and job descriptions leading to role confusion; Unclear roles or expectations from permanent multi-disciplinary team in the public health service.	Snell & Daniels 2014 Shezi 2014 Khunou 2016 Govender, *et al.*, 2015 Govender *et al,* 2017 Omole *et al.,* 2005

		Makua 2016 Kruse 2011
Factors influencing placement	Financial and Non-Financial reasons (Proximity to home, exposure/experience, supervisor support prior CSP) Self-centred reasons (personal reward and recognition).	Govender *et al.,* 2017 Thopola *et al.,* 2013 Maseko 2014 Kruse 2011
Rural placement versus urban placement	Intrinsic and extrinsic motivators in influencing the decision of whether or not to remain employed in the public health sector and working in rural areas Creating conducive working conditions in the public institutions particularly in the rural areas	Khan *et al.,* 2009 Maseko 2014 Kruse 2011

Challenges experienced/ observed	Inadequate or lack of supervision and support due to shortage of experienced senior personnel Poor relationships, lack of discipline and unprofessional behaviours displayed by CS practitioners Problems with acceptance in the workplace due to negative and reluctance in attitudes from seniors	Nkoane 2015 Thopola *et al.,* 2013 Omole *et al.,* 2005
	Misunderstanding/misinterpretation of community service initiative Low salaries for the work done	Beyers 2013 Govender *et al.,* 2015 Khunou 2016 Makau 2016 Tsotetsi 2012 Ndaba 2013

Table 3: Media reports/statements on challenges with community service (Matlhaba, Pienaar & Sehularo, 2019)

Date	Author	Media platform	Heading	Report
25 June 2008 https://www.iol.co.za >news>south-africa.	unknown	IOL	Nurses to qualify for salary after a year.	The Democratic Nursing Organisation of South Africa (DENOSA) said in a statement that professional nurses who are registered in the category of community service will from July 1 be paid their salaries according to the new scale as from date of commencement of community service (January 2008) according to a circular issued by the department
16 January 2015		The Times		Approximately 180 graduates are experiencing difficulty in obtaining community service placements.
2015		HEALTH-ENEWS		Democratic Nursing Organisation of South Africa (DENOSA) lashed out the North West Department of Health Human Resources after failing to absorb a group of community service after completion of their compulsory community service

23 May 2016 www.groundup.org.z a	Kelly, S.	GroudUp	No jobs for newly qualified nurses. NEWS| FREE STATE	Shows a photo of nurses protesting indicated that Free State Province failed to absorb an estimated 250 trained professional nurses who completed their 1 year mandatory community service.
28 November 2017. www.heraldlive.co.za .	Ellis, E.	Herald Live	Province to get additional 30 medical interns.	Junior Doctors Association of South Africa (JUDASA) took the Department of Health to task about unallocated graduate medical students due to unavailability of funds
23 November, 2017 www.ewn.co.za.	Mortlock, M	Eye Witness News	Nearly 300 student doctors don't have placements for 2018.	Nearly 300 student doctors do not have placements for 2018
26 June 2017	Case Number 43486/17	Court Case		A court case against the Gauteng Department of Health and nurses trade union where the department and SANC were ordered to place the nurse within the specific period

Table 4: Articles for literature control (Matlhaba, Pienaar & Sehularo, 2019)

Author	**Title**	**Design**	**Results**
Sanchel , Hierro, Rammen , Verhoeven *et al.,* (2014)	Are recent graduates enough prepared to perform obstetric skills in their rural and compulsory year? A study from Ecuador	A web- based survey	A negative correlation was found in the skills “episiotomy and repair”, and “umbilical vein catheterization”. Speculum examination, evaluation of cervical dilation during active labour, neonatal resuscitation and vacuum assisted vaginal delivery. For instance “episiotomy and repair ‘is important (strongly agree to agree) to 100% of residents, but in practice. Only 38.9 % of rural doctors performed the task three times as 8.3% only once during the internship, similar pattern is seen in others.

Amandu, Uys, Mwizerwa *et al.* (2013)	Introducing a new cadre into Uganda's health care system: Lesson learnt from the implementation process	Mixed methods approach	Despite the relevance, the implementation process of both programmes failed to meet acceptable standards. Was concluded that introducing a new cadre of nurses without proper preparation hinders realization of their full potential including contribution to the health care system.

Mbemba, Gagnon, *et al.,* (2013)	Interventions for supporting nurse retention in rural and remote areas: an umbrella review.	Systematic reviews	Of 517 screened publications, five reviews are included. Two reviews showed that financial-incentive programs have substantial evidence to improve the distribution of human resources for health. The other three reviews highlighted supportive relationships in nursing, information and communication technologies support and rural career pathways as factors influencing nurses' retention in rural and remote areas.

Adhikari (2015)	Vacant hospitals and under-employed nurses: a qualitative study of the nursing workforce management situation in Nepal.	An ethnographic, qualitative method	Study findings suggested that there is a severe mal-distribution of the nursing workforce in rural and urban health centres in Nepal. Although there is an oversupply of newly qualified nurses in hospitals in Kathmandu, the staffing situation outside the valley is undesirable. Additionally, the turn-over of junior nursing staff remains high in major urban hospitals. Most qualified nurses aspire to work in developed countries such as the UK, North America, Australia and New Zealand. Between 2000 and 2008, as many as 3000 nurses

			have left Nepal for jobs in the developed west. There is no effective management strategy in place to retain a nursing working force, particularly in rural Nepal.

Thammatacharee, Suphanchaimat, Wisaljohn (2013 *et al.,*	Attitudes towards working in rural areas of Thai medical, dental and pharmacy new graduated in 2012: a cross-sectional survey.	A cross-sectional survey.	There were 754 doctors (44.4%), 203 dentists (42.6%) and 268 pharmacists (83.8%) enrolled in the survey. Graduates from all professions had positive views towards working in rural areas. Approximately 22% of doctors, 31% of dentists and 52% of pharmacists selected 'close proximity to home' as the most important reason for workplace selection. The multivariable analysis showed a variation in attributes associated with the tendency to work in rural areas across the profession. In case of doctors, special track graduates had a 10% higher tendency to prefer rural work than those recruited through the national examination.
Honda (2015) & Vio	Incentives for nonphysician health professionals to work in the rural and remote areas of Mozambique	Qualitative study	The results indicated that the provision of basic government housing has the greatest impact on the probability of choosing a job at a public health facility, followed by the provision of formal education opportunities and the availability of equipment and medicine at a health facility.

	– a discrete choice of experiment for eliciting job preferences.		The sub-group suggests that job preferences vary according to stage of life and that incentive packages should vary accordingly. Recruitment strategies to encourage non-clinical professional to work in rural/remote areas should also consider birthplace, as those born in rural/remote are more willing to work remotely.
Dehghani, Mosalanejad & Dehghan-Nayeri, (2015)	Factors affecting professional ethics in nursing practice in Iran: a qualitative study.	A qualitative study using conventional content analysis approach.	After encoding and classifying the data, five major categories were identified: individual character and responsibility, communication challenges, organizational preconditions, support systems, educational and cultural development. Awareness of professional ethics and its contributing factors could help nurses and healthcare professionals provide better services for patients. At the same time, such understanding would be valuable for educational administrators for effective planning and management.

Results

Themes were derived from the research studies conducted on community service. Five themes and 16 sub-themes emerged during the analysis of the existing data based on the findings of cited studies. These themes were analysed using the adapted Pienaar's steps of data analysis (Pienaar, 2017:91). Each theme and sub-theme will be discussed separately, and is supported by references from the authors. The relevant literature is cited to ensure that literature control is done. Themes and sub-themes are discussed in tables below:

Theme 1: Benefits of community service

It is believed that the community service programme for health care professionals will not only benefit the professionals but all of the stakeholders. Sub-themes for this theme will be discussed below with support from the existing literature to ensure that literature control is done.

Sub-theme 1: Improved health service delivery, alleviated work pressure and constant supply of manpower

It is suggested from the existing literature that community service has improved health service delivery, alleviated work pressure, and improved the image of hospital managers. Further, it has provided a constant supply of manpower, and increased the utilisation of the health service by the community. This is claimed by findings from the study conducted in Limpopo Province, South Africa where the researchers aimed at exploring the perceptions of hospital managers with respect to the impact of doctors' community service (Omole *et al*., 2005: 55). These findings concur with the findings from the review article by Matsumoto, Inoue, Kajii and Takeuchi, (2010) on retention of physicians in rural Japan. It is stated that despite the number of factors leading to the general shortage of physicians in the 1950s, which became acute in the rural areas, it has continued until recent times (Matsumoto *et al.,* 2010:1). The authors stated that this challenge was however addressed by teamwork among

national, municipal government and public medical schools through a bound medical program followed by obligatory rural service (Matsumoto *et al.,* 2010:1). Omle *et al.,* (2005) and Matsumoto *et al.,* (2010) confirm that the South African Department of Health hoped to achieve through the introduction and implementation of community service was an impact on the number of stakeholders including health professional training organizations and communities (Mchunu, 2006:49).

Sub-theme 2: Increased the utilization of health service by the community

The study conducted by Omole *et al.,* (2005) revealed that because of the additional number of medical doctors in the facilities, there was an increase in the utilization of healthcare service by the community. Community service for doctors was seen to have brought some relief to the shortage of medical doctors particularly in the rural areas.

Sub-theme 3: Positive attitude towards and benefits of community service

Findings from several studies including that of Govender *et al,* (2017); Omole *et al.,* (2005); Wranz (2011) and Zaayman (2016) revealed that community service programmes were perceived as positive by participants as it provided them with the opportunity to gain knowledge and to develop required skills. The studies revealed that despite other challenges observed in many other research studies, the participants felt confident and were able to adapt and able to work under pressure.

Theme 2: Ineffective systems and support structures

Evidence revealed that ineffective structures and system to the community service programme remain a challenge. Lack of orientation programmes and the unavailability of institutional policies are cited by the majority of the previous studies.

Sub-theme 1: Lack of structures and systems to support the community service programme

Effective institutional supervision and management programmes are important and can have a positive impact on performance and competence of CSNs. This will ensure proper implementation and avoid problems that could result in the programme being ineffective or not meeting its objectives (Amandu *et al.*, 2013: 674). It is suggested that improper implementation hinders realization of the full potential of the programme including its contribution to the health care system (Amandu, *et al.,* 2013:670)**.** Effective institutional programmes including orientation and mentoring can be considered in order to improve the knowledge, skills and experiences of the CSNs. It is believed that new graduate nurses attending orientation programme before the beginning of their work may gain clinical competence and they may attain their new role faster and smoother (Cheng, Tsai, Chang & Liou, 2014:2). According to the authors, a pre-graduation clinical programme requires a student to practice under the supervision of a hospital registered nurse preceptor for a period of 6 weeks (Cheng *et al.,* 2014:3). The results of this study revealed that the programme was effective in increasing students' clinical competence (Cheng *et al.,* 2014:6).

Sub-theme 2: Inadequate/ lack knowledge, skill and experience acquisition

Some study findings revealed that CSNs had the knowledge, skills and values for nursing practice but lacked critical thinking in application to the nursing process. The majority of the studies revealed that CSNs lack skills, knowledge and experience. The study conducted by Snell and Daniels (2014) in the Western Cape revealed that professional nurses perceived CSNs who graduated from a degree programme to be incapable of managing bigger workloads such as being responsible for a ward when the professional nurses are not present (Snell & Daniels, 2014:150). These differences were also observed in the study conducted by Matlhaba (2016) in the North-West province were professional nurses perceived diploma trained final year students to be competent in comparison to the degree trained (Matlhaba, 2016).

Furthermore, in the study conducted by Shezi in KwaZulu Natal it was revealed that not all CSNs were fully competent and independent enough to practise autonomously during their community service though some acquired some knowledge and skills (Shezi, 2014:v). These findings concur with those from the study conducted in Ecuador on evaluation of recent graduate doctors' preparedness to carry out obstetric skills in their rural and compulsory year. A negative correlation was found in the skills; episiotomy and repair, umbilical vein catheterization, speculum examination, evaluation of cervical dilation during active labour, neonatal resuscitation and vacuum assisted vaginal delivery (Sanchel *et al.,* 2014).

Sub-theme 3: Unavailability of Scope of Practice and job descriptions leading to role confusion

From the existing literature, there has been a sequence of misperceptions and doubts amongst the CSNs as well as their seniors due to unavailability of clear policy on their (CSNs) professional role and responsibilities in the health care facilities. This is seen to be a major challenge that has a negative impact on the CSNs performance. Furthermore, literature revealed that different stakeholders including the SANC were blamed because there was no scope of practice and job descriptions, which specifically addresses the level of responsibilities for CSNs (Khunou, 2016:102; Govender, *et al.*, 2015:2).

Theme 3: Factors influencing placement

The majority of the studies revealed that participants stated financial and non-financial incentives as a motivator for health professionals to remain in the rural or remote areas during community service and after completion of the programme in South Africa (Govender *et al.,* 2017; Thopola *et al.,* 2013; Maseko 2014; Kruse 2011). These findings concur with a systematic review study by Mbemba *et al.,* (2013:1) which highlighted substantial evidence that financial and non-financial incentive programs have the potential to improve the distribution of human resources for health and are factors influencing nurse retention in rural and remote areas.

However, in Peru, the health professionals are not allowed to remain in the rural areas after the completion of their community service programme (Frehywot *et al.,* 2010:366). It is stated that if they remain in the rural areas after completion of the programme, they are often paid less than before when they were fulfilling the compulsory community service requirements. This is in contrast with many countries where health care professionals are offered greater financial incentives for remaining in the rural areas (Frehywot *et al.,* 2010:366).

Sub-theme 1: Financial and non-Financial reasons (Proximity to home, exposure/experience, supervisor support prior CSP)

Financial and non-financial reasons were cited as one of the factors influencing placement during community service. Findings from several studies including that of Maseko 2014 and Kruse 2011 suggested that some participants' choices of placement were influenced by proximity to home and previous exposure and experiences prior to CSP. These results concur with the results from the study contacted by Thammatacharee *et al*., (2013) in Thailand. The study aimed to explore the current attitudes of new medical, dental and pharmacy graduates as well as to determine the linkage between their characteristics and preference for working in rural areas (Thammatacharee *et al.,* 2013:1). The study results revealed that approximately 22% of doctors, 31% of dentists and 52% pharmacists selected "close proximity to hometown" as the most important reason for workplace selection (Thammatacharee *et al.,* 2013:6). The study also cited the recruitment method for training as a non-financial reason for workplace selection. Findings revealed that the multivariable analysis showed a variation in attributes associated with a tendency to prefer rural work than those recruited through the national entrance examination (Thammatacharee *et al.,* 2013:1).

Sub-theme 2: Self-centred reasons (personal reward and recognition)

Few studies revealed that participants considered personal reasons and recognition when they were applying for their placement for community service (Maseko, 2014 & Kruse 2011). The issues of families and religions were noted to be of a focus on placement application.

Theme 4: Rural placement versus urban placement

The studies conducted by Khan *et al.,* (2009); Maseko (2014) and Kruse (2011) revealed that there was some indecisiveness and change of heart when it came to choosing between rural and urban placement. For some reasons, rural area placements are usually associated with increased workload and poor financial and non-financial incentives that put rural health care professionals at a disadvantage (Fritzen, 2007), making the retention of health workers equally challenging. Poor strategies on health care professionals' retention in some health facilities translated into staff shortages, increased workloads, stress levels, and a demotivated workforce (Buchan *et al.,* 2013: 834). WHO reports on increasing the attraction and retention of health care professionals in rural and remote areas; and also highlights the need for this through improved retention strategies (WHO, 2010) Development of such policies on retention and motivation should incorporate the voices of health workers (WHO, 2010). In the preliminary investigation by the Rural Health Advocacy Project (RHAP) within the two provinces (Eastern Cape & Northern Cape) allocation of medical officers (MO), it was found that majority of placements in the two provinces favoured urban facilities (Rural Health Update, 2016). These investigation findings concur with the statistic stated by Buchan *et al.,* (2013:834) where some urban areas in Senegal which is mostly urban but having an estimation of 60% of physicians with only 23% of total population, and Canada with 99.8% of rural territory with 24% of the population with only 9.3% of physicians.

Sub-theme 1: Motivators in influencing the decision of whether or not to remain employed in the public health sector and working in rural areas

It is reported from the existing literature that health care professionals would choose to work in the rural and remote areas due to a variety of different reasons. However, it is evident that many of those reasons are cited as challenges that affect recruitment and retention of health care professionals in those areas. Despite WHO's appeal for strategies to recruit and retain health care professionals in the rural and remote areas, the challenges still exist in many countries (2010). Studies conducted by Khan *et al.,* (2009); Maseko (2014); and Kruse (2011) reflected that participants showed some interest in working in the rural areas after completion of their community service with some giving factors which might be seen as motivators for their decisions. Human and material resources, working conditions, incentives and professional development are factors that are influential in whether health care professions would or would not remain in the rural areas. According to Mbemba *et al.,* (2013:2), these personal and social factors are interconnected and influence the nurses and other health care professionals' decisions to stay or to leave rural and remote areas. These findings concur with the study conducted by Adhikari (2015) in Nepal. The study revealed that lack of supervision; work orientation, rewards incentives and promotion opportunities were mentioned as further key factors on newly qualified nurses (Adhikari, 2015: 294). The researcher suggested that in order for the rural and government posts to be attractive to newly qualified nurses, all of the above factors, if attended to, can be used as a recruitment and retention strategy for rural health service (Adhikari, 2015: 295). These results are supported by those from the study conducted by Honda & Vio, (2015:1) in Mozambique.

Sub-theme 2: Creating conducive working conditions in the public institutions particularly in the rural areas

Conducive working conditions can be used as a strategy to retain CSNs in the rural areas, which is one of the objectives of the programme. The World Health Organization (WHO)'s recommendation on retention strategy is that it should be

likened to the broader national and local health system structures and policies (WHO, 2010). Creating a conducive working environment with improved health facilities, improved conditions of service, provision of decent staff accommodation or housing allowance, equal training opportunities, transportation allowance or provided transportation improved salary scales, recruitment of more staff and regularisation of allowances can all be used as strategies to recruit and retain health care professionals in rural areas after completion of their community service programme. It is evident that improved health care infrastructures and good living conditions of the health care providers can have a positive impact on recruitment and retention in the rural health facilities (Darkwa *et al.,* 2015: 10).

Theme 5: Challenges experienced/ observed

Sub-themes emerged from this theme are discussed below:

Sub-theme 1: Inadequate or lack of supervision and support due to shortage of experienced senior personnel

Staff shortages were found to be a major contributor to the lack of support given to CSNs during their community service period. The majority of studies revealed that CSNs experienced lack of support, which has a negative impact of their competence. In the study conducted by Nkoane in Gauteng province, the study concluded by stating that CSNs lacked support and supervision from experienced and senior personnel in order to acquire clinical experience and skills necessary to render quality health care service (Nkoane, 2015:68). The same sentiment is shared by Thopola *et al.,* (2013:178) in the study conducted in Limpopo province and also observed in the study conducted by Omole *et al.,* (2005) where participants revealed that shortages of senior doctors and budgetary constraints remain a challenge for activities including teaching and supervision of community service doctors (Omole *et al.,* 2005:57).

Sub-theme 2: Poor relationships, lack of discipline and unprofessional behaviours displayed by community service practitioners

Majority of the studies revealed that poor relationships, lack of discipline as well as unprofessional behaviour was displayed by the community service practitioners during their community service (Nkoane 2015; Thopola *et al.,* 2013; Omole *et al.,* 2005; Beyers 2013; Govender *et al.,* 2015; Khunou 2016; Makau 2016; Tsotetsi 2012 and Ndaba 2013). However, it was noted that these behaviours were triggered by many factors including a feeling of unacceptance, and feeling overwhelmed due to lack of mentoring and support. These results concur with the study conducted by Dehghani, Mosalanejad and Dehghan-Nayeri, (2015) in Iran. The study aimed at exploring and describing factors affecting professional ethics in clinical practice. The study revealed that there are several factors that affect professionals' behaviour, including lack of support, shortage of human and resource materials deficiency of clinical standards, environmental factors including facilities and equipment, lack of efficient organization, control and supervision (Dehghani, *et al.,* 2015: 7).

Sub-theme 3: Problems with acceptance in the workplace due to negative and reluctance attitudes from seniors

Majority of the studies revealed that CSNs experienced some negative attitudes and feeling of unacceptance from their seniors during community service. The study conducted by Khunou (2016) in the North-West province revealed that CSNs felt they were blamed for mistakes and at the same time felt bullied by their seniors (Khunou, 2016:155). The study conducted by Makau (2016) in Gauteng province revealed that CSNs experienced some attitudes of reluctance. However, the study conducted by Omole *et al.,* (2005:55) revealed that community service doctors displayed poor working relationships with the health professional team in the rural area.

Sub-theme 4: Misunderstanding/misinterpretation of community service programme

The study conducted by Govender *et al.,* (2017:17) revealed that some participants were actually not sure or lacked understanding of the CSP objectives as they were quoted as saying it is the need to pay back in service to the government while others felt it was service to the community. Others understood it as the opportunity to gain more experience in preparation of for their future as professional nurses.

Sub-theme 5: Low salaries for the work done

Most studies reported that participants expressed some dissatisfaction with regard to their remuneration. They [participants] suggested that salary scales should be increased and all allowances should be regularised. Some participants felt that they have been cheated financially as they are being paid lower salaries that other health professionals (Govender *et al.,* 2017:20). Participants in the study conducted by Thopola *et al.,* also expressed that the salary scale given was not satisfactory based on the workload they had to bear (Thopola *et al.,* 2013:175).

Discussion

This article has considered the legislation, policies and regulations that govern clinical competence in community service programme in different countries. It was found that despite the various strategies used by different countries to deal with the issue of recruitment and retention, compulsory community service is used by many. However, there are many contributory factors to lack of competence, which include lack of human and resource management, lack of proper or effective support structures and incentives (financial & non-financial). It is evident that irrespective of those contributory factors to poor clinical competence, there is enough research done to address the main objective of the community service programme for graduate health care professionals, which is seen to be common in many countries. That objective is to ensure equitable distribution of health care professionals with an

emphasis on rural and underserved populations and to enable and encourage community service officers to remain in public service, particularly in rural and underserved areas.

From the South African perspective, it is clear that even though the government's intention to introduce this community service programme is good, there are still more challenges which are administrative and operational. All of these mentioned challenges are impacting negatively on clinical competence of practitioners, particularly the nurses. The major challenge cited in the majority of literature is the unavailability of policies governing the community service programme at the health care facilities. This is seen as major challenge as personnel at the facilities show lack of understanding of what is expected of them with regard to handling community service practitioners. Majority of studies revealed that CSNs were not supported by senior or experienced professional nurses during their time in the facilities, which posts a challenge as the CSNs still need guidance and mentoring with their daily routine. Unavailability of proper and clear orientation programmes at the commencement of the community service showed clearly that those persons at the facilities have little concept on what their contribution towards a successful year of community service for a nurse to become a competent, independent practitioner entails. Unavailability of posts for those completing the programme is also seen as disturbing as it is expected that as the government is aware of how many trainees are at the training institutions, proper provision should be made for them on completion of the programme. This aspect requires urgent attention as it causes uncertainties during the programme as to whether community service practitioners will be absorbed or not after completion.

Conclusion

From the existing literature, it is clear that clinical competence in community service is compromised by many factors. It is concluded that the objectives of the community service can be achieved by having all stakeholders on board and introducing clear policies and regulations especially at the provincial and institutional level. This will have a positive impact on the clinical competence of CSNs.

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Competing interests

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Author contributions

K.L.M. was responsible for finalisation of data analysis and writing the manuscript. L.A.S. was responsible for conceptualization and proof reading of the manuscript, A.J.P. finalized the data collection, made conceptual contributions to the whole manuscript.

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Desk review on assessment tools for clinical competence of newly qualified nurses

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Abstract

Introduction: The assessment of competence of practising nurses has been identified as crucially important in maintaining professional standards, identifying areas for professional development and educational needs and ensuring that nurse competencies are put to the best possible use in patient care. A desk review on clinical competence or competencies, concepts related to clinical competence, country specifics on assessment of clinical competence as well as development of assessment tools are given in this manuscript.

Objectives: The objective of the manuscript was to highlight expected clinical competencies for newly qualified nurses as well as to highlight the different clinical competence evaluation tools available in South Africa and abroad.

Methodology: The desk review focused on the existing competencies for newly qualified nurses in South Africa and abroad, the evaluation of these competencies and the tools available to evaluate these competencies.

Results: Seven (7) countries were identified and each country's competencies' specifics were explored. Furthermore, six (6) existing evaluation tools were identified and explored whereby one (1) of the identified countries tool was adapted following the granting of permission. Its forty-seven (47) item tool formed the basis of the clinical competence evaluation tool developed for community service nurses in the North West Province, South Africa.

Discussions: The result of this desk review was employed as the foundation for the development of a clinical competence assessment tool for community service nurse in the North West Province, South Africa.

Key words: Competence, clinical competence, desk review, evaluation tool, new qualified nurse

Introduction

A desk review on clinical competence or competencies, concepts related to clinical competence, country specifics on assessment of clinical competence as well as development of assessment tools is given in this manuscript. Desk research is the collection of secondary data from internal sources, the internet, libraries, trade associations, government agencies, and published reports (Whitehead, 2005). However, Whitehead, (2005) defines desk research as secondary data or that which can be collected without fieldwork. Desk research is frequently carried out at the beginning of a study as a stage-gate to establish if more costly primary research is justified. Key sources and the uses of secondary research are discussed at the beginning of this section.

Definition of competence

Competence

There are many definitions of competence in nursing that exist, and many differences in the interpretation of these definitions (Naji, 2016). According to Naji (2016), it is these differences that add to the confusion as to what competence is and is not. In contrast to this, Tilley (2008) points out in a review of the literature that define the attributes of competence that attributing to this reality was the realization that competence is multifaceted and difficult to measure, that nursing careers are widely divergent with various levels of practice, different regulatory processors exist, and there is an inherent evolution of practices from the new entry level nurse to the experienced (Tilley, 2008). Difficulty in defining competence is strongly linked to the reality that there are two dominant common uses for the concept of competence, which is maintenance of competence, and preparing for initial licensing (Tilley, 2008). According to the Canadian Nurses Association (CAN), competence is defined as the integrated knowledge, skills, judgment and attributes required of a registered nurse to practise safely and ethically in a designated role and setting (CNA, 2010). The Canadian Council for Practical Nurse Regulator (CCPNR) defines competence

as the quality or ability of a practical nurse to integrate and apply the knowledge, skills, judgments and personal attributes required to practise safely and ethically in a designated role and setting. Personal attributes include, but are not limited to, attitudes, values and beliefs (CCPNR, 2013). The College of Nurses of Ontario (CNO) define competence as the ability of a nurse to integrate the professional attributes required to perform in a given role, situation or practice setting. Professional attributes include, but are not limited to, knowledge, skill, judgment, values and beliefs. (CNO, 2014)

According to SANC's Nursing Education and Training Standards, competence is defined as the combination of knowledge, psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency (SANC, 2005). According to Regulation 174 in the Nursing Act, competence is defined as the ability of a practitioner to integrate the professional attributes including, but not limited to, skills, judgement, values and beliefs required to perform as a professional nurse or midwife in all situations and practice settings (Nursing Act, 2005). It is suggested that to achieve competence, knowledge and skills need to be combined with attitudes and values in the clinical setting (Naji, 2008).

Assessing continuing competence

Assessing continuing competence based solely on skills and knowledge does not provide a holistic picture. Therefore, including dimensions to assess communication, motivation, and behavior is important in evaluating the overall competency of the practicing nurse (Wilkinson, 2013). Barriers to developing a common definition of continuing competency include the difficulty in creating a standard for competency evaluation and the need to decide what competencies all practicing registered nurses must be able to demonstrate and whether they should be general of fundamental (Allen *et al.* 2008). According to Wilkinson (2013), the concept of continuing competency must be made clear to understand what type of assessment is reliable and what needs to be developed further.

Professional competence in Nursing Practice

Professional competence is comprised of the characteristics associated with the profession and the professionals and influences the way in which those professionals act and react (Dehghani, Mosalanejad & Dehghan-Nayeri, 2015). Heres and Lasthuizen (2013) refer to the components of professional competence as being knowledge, cognitive competence, business competence and ethical and personal behavioral competence.

According to Heres and Lasthuizen, (2013), ethical competence encompasses a set of knowledge, skills, and attitudes and abilities that enable a person to adequately deal with moral challenges and to make decisions and behaviours that meet high ethical standards. Cognitive competence refers to using critical thinking skills to effectively solve the problem and consistently make the right judgments, at the right time for the right reasons and to take responsibility and accountability for the action (Benner, Hughes & Sutphen 2008).

Evidence-Based Practice competence

Evidence-Based Practice is defined as a problem-solving method to clinical decision making within the healthcare facility that integrates the best existing scientific evidence with the best available experimental (patients and practitioner) (Naji, 2016). According to Naji, (2016) the importance of EBP has been recognized in nursing since the middle of 1990s. The author stated that in order for the nurses to integrate EBP, nurses and student nurses must understand and develop their EBP competency by engaging them in the EBP process.

Organisations including Institute of Medicine (IOM) (2010) and World Health Organization (2012) emphasize the importance of EBP in nursing education, practice and research (Naji, 2016). According to Naji (2016), IOM (2010) mandated that all health professionals be educated to deliver patient-centred care as members of interdisciplinary teams emphasizing EBP, quality improvement approaches, and informatics.

Developing a tool of competence

Le Deist and Whinterton (2005) suggest that the reason for developing models of competence is to find local solutions to human resource needs. Strasser, London and Kortenbout (2005) argued that narrowly delineating nurse competencies is no easy task, especially when one moves from nursing theory to practice. According to Ladhani, Stevens and Scherpbier (2014) some objected to the apparent reduction of nursing to a series of tasks, (while) others believed that outlining tasks would help clarify and specify skills that must be included in training and educational programs. After this study was done,

Alexander and Runciman (2003) published a framework of competence for general nursing, and the International Council of Nurses [ICN] (2009) provided an implementation model for that framework. Future application and assessment of the impact of this framework will add to the growing body of knowledge on competence. In addition, there is a need to enhance understanding of a minimum competence level below which a person is deemed incompetent.

Assessing competence

Assessment of the competence of practising nurses has been identified as crucially important in maintaining professional standards, identifying areas for professional development and educational needs and ensuring that nurse competencies are put to the best possible use in patient care (EdCan, 2008). According to Schub and Heering (2016), assessing clinical competencies involves the utilization of competency assessment tools to determine if a nurse possesses the ability to perform specific tasks in the clinical setting. The National Cancer Nursing Education Project in Australia conducted a review on 54 articles published between the years 2000 and 2007 on assessment of clinical competence (EdCaN, 2008). The authors found that most studies on clinical competence assessment were descriptive, reporting qualitative findings rather than evidence-driven data on the validity and reliability of competency assessment tools. According to the authors of the literature review, no assessment method has been proven superior and further studies are

necessary to develop evidence-based guidelines for clinical competence assessment (EdCaN, 2008). In the integrated review conducted by Wilkinson (2013), 65 articles on competency assessment tools for registered nurses were reviewed. The search for tools published in the past decade focused on self-assessment of continuing competence in practicing nurses and graduate nurses (Wilkinson, 2013). The results of the review showed an improvement in the development and availability of tools. However, the author conclude that there is a need for further research to evaluate the tools critically which can potentially lead to the development of a more comprehensive competence assessment instrument (Wilkinson, 2013).

From the existing literature, it is evident that there is lack of consensus about the tool to be used on how clinical competence should be evaluated. It has also been suggested that this lack of consensus raises the potential for confusion and repetition as nurses attempt to meet the requirements of a number of different systems (Schub & Heering, 2016). According to American Nursing Association (ANA), assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, regulatory agencies and other key stakeholders (ANA, 2008). ANA believes that nursing competence can be defined, measured, and evaluated. However, no single evaluation tool or method can guarantee competence. This information shows that more studies are needed for the development of effective evaluation tool(s) for clinical competence.

Desk Review methodology

Purpose of desk review

The purpose of this desk review was to assess the competencies of newly qualified nurses, the evaluation of these competencies and the tools developed and employed to evaluate these competencies. The results from this desk review will assist in the development of a tool to evaluate clinical competence of community service nurses (CSNs) in the Northwest province, South Africa.

Desk Review scope

The desk review focused on the existing competencies for newly qualified nurses in South Africa and abroad, the evaluation of these competencies and the available tools to evaluate these competencies. The following country's specifics are looked into:

- United State of America (USA)
- Australia
- Canada
- United Kingdom (UK)
- Ireland
- Hong Kong
- South Africa (RSA)

Research approach

The research methodology followed to achieve the aim of this manuscript is a desk-top literature review on various source documents such as available clinical competence evaluation tools for newly qualified nurses across the board.

Review questions

What are the expected competencies for newly qualified nurses?

Which clinical competence evaluation tools are available for newly qualified nurses?

Research objective

The objective of the paper is to highlight expected clinical competencies for newly qualified nurses as well as to highlight the different clinical competence evaluation tools available in South Africa and abroad.

Ethical consideration

The researcher has acknowledged all sources used in this review as a way of avoiding plagiarism. Researcher selected all sources used in desk review without any bias.

Results according to country specifics on competencies

Nursing and midwifery are regulated professions around the world. Many boards of nursing began to explore the issue of competencies for graduating nurses in their countries in the early 1980s (Tilley, 2008). Each regulatory body has standards to protect the public, advance practice, provide a reference for resolving concerns related to practice, approve education programmes, develop guidelines, assist with the legal decision, provide public information and ensure nurses' competency (Saskatchewan Registered Nurses Association, 2006). A high standard of practice has been maintained by all nursing regulatory bodies' worldwide. These practice standards that serve as requirements for quality patient care are outlined in the training syllabi of nurses and midwives at the accredited nursing education training institutions. These practice standards have focused on clinical competency achievement.

Table 1: Country specifics core competencies (Matlhaba, Pienaar & Sehularo, 2019)

Country	**Framework**	**Core Competencies**
United State of America	Model of Professional Nursing Practice Regulation	1. Quality 2. Safety 3. Evidence
Australia	National Competency Standards for the Registered Nurses	1. Professional Practice 2. Critical Thinking and Analysis 3. Provision and Coordination of Care 4. Collaborative and Therapeutic

Canada	Entry-to-Practice Competencies for Licensed Practical Nurses.	1. Professional practice 2. Legal practice 3. Ethical practice
		4. Foundations of practice 5. Collaborative practice
	Canadian Nurse Practitioner Core Competency Framework	1. Professional Role 2. Responsibility and Accountability 3. Health Assessment and Diagnosis 4. Therapeutic Management 5. Health Promotion and Prevention of illness and Injury

	College of Nurses of Ontario - Entry-to-practice competencies for Ontario Registered Practice Nurses	1. Professional responsibility and accountability 2. Ethical practice 3. Service to the public 4. Self-regulation

		5. Knowledge 6. Knowledge application.

Ireland	Competence assessment tool for nurses	1. Professional/ethical practice 2. Holistic approaches to care & the integration of knowledge 3. Interpersonal relationships 4. Organization and management of care 5. Personal and professional development
United Kingdom	Standards for competence for registered nurses	1. Professional values 2. Communication and interpersonal skills 3. Nursing practice and decision making 4. Leadership, management and team working.

Singapore	Core Competencies of Registered Nurses	1. Professional, Legal and Ethical Nursing Practice Competence 2. Management of Care Competence 3. Leadership and Nursing Management Competence 4. Professional Development
Hong Kong	Nursing Council of Hong Kong: Core- Competencies for Registered Nurses	1. Professional, Legal and Ethical Nursing Practice 2. Health Promotion and Education 3. Management and Leadership 4. Nursing Research 5. Personal and Professional Development

Nursing Competence in United States of America

The public has a right to expect registered nurses to demonstrate professional competence throughout their careers. ANA believes the registered nurse is individually responsible and accountable for maintaining professional competence. The ANA further believes that it is the nursing profession's responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public. The employer is responsible and accountable for providing an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders.

The American Association of Colleges of Nursing (AACN) in 2008 included EBP competencies to prepare future nurses (AACN, 2008). Stevens (2009) highlighted the importance of EBP skills in nursing education and the inclusion of EBP skills in nursing education would deliver a foundation for EBP competencies in practice.

Model of Professional Nursing Practice Regulation in the USA

In 2006, the Model of Professional Nursing Practice Regulation emerged from ANA work and informed the discussions of specialty nursing and advanced practice registered nurse practice. The lowest level in the model represents the responsibility of the professional and specialty nursing organizations to their members and the public to define the scope and standards of practice for nursing. The next level up the pyramid represents the regulation provided by the nurse practice acts, rules, and regulations in the pertinent licensing jurisdictions. Institutional policies and procedures provide further considerations in the regulation of nursing practice for the registered nurse and advanced practice registered nurse. Note that the highest level is that of self -determination by the nurse after consideration of all the other levels of input about professional nursing practice regulation.

The outcome is safe, quality, and evidence-based practice.

Assessment of Competence in USA

ANA believes that in the practice of nursing, competence can be defined, measured, and evaluated as no single evaluation method or tool can guarantee competence. Competence is situational and dynamic; it is both an outcome and an ongoing process. Context determines what competencies are necessary. Nurses are expected to demonstrate professional competence throughout their careers. This responsibility is shared across a continuum. The registered nurse is individually responsible and accountable for maintaining professional competence. It is the nursing profession's responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards of competence to protect the public. The employer is responsible and accountable to provide a practice environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders (ANA, 2010).

Competence in nursing practice must be evaluated by the individual nurse (selfassessment), nurse peers, and nurses in the roles of supervisor, coach, mentor, or preceptor. In addition, other aspects of nursing performance may be evaluated by professional colleagues and patients. Competence can be evaluated by using tools that capture objective and subjective data about the individual's knowledge base and actual performance and are appropriate for the specific situation and the desired outcome of the competence evaluation (ANA, 2008).

Canada overview

In Canada, nursing education and health care are provincial responsibilities under the Canadian Constitution. Therefore, the provinces are the decision-making authorities of the education systems. However, national coordination through professional associations such as the Canadian Nurses Association (CAN) is achieved through the promulgation of guidelines and standards. CNA is a federation of 11 provincial and territorial nurses' associations and colleges that represent more

than 136,200 registered nurse and nurse practitioner members, which is approximately 53% of employed nurses. Quebec is not a member of CAN (CAN, 2009).

The Canadian Association of Schools of Nursing is an official national agency responsible for the accreditation of nursing programmes throughout Canada. Their accreditation is a voluntary process as compared to that of the United States in that it requires a self-evaluation report, which includes the information on the nursing programme, administration, faculty, students, curriculum, learning resources, and graduates and an onsite visit (CASN, 2009). In addition to profession-specific accreditation processes, there is a review of nursing programmes, which form part of periodic quality review processes established by provincial authorities for universities and colleges.

In Canada, the nursing regulatory system reflects the country's federal, provincial and territorial government structure. Provincial and territorial governments are responsible for health care delivery and regulate all the health care professions. The regulation of provinces and territories grant is the responsibility of the professional colleges and/or nursing associations. It is for this reason why a nurse seeking to practice nursing in a specific province or territory has to apply for licensing and registration at the college and/or association in that province or territory. Hence, there is no national license in Canada. The licensing of nurses lies within each province or territory jurisdiction (CNA, 2010). The licensing fee includes both licensure registration and membership in the provincial and national nurses association in other provinces except in Ontario and Quebec.

In all provinces, except Quebec, licensure candidates are required to take the Canadian Registered Nurse Examination (CRNE) that is developed by CNA. This examination is a multiple-choice examination that is competence-based and replicates a primary health care nursing model. The examination consists of multiple-choice questions, which 40% of those questions are independent type questions whereas 60% are case-based.

The framework developed to identify and organise the competencies in the CRNE is developed to assess the competence of nurses focusing on the following competencies:

- Professional practice including accountability for safe, competent and ethical nursing practice;

Nurse-Person relationship looking at the therapeutic partnerships established to promote the health of the person;

- Nursing Practice: Health and Wellness focusing on recognition and the value of health and wellness as a resource; and
- Nursing Practice: Alterations in Health: which focuses on care across the lifespan for the person experiencing alterations in health that require acute, chronic, rehabilitative or palliative care (CNA, 2009).

The renewal of license varies by province but is commonly on an annual basis. Most provinces require nurses to have certainly continued competencies for the annual registration renewal. The Code of Ethics and Standards of Practice of the jurisdiction are the basis of continued competency programmes and is the framework used by nurses to reflect on their practice as a way of maintaining their competence throughout their nursing career (CNA, 2010).

Ontario's scope of practice statement indicates that the practice of nursing is the promotion of health and the assessment of the provision of care for, and the treatment of health conditions by supportive, preventive, therapeutic, palliative, and rehabilitative means to attain or maintain optimal function (CNO, 2014). Nova Scotia's definition of practice, contained within the Registered Nurses Association Act of 1985 also addresses health promotion, illness prevention and the provision of care. It defines nursing as "the application of professional nursing knowledge or services for compensation or the purpose of assisting a person to achieve and maintain optimal health through promoting, maintaining and restoring health; preventing illness, injury or disability; caring for the sick and dying; health teaching and health counselling; or coordinating care (CRNNS, 2009).

United Kingdom overview

The assessment of clinical competence has become central to nursing education, which in the UK has moved completely into the higher education sector in the decades (Garside & Nhemachena, 2013). The Nursing and Midwifery Council (NMC) was established under the Nursing and Midwifery Order of 2001 as the successor to the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC) and the four National Boards for Nurses, Midwives and Health Visitors for England, Northern Ireland, Scotland and Wales. In the United Kingdom, it is the responsibility of the NMC to register all nurses, midwives and specialist community public health nurses as well as ensuring proper qualification in terms of competence and readiness to practice. Furthermore, the NMC institutes the standards of proficiency required from the applicants to different parts of the register. These standards are necessary for safety and effectiveness in nursing practice.

As the developers of the proficiency standards, the NMC identifies the comparability between the standards attained by all student nurses and realises that the definition of the scope of professional practice is through the application of these standards to practice within the different nursing environments.

The proficiency standards outline the overarching principles of being able to practice as a nurse and the situation in which these standards are accomplished describes the scope of professional practice. Therefore, applicants for entry to the nurses' part of the register must achieve these standards in their specific areas of specialisation (NMC, 2009).

Ireland: an overview

According to the Nursing and Midwifery Board of Ireland (NMBI), competence is a complex multidimensional phenomenon and is defined as the ability of the registered nurse to practice safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice (NMBI 2015). The board describe the five domains of competencies the registered nurse is expected to possess in preparation for practice. According to the board, the aim is to ensure that the candidate nurse

acquires the skills of critical analysis, problem-solving, decision-making, reflective skills and abilities essential to the art and science of nursing (NMBI, 2015). Safe and effective practice requires a sound underpinning of theoretical knowledge that informs practice and is in turn informed by that practice. Within a complex and changing healthcare environment, it is essential that the best available evidence informs practice.

Assessment strategy

The assessment strategy recognizes the knowledge, expertise and previous experience of the candidate nurse. It acknowledges that the nurse is registered on a professional register of nurses maintained by a nursing regulatory body in another country. In addition, it also takes into account the individualized instructions set out in each nurse's NMBI decision letter, which states the length of the required period of adaptation. The Competence Assessment Tool is designed to allow for a transparent assessment process that is userfriendly. The focus is on facilitating learning opportunities that allow the candidate nurse to develop independent learning skills and the performance criteria of competence associated with lifelong learning and continuing professional development. Evidence (NMBI, 2015)

South Africa: an overview of nursing competence

The practice of Nursing/Midwifery is grounded in standards and ethical values and supported by a system of professional regulation. It is the duty of the nursing profession, through its regulatory bodies or councils, to determine the scope of practice for every level of nursing; to identify desirable standards of practice and competencies; and to bring these to the attention of every nurse. The SANC is a regulatory body authorised by the Nursing Act (33 of 2005). SANC advances and upholds the Scope of Practice, Professional

Standards and Competencies through Section 3 (e) which specifies that the objects of the Council including the maintenance of professional conduct; practice standards

for nurse practitioners as well as professional and ethical standards within the nursing practice. Section 4(1)(l)(i) and (iv) maintain that the Council must determine the scope of practice of nurses and the requirements for any nurse to remain competent in the manner prescribed.

Another regulation of nursing CPD is by the South African Qualifications Authority (SAQA) who registered a unit standard titled 'Take responsibility for own personal and professional development and contribute to the growth of nursing profession (SAQA, 2007). This unit will enable the leaner to function as a clinically focused, service orientated, independent registered professional nurse, who is able to render comprehensive care across all spheres of health (SAQA, 2007).

The health care legislation makes references to promoting a Continuous Professional Development (CPD) program for nurses, as stipulated by the Department of Health (DoH) Nursing Strategy for South Africa 2008. The DoH also indicates that SANC is to regulate CPD program for nurses, with the national and provincial DoH as implementation partners (DoH, 2008). The S.A health care system is being restructured with the National Health Insurance System (NHIS) being introduced which impacts on nursing to change to align to the new system (DoH, 2008).

Regulation of community service programme was introduced and implemented on 01 January 2008. As specified in the Government Gazette Notice No. 765 of 24 August 2007, the purpose of implementing community service was to improve the provision of health care services in South Africa by empowering young professionals to develop their skills base, enhancing their knowledge, while inculcating professional behavioural patterns and critical thinking consistent with professional development (SANC, 2007).

Available competence evaluation tools

The table below depicts the competence evaluation tools per authors:

Table 2: Competence Evaluation Tools per authors (Matlhaba, Pienaar & Sehularo, 2019)

County	Author/s	Sample	Tool Design	Domains & Items

Sweden	Nilsson, Johansson, Egmar, Florin, Leksell, *et al.* (2014)	Both student nurses prior to graduates & Practical nurses	Questionnaire (8- point Linkert scale)	8 Domains with 88 items • Nursing care • Value-based nursing care • Medical/technical care • Teaching/ learning and support • Documentation and information technology • Legislation in nursing and safety planning • Leadership in and development of nursing care • Education and supervision of

				staff/students
Taiwan	Liou & Cheng (2014)	340 2-year RN-to-BSN program	Questionnaire (5- point Linkert scale)	7 Domains with 47 items • Safe care • Professional ethics • Assessment • Critical thinking • Collaboration and communication • Basic nursing routines • Technical skills
Taiwan	Lin, Hsu, Li, Mathews & Haung (2010)	1431 Public health Nurses	Self-assessment questionnaire (4- point Linkert scale)	4 Domains with 38 items • Basic care competency • Community health management competency

				• Teaching competency • Self-development competency
Jordan	Safadi, Jaradeh, Bandak & Froelicher (2010)	258 Jordanian nursing graduates	Questionnaire (5- point Linkert scale)	5 Domains with 27 items Management • Professionalism • Problem-solving • Nursing process • Knowledge of basic nursing principles

Europe	Cowan, Wilson-Barnett, Norma & Murrells (2008)	588 Registered general nurses	Self-assessment questionnaire (4- point Linkert scale)	8 Domains with 108 items • Assessment • Care delivery • Communication
				• Health promotion • Personal and professional development • Professional and ethical practice • Research and development • Teamwork

China	Liu, Kunaiktikul, Senaratana, Tonmukaykul & Erikson (2007)	815 clinical registered nurses	Questionnaire (5- point Linkert scale)	7 Domains with 58 items • Critical thinking and research aptitude • Clinical care • Leadership • Interpersonal relationships • Legal/ethical practice • Professional development • Teaching/ coaching

Conclusion

Despite all the available competencies across the globe, it was found that there is a wide range of concepts used for the description of competencies by each county. However, all the competencies are built up from skills, knowledge, attitudes and values that are the main components in quality care for the patients. The most common descriptions includes, but is not limited to, professional practice, ethics and legal practice, leadership and management, teamwork and collaboration as well as communication competencies. Therefore, there is still a need, specifically in the North West Province of South Africa, for specific competencies for CSNs. Under the rapid growth of economy, rapid advances in the development of nursing science and technology as well as living standards and increasing demand for access to a high quality health care service, CSNs have to maintain and increase their competence to meet the requirements of change. An ongoing clinical competence assessment will allow CSNs to self-monitor, increase nurses' strengths, improve weaknesses, and demonstrate their abilities to maintain a high standard of nursing practices. The results of assessment will be the foundation for the development of clinical competence assessment tool for CSN in the NWP, S.A.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Author contributions

K.L.M. was responsible for finalization of data analysis and writing the manuscript. L.A.S. was responsible for conceptualization and proof reading of the manuscript, A.J.P. made conceptual contributions and finalisation of the whole manuscript.

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Manuscript Six

Manuscript six:

Development and validation of a clinical competence evaluation tool (CCET) for community service nurses in North West Province, South Africa (To be submitted to *Health SA Gesondheid).*

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Development and validation of a clinical competence evaluation tool for community service nurses in North West Province, South Africa

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Abstract

Introduction: Community service is an initiative for newly qualified South African professional nurses who plan to register for the first time as a professional nurse in terms of the Act, after meeting the prescribed requirements to qualify.. It is a national requirement that newly qualified nurses perform remunerated community service for a period of one year before registration as professional nurses. However, since the introduction of this initiative in 2008, little has been done to evaluate their clinical competence during the 12-months as community service nurses. It therefore became of paramount importance for the researcher to establish some method of evaluating the community service nurses' clinical competence during their compulsary service, hence the need to develop and validate a clinical competency evaluation tool for the North West Province of South Africa.

Aim: The aim of this study was to develop and validate a clinical competence evaluation tool for community service nurses in North West Province, South Africa.

Methodology: The tool was developed following the LoBiondo-Wood and Haber's four steps of tool development. Ten (10) experts participated in the validation process resulting in the content validity index and the content validity ratio, which was established to measure validity of the tool. The tool was piloted at one of the public hospitals in the NWP where the study was conducted, and eleven (11) out of thirteen (13) CSNs participated in this process. SPSS version 25 was employed and the reliability of the tool was measured using Cronbach's alpha.

Results: This newly developed tool's CVI has exceeded 0.80 and is indicated at 0.98, which reflects excellent content validity. The higher the CVR score the greater the agreement amongst the experts. The Cronbach's alpha coefficients in the six (6) competencies are all greater than 0.7 implying that the tool developed in this study is reliable. All the experts indicated that the tool is clear, simple, general, accessible and important.

Conclusion: This was the first tool to be developed for evaluating clinical competence of community service nurses in North West Province of South Africa. The tool was piloted for reliability and validity using expert validation and Cronbach's alpha respectively to enhance the accuracy of its evaluation.

Key words: clinical competence, competence, community service, community service nurses, evaluation tool, experts, newly qualified nurse, tool development, validation.

Introduction and background

Clinical competence of nurses and midwives has been priority for the profession's regulatory bodies worldwide. The South African Nursing Council (SANC) stipulates under their Nursing Act (33 of 2005), that the mission of SANC is to "safeguard the health and well-being of the public by ensuring that nurses and midwives keep their skills and knowledge up to date, and uphold the standards of their professional code". Further SANC states that "nurses who acquire the knowledge, skills and behaviours that meet our standards will be equipped to meet these present and future challenges, improve health and wellbeing and drive up standards and quality, working in a range of roles including practitioner, educator, leader and researcher" (SANC, 2005). Therefore, newly qualified nurses are assisted to make the transition through to the working environment. During this transition phase, they are expected to become competent practitioners ready to meet the real-life challenges of the health care system.

In South Africa, since 2008 it is mandatory for nurses who have qualified as a Nurse (General, Psychiatric and Community) and Midwife leading to registration in Government Gazette Notice No R425 of 22 February 1985 to undergo a 12-months' community service before they can be registered as professional nurses. During this community service period, community service nurses (CSNs) are allocated to different public healthcare facilities. However, since the inception of this community service, little has be done to evaluate their clinical competence as despite it being expected of them to be competent practitioners when resuming their duties as professional nurses. It was therefore of paramount importance for the researcher for the researcher to establish some method of evaluating their clinical competence during their compulsory service, hence the need to develop and validate a clinical competency evaluation tool.

From the literature it can be established that several clinical competence evaluation tools already exist including those of Nilsson *et al.,* (2014); Liou and Cheng (2014); Lin, Hsu, Li, Mathews and Haung (2010); Safadi *et al.,* (2010); Cowan *et al.,* (2008) & Liu *et al.,* (2007). However, also established from the literature, there are no clinical competence evaluation tools specifically developed for CSNs in South Africa

(SA), particularly for those in the North West province (NWP). The lack of an evaluation tool for clinical competence of CSNs in the NWP prompted the researcher to develop a tool of this nature.

Competence is regarded as the “ability to perform a work-role to a defined standard with reference to real working environments that ideally includes a person’s ability to demonstrate their cognitive knowledge, skills, behaviours and attitudes in any given situation” (Franklin & Melville, 2015:26). Hickey (2010:36) describes clinical competence as the “theoretical and clinical knowledge used in the practice of nursing, incorporating the psychomotor skills and problem-solving ability with the goal of safely providing care for health care users”. Benner (1984) emphasised that as nurses’ progress through various levels of ability their clinical competence develops over time. It is noteworthy to mention that this research focuses predominantly on clinical competence of CSNs. Therefore, for the purpose of this research, clinical competence is considered the abilities of the CSNs to “work competently in providing quality nursing care to the patient under their care during community service period” (Matlhaba et al., 2019).

Aim

The aim of this study was to develop and validate a clinical competence evaluation tool for CSNs in North West Province, South Africa.

Materials and methods

Materials and methods used to develop and validate a clinical competence evaluation tool for CSNs are discussed below:

Population and sample

Burns and Grove (2009:42) define a population as “all the components, including characters, objects or elements that meet certain criteria for inclusion in a particular world”. Similarly, Brink *et al.,* (2012:131) and Polit and Beck (2012:738) agree that a “collection of objects, events or individuals” with the same mutual “characteristics that the researcher is interested in studying” or the “aggregate of all cases that conform to some designed set of specifications”. A sample then is a portion of the target population selected to participate in the research study (Brink *et al.,* 2012:131). The population for this section of the study was experts in the nursing education and practice as well as the CSNs who were engaged with their community service during data collection.

Sampling methods, demarcation and description of the sample

Sampling of experts

In this study, ten (10) experts participated in the validation of the tool. Experts were selected from different provinces of South Africa including North West, Gauteng, Limpopo and Kwa-Zulu Natal from nursing education institutions (NEIs) and nursing practice as well as from labour movements and governance. These experts were purposively identified because they are registered with the South African Nursing Council (SANC) as professional nurses. They are considered nurse leaders in their different nursing fields and labour unions/federations. They are also both directly and indirectly involved in nursing education, training and practice. Their areas of expertise include hospitals; higher education institutions; nursing colleges; nursing governance; government; and labour movements. Ten of these experts were invited to participate in this research; they were initially contacted telephonically and via social media (Facebook messenger), where upon they provided the researcher with their email addresses to which a formal letter of request was sent and positive responses were then received.

Sampling of CSNs

Eleven (11) CSNs from one regional level 2 hospital participated in the pilot study. The researcher used a cluster sampling method to select participants for the pilot study. This method of sampling is used when the elements of a population are spread over a wide geographical area (Satake, 2015:422). According to De Vos *et al.,* (2011:230), one advantage of cluster sampling is when there are economic considerations, which was of relevant consideration for this study. The CSNs were performing community service across all the four regions of the province, which was considered an obstacle for the researcher (Babbie 2015:212). Therefore, the participants used in this study were placed in one of the selected hospitals for more than six (6) months for their community service. Participants were given the tool to complete and return after a week. Initially, 13 tools were provided, however, eleven (11) of the (13) tools were received back. The returned and completed tools were forwarded to the statistician for results analysis.

Ethical considerations

Approval for this study was first obtained from the scientific committee of the School of Nursing Science (SONS), Faculty of Agriculture, Science and Technology (FAST) “Health Science Ethics Committee” (HSEC) of the North-West University. The fundamental ethical principles as stipulated by Brink *et al.,* (2012:34) were ensured as fully described in Section Two.

Development process of the tool

The tool development process followed the four steps on tool development described by LoBiondo-Wood and Haber (2010). Figure 1 below depicts the steps described:

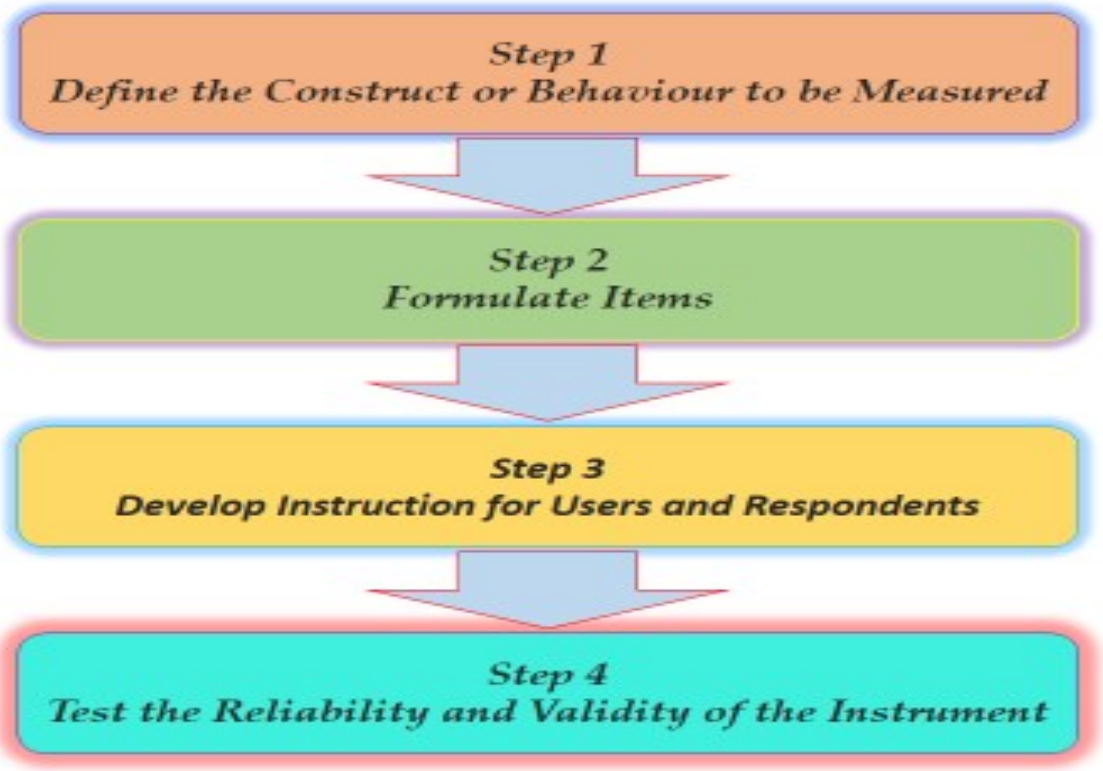

Figure 1: Research instrument development process (LoBiondo-Wood & Haber, 2010:208)

In Step 1, the empirical phase, construct or behaviour to be measured was defined as being the clinical competence of CSNs during their community service in the NWP. This was established during the qualitative phase via multiple stages, namely:

(1) focus group discussions using semi-structured questions to explore and describe perceptions of PNs concerning the clinical competence of CSNs during community service;

(2) focus group discussions using semi-structured questions to explore and describe the experiences of CSNs during their placement,

(3) a World café methodology was applied to engage in a preliminary development phase, noting where the domains emerged from the PNs' perceptions about the clinical competence of CSNs during their community service;

(4) A complete literature study to explore the legislation, regulation and polices governing community service for the nurses was carried out,

(5) a desk review on available clinical competence evaluation tools for newly qualified nurses was performed.

It is during such multiple stages that the internal validity of the qualitative phase was ensured through crystallisation. Crystallisation being when several investigators, sources and methods are used to compare the results with one another (Maree, 2016).

In Step 2, a 47-item self-assessment instrument developed in Iran by Liou and Cheng (2014) was identified from the desk review as a suitable baseline tool to be adjusted to formulate competencies, domains and items for the current tool. Written permission was obtained from Liou and Cheng (2014) to utilise their 47-item self-assessment instrument (Annexure A).

In Step 3, instructions on how to utilise the tool was developed for the users, with the instructions being briefly discussed below. In this development phase, instructions were included on how the tool should be completed, for example, how the five sections of the tool were to be completed by the particular individuals involved, including, the CSNs, the peer and the mentor.

In Step 4, the validation phase, the developed tool was tested for reliability and validity.

The tool was validated for face, content and construct validity through expert validation (Polit & Beck, 2012: 336). Furthermore, this tool was evaluated and validated following the approach suggested by Streiner and Norman (2005, whose process involves the five stages, namely:

1) Preliminary conceptual decisions.

2) Item generation.

3) Evaluation of face validity.

4) Field trails to evaluate consistency and construct validity.

5) Generation of the refined tool.

Results

The clinical competence evaluation tool developed in this study is comprised of the following main competencies: legal practice, ethics and professional practice, operational (unit) management and leadership, contextual clinical and technical competence, therapeutic environment and quality nursing care. The competencies typically focus on the general qualities of a competent CSN in preparation for registration as a professional nurse as required by the SANC Regulation 765. The rating scale of this tool adapted the novice to expert model of skill acquisition (Benner, 1984). This developed tool consists of 6 competencies, 17 domains and 144 items. Each item will be rated on a five-point Likert scale, which will be representative of the CSNs' level of competence.

The figure below depicts the CSNs' clinical competence evaluation tool (CCET) (Annexure A) including competencies.

Figure 2: CSNs' Clinical competence evaluation tool (Matlhaba, Pienaar & Sehularo, 2019)

Instructions for evaluating clinical competence of CSNs

It is expected from the CSNs to demonstrate the skills, knowledge and attitude to perform against all the competencies, domains and items of this evaluation tool. This evaluation tool consist of three sections, namely: self-evaluation, peer-evaluation and mentorship evaluation.

According to Burgess, van Diggele and Mellis (2018), mentorship is a process in which a knowledgeable and experienced person known as mentor provides and equips an inexperienced person, known as a mentee, with essential skills for professional growth and development. Oduro-Arhin (2018) defined mentorship as collaboration between an inexperienced (mentee) and experienced person (mentor) to uncover and ensure acquisition of capabilities by mentees. Furthermore, this collaboration is aimed at supporting mentees towards professional success (Oduro-

Arhin, 2018). According to Nowell *et al.,* (2017), mentorship is an empowering relationship of associates in which they share knowledge that include learning from one another and importantly, there is mutual respect. Furthermore, mentorship is defined by Tiew *et al.,* (2017) as a relationship between a knowledgeable mentor and inexperienced mentees. This relationship is aimed at providing the mentee with support towards professional and personal development (Tiew *et al*., 2017). As WHO (2005) pointed out, clinical mentorship is a systematic practical training and consultation process intended to foster ongoing professional development. Peretomode and Ikoya, (2019) in their study, concluded that mentorship is an essential system for guidance and professional development. Therefore, in this study, a mentor would be able to evaluate the clinical competence of CSNs during placement in the NWP.

According to Di Paola and Wagner (2018), evaluation is a formal process used to pass judgement on the quality of the individuals' performance. Subsequently, Stufflebeam (2000) stressed that evaluation is a dynamic and a key instrument used for accountability, the user's well-being and improvement. At the same time, evaluation is referred to by the Merriam-Webster online dictionary as "determination of the value, nature, character, or quality of something or someone" (https://www.merriam-webster.com/dictionary/evaluate, 2019**)**. Pivotally, Twersky and Lindblom (2012) define evaluation as a vital independent systematic investigation into how, why and to what level objectives are attained in a specific context. Vedung (2017) also asserts that, evaluation is the process of differentiating the worth or value of an object from the worthless. It is noteworthy to mention that evaluation is a process of conducting research and evaluation is perceived as an essential instrument for development (Furubo & Vestman, 2019).

However, for the purpose of this research, evaluation refers to the process whereby the CSN evaluates themselves, and then are evaluated by their peers and mentor.

- **Self – evaluation:** Evaluation of self against each of the competencies, domains and items using the provided rating scale (See Table 1) (Sokhan, Haghighi, Bagheri & Ebrahimi, 2011:1848). Therefore in this tool the CSN is expected to evaluate themselves against the competencies and provide an

honest response that can be verified through assessment as in section B and C of the tool;

- **Peer – evaluation:** Discuss the tool and share the instructions with your peers and request to be evaluated against all the competencies, domains and items using the rating scale provided (See Table 2). A peer is any CSNs or colleague with whom you have worked with in a particular unit. Compare their peer-evaluation results with those of your self-evaluation (Sokhan *et al.,* 2011)
- **Mentor – evaluation:** Discuss the tool and share the instructions with your mentor and request to be evaluated against all the competencies, domains and items using the rating scale provided (See Table 2). A mentor is any experienced practitioner registered with SANC as a professional nurse who has more than 2 years of experience, and who is working closely with the CSN on a daily basis in a particular unit (Mhlaba, 2011).

According to Benner (1984), the competence evaluation should reflect the performance level of individual nurses, thus Benner's (1984) level of competence underpinned this evaluation tool. Therefore, with this tool, the users will be able to evaluate themselves or be evaluated by their peers or mentors using the rating scale of 1 – 5, which represents novice, advanced beginner, competent, proficient and expert. The table below depicts the levels of competence described by Benner (1984). Additional literature brought in to enrich Benner's description came from Liou and Cheng (2014) and Madale *et al.,* (2016).

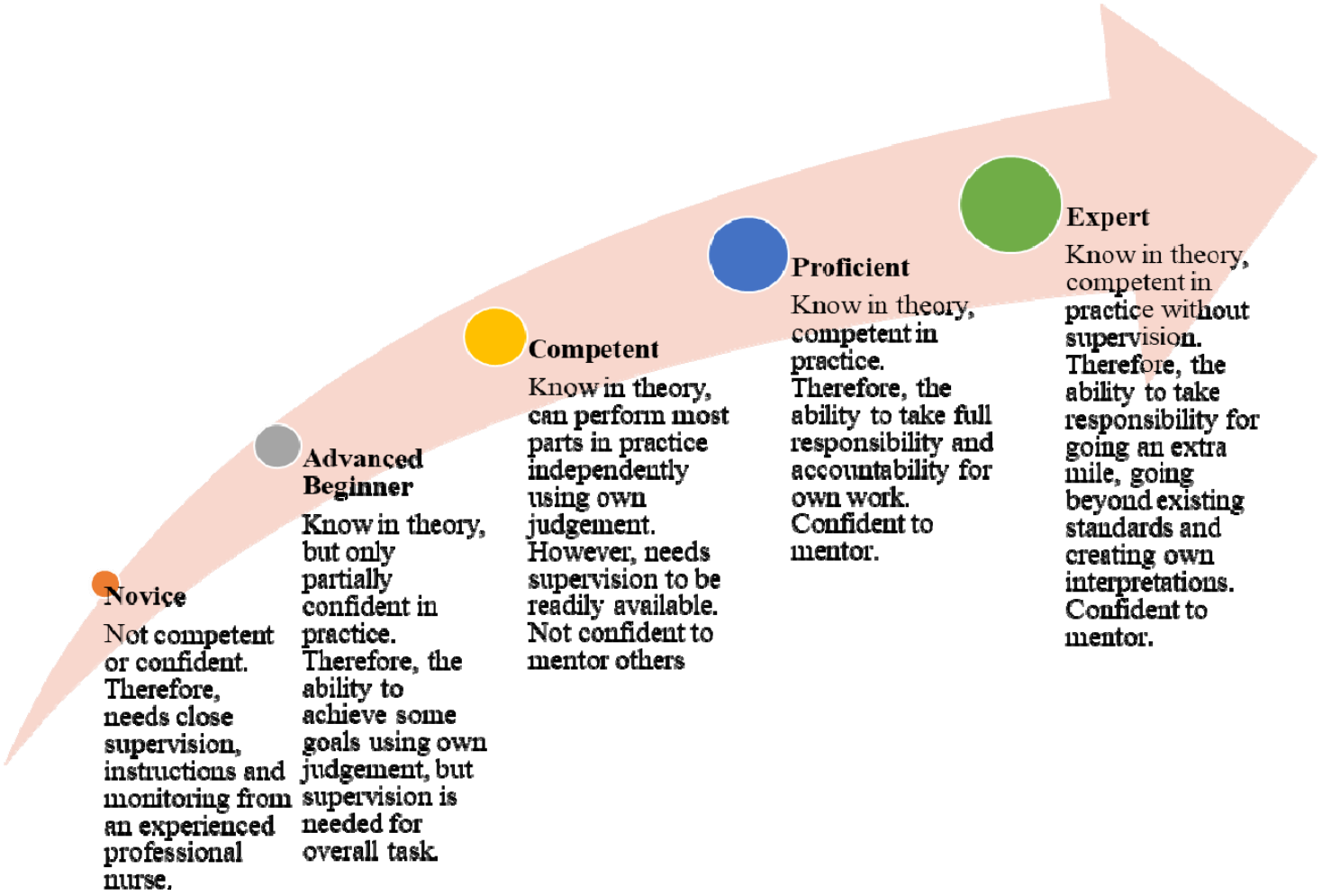

Figure 3: Rating scale for CSNs (adapted from Benner 1984; Liou & Cheng, 2014; Madale et al., 2016)

Table 1: Competencies and descriptors (Matlhaba, Pienaar & Sehularo, 2019)

Competencies	**At the end of his/her educational programme the community service nurse should be able to:**
1. Legal practice	☐ Identify and address legal issues based on critical reflection on the suitability of the different legal systems of the nursing and midwifery practice within the legal framework.
2. Ethics and Professional Practice	☐ Identify and address ethical and moral issues based on critical reflection on the suitability of different ethical value systems of the nursing and midwifery practice within the ethical and moral framework.
3. Operational Management (Unit) and Leadership	☐ Manage the unit from shift inception (taking over) to shift ending (handing over).
4. Contextual clinical and technical competence	☐ Provide holistic nursing care in different disciplines such as Medical/Surgical; Midwifery and Mental Health and within a Community Nursing or Public health setting.
5. Therapeutic environment	☐ Create and promote a safe and clean environment for the health care user under her/ his care.

6. Quality nursing care	☐ Provide comprehensive/excellent nursing care for the health care user, family and the community at large.

Presentation, interpretation and analysis of the results

Analysis of the results is presented in two sections, namely: 1) analysis from the validation process and 2) analysis from the reliability test process. This tool was developed following the four steps on instrument development described by LoBiondo-Wood and Haber (2010). Furthermore, the tool was validated and tested for reliability using experts' validation by applying the CVI and CVR processes as well as the Cronbach's Alpha using the SPSS version 25 programme. The validity and reliability testing of this tool showed statistical significant results as displayed below in this section. Therefore, the following discussion confirms the validity and reliability of this developed clinical competence evaluation tool (CCET). For validity, experts were requested to complete the form with experts' instructions (Annexure B11). The discussion below was based on the results from the experts.

Analysis from the validation process

The tool was found to be understandable, easy to complete and most likely to be used by the experts. Experts also found that the tool was appropriate and will contribute to the professional development of the CSNs in preparation of their roles as professional nurses after completion of the community service. Except for the statistical evidence, some experts also qualified their scoring by adding remarks at the end as stated below:

"I found the tool being sufficient enough to guide, assess and assist in building and grooming the future nurses to become those that the profession can be proud of. Essentials are vital and I have found them to be enough and non-complicated" (Expert 5, female, age above 45, PhD, Government).

"The tool is very relevant and displays the competencies needed after completion of the community service (Expert 1, female, age 31-35, PhD, University).

Adding to the following some experts suggested that the evaluation intervals should be done on a quarterly basis. This is what they indicated:

"The evaluation of community service nurse practitioner within a week of commencement of community service appears too soon. One would recommend that the evaluation be done on a quarterly basis (every three months)" (expert 7, age above 45, PhD, Government)

"CSN to be evaluated for competency on quarterly basis, preferably after every 3 months because one can only be partially competent with practice, CSN have little exposure, if not none, to management of the unit or to the ordering of ward equipment such as drugs, dry/wet dispensary, stationery, etc." (Expert 10, female, age above 45, Masters, College).

Even though all of the experts rated the tool as essential and useful, some experts expressed their concern regarding its length. Below is the evidence from experts' feedback:

"The tool is quite long and has the potential of not being fully completed.

The layout of the tool might be the reason why it looks quite long"
(Expert 2, female, age above 45, Masters, University).

"The tool is comprehensive but once used you might find areas will need amendment. In some instances, nurses might object to the length of it"
(Expert 3, female, age above 45, PhD, Governance)".

However, whilst not dismissing the comments above, Benner (1984) cited in (Peate, 2016:111) states that practice is within a prolonged period and a novice is unable to use flexible judgement. Based on the abovementioned statement, it can therefore be deduced that CSNs cannot be expected to be completely competent immediately after commencement of the community service, as they have no experience in many of the situations in which they are expected to perform. CSNs might lack confidence to demonstrate safe nursing practice and require continual verbal and physical cues (Peate, 2016:111). Therefore, several meetings with the mentor according to the CCET could improve the level of confidence and competence of the CSNs, who will be preparing themselves for a professional nurse's role after completion of the 12-months period.

The other concern raised by some experts is that the tool is evaluating clinical competence of CSNs in all disciplines, whereas some CSNs are not placed in those disciplines during their community service. This statement was supported by the results of objective 1 and 2 of this study, where some CSNs and PNs mentioned the challenges or discrepancies with CSNs' allocations in the facilities (Matlhaba *et al.,* 2019). However, the researcher envisions that in the near future, specific CCETs can be developed where the focus will be on specific disciplines such as mental-health nursing and Maternal and Neonatal care. Responding to the comments, it is common cause that the CSN qualifies in all disciplines (R425); therefore the baseline assessment should be done in all disciplines.

Discussion from the content validity index (CVI) and content validity ratio (CVR)

Validity is the degree to which an instrument measures what it is supposed to be measuring (Polit & Beck, 2008:471). Content validity refers to the sampling adequacy of items for the construct that is being measured (Polit & Beck, 2008: 471). The researcher used the CVI and CVR to measure validity.

The results of this study show that the content validity of the CCET for CSNs is high as the CVI values of this tool exceed 0.70. However, Davis (1992) in (Polit & Beck, 2008:459) suggests that a CVI exceeding 0.80 is preferred. This tool's CVI has exceeded 0.80 being at 0.98, which reflects that it has exceptional content validity. This higher CVR score indicates greater agreement amongst panel members (Gilbert & Prion, 2016:531). See Tables 2-4:

Tables 2-4 below depicts the demographics of experts, results of overall content validity of the CCET and results of content validity of the CCET for each domain respectively.

Table 2: Demographic characteristics of experts (Matlhaba, Pienaar & Sehularo, 2019)

Demographic characteristics of experts					
Expert number	**Age Group**	**Gender**	**Qualification**	**Work experience**	**Area of Specialty**
Expert 1	31-35	Female	PhD	10-20	Academic (University)
Expert 2	Above 45	Female	Masters	Above 30 years	Academic (University)
Expert 3	Above 45	Female	PhD	Above 30 years	Governance (SANC)
Expert 4	Below 30	Male	Degree	Less than 10 years	Government (Hospital)
Expert 5	Above 45	Female	Masters	21-30 years	Government (Hospital)

Expert 6	Above 45	Female	PhD	Above 30 years	Government (LDoH)
Expert 7	Above 45	Male	PhD	Above 30 years	Government (NWDoH)
Expert 8	Above 45	Male	Masters	21-30 years	Labour movement
Expert 9	Above 45	Female	PhD	Above 30 years	Professional Association
Expert 10	Above 45	Female	Masters	21-30	Academic (College)

From the above table, this study complied with the suggestions by Gilbert and Prion (2016:530) on sampling of experts. According to Gilbert and Prion (2016:530), the content evaluation panel should be composed of persons who are experts in the domain being studied. Ideally, there should be a range of experts (also known as subject matter experts) on this panel at various professional levels. In content areas where it is difficult to find experts, the use of three experts is acceptable; normally, a panel of 5-10 experts is preferred (Gilbert & Prion, 2016:530).

In this study, the table below personifies the results of content validity of the CCET for each domain.

Table 3: Results of content validity of the Clinical Competence Evaluation Tool for each domain (Matlhaba, Pienaar & Sehularo, 2019)

CVI is CVI = (Ne – N/2)/(N/2) where: **Ne is the number of experts identifying an item as "essential" and** **N is the total number of experts (N/2 is half the total number of experts).**					
Domain	**Essential or Useful Domains (*n*)**	**Not Necessary Domains (*n*)**	**Unrated domains**	**Total number of Experts**	**Essential or Useful Domains (CVR)**
Domain 1	10	0	0	10	1
Domain 2	10	0	0	10	1
Domain 3	10	0	0	10	1
Domain 4	10	0	0	10	1

Domain 5	10	0	0	10	1
Domain 6	10	0	0	10	1
Domain 7	10	0	0	10	1
Domain 8	10	0	0	10	1
Domain 9	10	0	0	10	1
Domain 10	9	1	0	10	0.8
Domain 11	10	0	0	10	1
Domain 12	10	0	0	10	1
Domain 13	10	0	0	10	1
Domain 14	10	0	0	10	1

Domain 15	10	0	0	10	1
Domain 16	10	0	0	10	1
Domain 17	10	0	0	10	1
Content Validity Index (CVI): 0.98					

The table above presents the results from the CVI. As mentioned previously, each of the experts was supplied with the CCET (Table 2) and the instruction form (Annexure B11). Each expert was asked to rate each of the items as ‘‘essential,’’ ‘‘useful,’’ or ‘‘not necessary.’’ (Section 1).

Table 4: Results of overall content validity of the Clinical Competence Evaluation Tool (Matlhaba, Pienaar & Sehularo, 2019)

CVR is CVR = (Ne – N/2)/(N/2) where: **Ne is the number of experts identifying an item as "essential" and** **N is the total number of experts (N/2 is half the total number of experts).**					
CCET	**Rated tool as Essential or Useful**	**Rated tool as Not Necessary**	**Unrated tool**	**Total number of Experts**	**Essential or Useful Domains (CVR%)**
CCET	10	0	0	10	1
Content Validity Ration of overall tool: 1					

The table above presents the results from the CVR. As part of the instructions to the experts, each of the experts was supplied with the CCET (Table 2) and the instruction form (Annexure B11). Each expert was asked to rate each of the items in the tool as "Very likely to be utilised, "somewhat likely to be utilised, "likely to be utilised and "unlikely to be utilised" (Section 2).

Gilbert and Prion (2016:530) suggest that when all the experts say that the tested skill is ''essential,'' or when none of the experts says the skill is ''essential,'' the researcher can be confident to include or delete the particular item. It is when there is no consensus amongst the experts that item issues arise. The authors further suggest that two assumptions are made, each of which are consistent with established psychophysical principles:

- Any item, performance which is perceived to be ‘‘essential’’ by more than half of the experts, has some degree of content validity.
- The more experts (beyond 50%), perceiving an item as “essential”, the greater the extent of its content validity (Gilbert & Prion, 2016:531).

Lawshe (1975) cited in Ayre and Scally, (2014) suggested that CVR values range between −1 (perfect disagreement) and +1 (perfect agreement) with CVR values above zero indicating that over half of panel members agree an item is essential. Therefore, in this study, all 10 of the experts rated the tool essential and useful, likely and very likely to be used, hence the CVR value for this tool is 1, which indicates perfect agreement between the experts. No items were deleted from the tool.

Analysis of results from reliability testing process

This developed tool was tested for its reliability for the evaluation of clinical competence of CSNs during their community service placement. The results were established from a sample size of 11 participants.

Section A: Demographic information

Sample size: N = 11 participants.

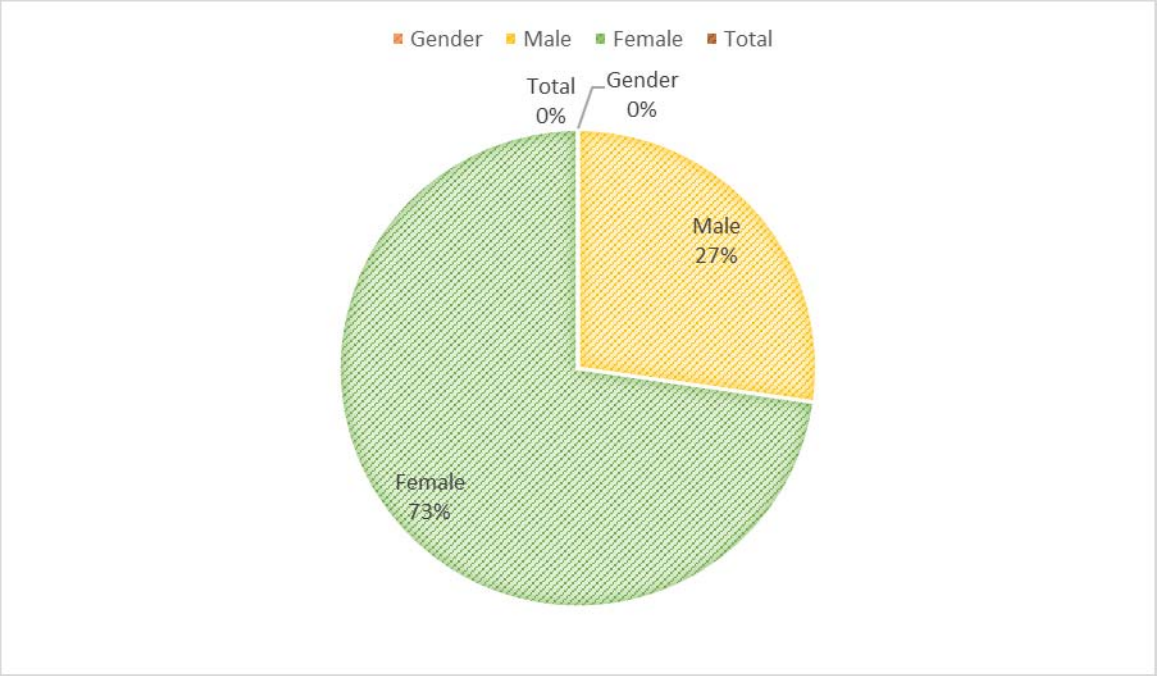

Figure 4: Gender (Matlhaba, Pienaar & Sehularo, 2019)

The above figure shows that the majority of the participants are females (8 = 72.7%) and a third of the participants are males (3 = 27.3%). The demarcation is an indication that more females feature in the nursing profession. This reflection concurs with the results of the study conducted by Ogunyewo *et al.,* (2015) in Nigeria. The study reported that 83.33% of participants who chose nursing as a career were female, furthermore, 91.25% of participants agreed that nursing is primarily for women (Ogunyewo et *al.,* 2015). Supporting the above-mentioned notion, Zamanzadeh et *al.,* (2013) stated that men due to male gender characteristics and existing public image do not often consider nursing as a career choice. According to Evans and Frank, (2003) and O' Lynn (2004) cited in Zamanzadeh *et al.,* (2013), the feminine nature of nursing has been so prevalent, that the caring image of the profession has been used to symbolize the epitome of femininity (Evans & Frank, 2003). O' Lynn, (2004) ascertains that one of the major obstacles that may discourage men to enter the nursing profession is the traditional female image. Therefore, nursing is regarded as a feminine profession around the globe. In addition, the SANC in the Nursing Act (33 of 2005) asserts that there are more female than male nurses in their annual statistical records.

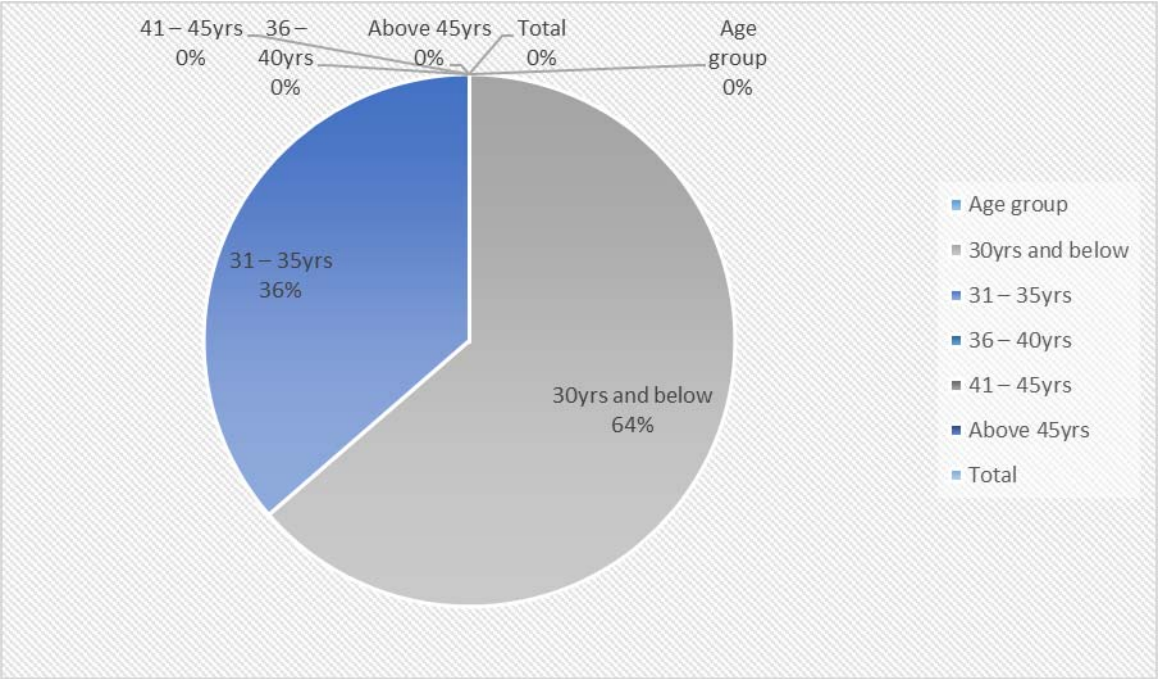

Figure 5: Age group (Matlhaba, Pienaar & Sehularo, 2019)

The figure above shows that the majority of the participants are 30 years old and below, which could be a clear indication that those admitted to the 4-year nursing training programs are amongst the youth. It could also be a reflection that nursing is perceived to be attractive to school leavers. This notion is supported by existing literature on the perceptions on nursing as a career of choice. The results of the studies conducted by Mohamed and El-Sayed (2013) in Egypt and Rajasree (2016) in Saudi Arabia reveal that 89.39% and 85.5% of participants respectively had positive perceptions of nursing as a career. In the study conducted by Ogunyewo *et al.,* (2015) in Nigeria, 46.25% of participants were willing to consider nursing in the future.

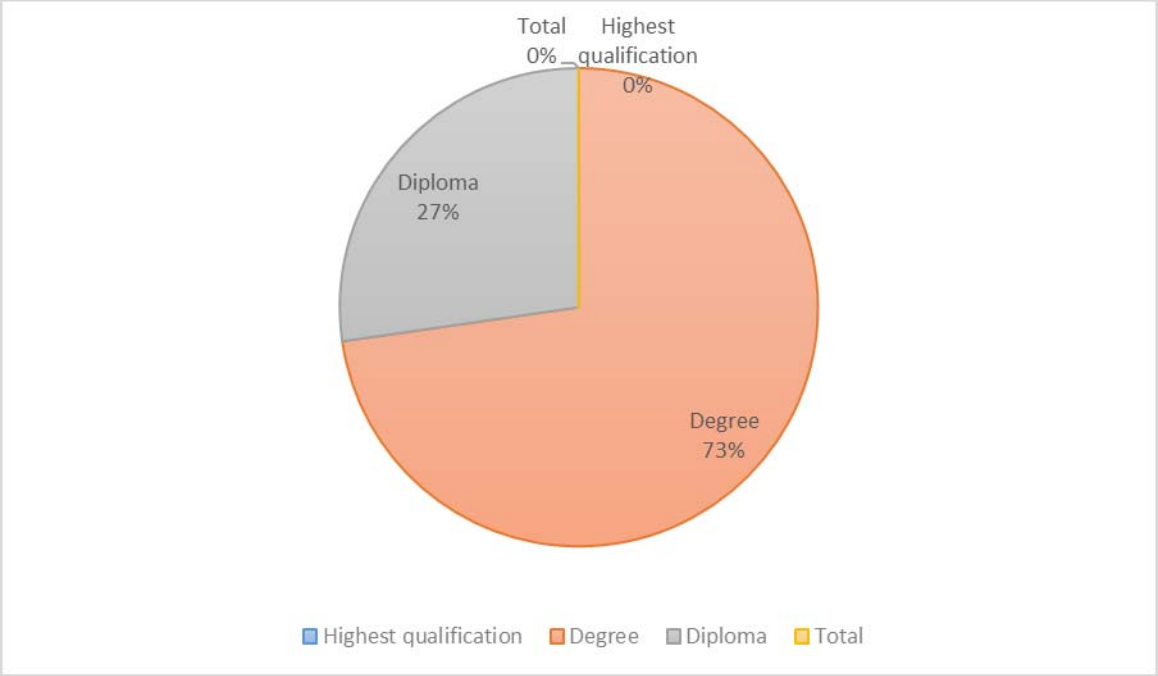

Figure 6: Highest educational qualification obtained (Matlhaba, Pienaar & Sehularo, 2019)

The figure above shows that only a third of the participants are diploma holders. The difference in the participants' percentage in this study can be attributed to the fact that there is an increase in public recognition of degree-qualified nurses rather than diploma qualified nurses. This is seen in many countries including Canada, Australia, New Zealand, Norway, Spain, and others where a bachelor's degree is a requirement for entry into professional nursing (Aiken *et al.,* 2014). However, in South Africa there is currently no differentiation between degree-qualified and diploma-qualified nurses in the clinical practice (Roets *et al.*, 2016). The duration of both the degree and diploma programmes is four years. On completion of the 4-year training, both the degree and diploma graduates nurse will be registered with SANC as a general, community health and psychiatric nurse and midwife after completion of their 12-months community service.

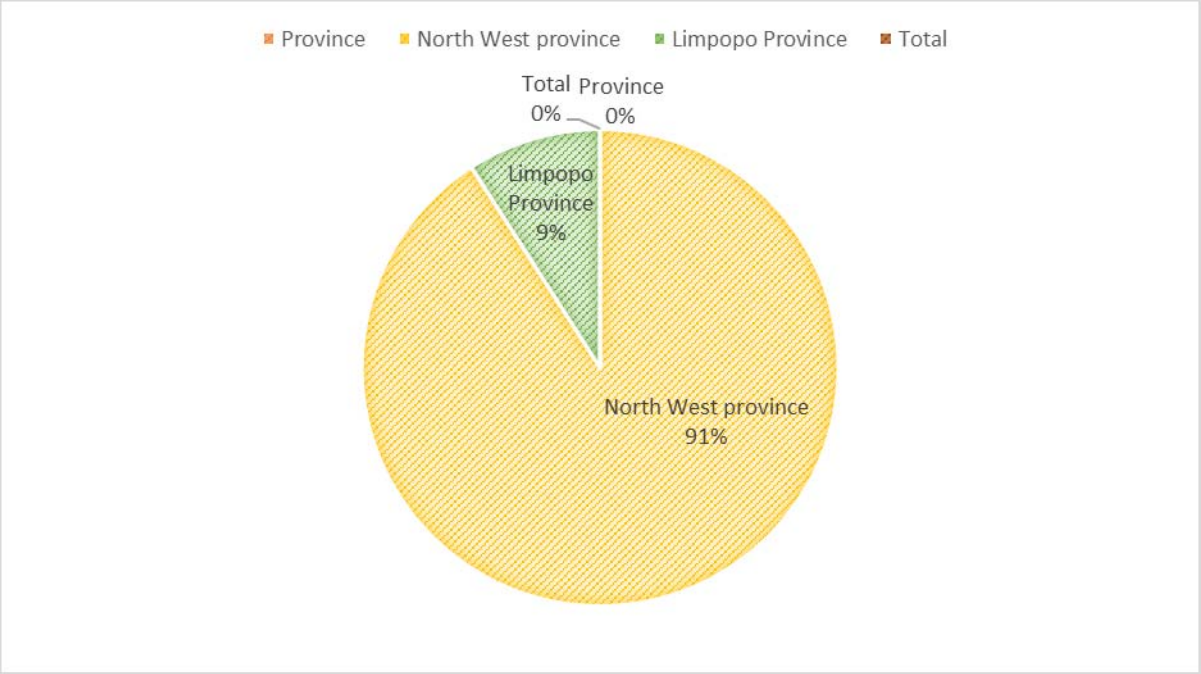

Figure 7: Province of training (Matlhaba, Pienaar & Sehularo, 2019)

From the results, 1 out of the 11 participants completed nursing training in Limpopo province. The allocation of this participant in the NWP it is due to the fact that CSNs can be assigned anywhere across the country, and not automatically in their province of training.

Section B: Reliability analysis

Cronbach's alpha(α) reliability coefficient whose numerical value ranges from 0 to 1, measures the reliability (or internal consistency) of a questionnaire (or survey) consisting of Likert-type scales and items. A high value (close to 1) for Cronbach's alpha reliability coefficient indicates good internal consistency of the items in the scale.

Table 5: Reliability analysis (Matlhaba, Pienaar & Sehularo, 2019)

Subscale (Competencies)	**Cronbach's Alpha (α)**	**No. of Items**	**Internal consistency**
Legal practice	0.919	15	Excellent
Ethics and professional practice	0.900	14	Excellent
Operational (Unit) Management and leadership	0.901	19	Excellent
Contextual clinical & technical competence	0.963	81	Excellent
Therapeutic environment	0.892	9	Good
Quality nursing care	0.808	6	Good
Total	0.971	144	Excellent

The Cronbach's alpha coefficients in Table 6 are all greater than 0.7, and this implies that the questionnaire used for this study was proven to be reliable. It therefore indicates that the variables cited above are appropriate for exploratory factor analysis (EFA). EFA refers to a factor analysis undertaken to explore the underlying dimensionality of a set of variables (Polit & Beck, 2012:727). It further confirms that similar results would always be produced for repeated study elsewhere. Hancock *et al. (*2010:105) confirms that if variable are reliable, results will be consistence.

Section C: Descriptive Statistics (Competencies)

Table 6: Legal Practice (Matlhaba, Pienaar & Sehularo, 2019)

Scale: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert	**N**	**Mean**	**Standard Deviation**
Legal Practice			
The Constitution of the Republic of South Africa (RSA), 1996 (Act 108 of 1996)	11	3.82	0.98
SANC Nursing Act, No.33 of 2005	11	3.82	0.87
National Health Act, No 61 of 2003	11	3.55	0.82
Mental Health Care Act No 17 of 2002	11	3.27	1.27
SANC Regulations related to performance of Community Service (R. 765)	11	3.73	0.90
SANC Regulations setting out Acts or Omissions (R. 767)	11	3.73	1.01
SANC Regulations relating to the conducting of inquiries into alleged unfitness to practice due to disability or impairment of persons registered in terms of the Nursing Act, 2005 (R. 619)	11	3.27	0.79

SANC Regulations relating to the institution and conduct of enquiries into alleged unprofessional conduct of persons registered in terms of the Nursing Act, 2005 (R. 1051)	10	3.10	0.99
Policy of Community Service for Health Professionals 1997	10	3.30	0.67
Adhering to Batho-pele principles	11	4.09	0.83
Respecting Health care users' Rights Charter	10	4.20	0.92
General Regulations made in terms of the Medicines and Related Substances Act, 1965	10	3.60	1.17
Medicines and Related Substances Amendment Act, No 72 of 2008	10	3.20	0.92
Regulations relating to the keeping, supply, administering or prescribing of medicines (R. 1044)	11	3.64	0.92
Regulations relating to blood and blood products – (R. 179)	11	3.73	1.19
OVERALL MEAN (RATING)		3.60	

The overall mean for legal practice was established to be 3.60. The information above reflects that the participants were competent in matters that relate to their legal mandates with reference adherence of legal standards applicable to the nursing profession.

Table 7: Ethics and Professional Practice (Matlhaba, Pienaar & Sehularo, 2019)

Scale: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert	**N**	**Mean**	**Standard Deviation**
Ethics and Professional Practice			
Professionalism and Advocacy for healthcare users	11	3.91	0.83
Maintaining appropriate appearance, attire and conduct	11	4.00	0.77
Healthcare user's advocacy (support to get the best care from all healthcare providers in the team)	11	3.82	0.98
Time management/ Punctuality	11	3.91	0.70
Demonstrating cultural awareness	11	3.64	0.81
Respecting healthcare user's cultural diversity	11	3.82	0.75
Respect the healthcare users cultural requests (nondestructive) in all facets of care	11	4.00	0.89
Respect towards healthcare users and their families	11	4.55	0.69
Respect towards colleagues and other stakeholders	11	4.55	0.82
Professional attitudes towards the nursing profession, e.g. protocol and public conduct	11	4.45	0.69
Good interpersonal relation; good intrapersonal	11	4.36	0.67
relations)			

Responsible and accountable to self-actions	11	4.36	0.67
Ability to accept constructive criticism	11	4.45	0.69
Ability to work independently	11	4.00	0.63
OVERALL MEAN (RATING)		4.13	

The overall mean rating for ethics and professional practice is 4.13 and is a reflection that the participants where proficient in their adherence to ethical and professional conduct of the nursing profession.

Table 8: Operational (Unit) Management and Leadership (Matlhaba, Pienaar & Sehularo, 2019)

Scale: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert	**N**	**Mean**	**Standard Deviation**
Operational (Unit) Management and Leadership			
Developing demonstrations/ in-service trainings in the unit	11	3.91	0.83
Mentoring maximizing opportunities for learning and teaching	11	3.91	0.83
Performing shift report (taking over and handing over)	11	4.09	0.94
Delegation of duties following the principles of delegation	11	4.00	0.89
Developing health educational programme for healthcare users and relatives/ families	11	3.82	0.87
Compiling duty roster schedule to ensure ward coverage	11	4.00	1.00
Supervision of sub-ordinates	10	3.80	0.92

Ordering and control of medication and schedule drugs	11	3.73	0.90
Ensuring effective communication channels amongst members of the multidisciplinary team	11	3.64	0.50
Planning and adhering to the budget of the unit	11	3.09	1.14
Ordering of equipment and supplies for the unit	11	3.45	1.04
Disaster management	11	3.09	0.83
Participate in the unit policy development and implementation	11	2.73	0.65
Participate in education, training and development in the unit	11	3.36	0.81
Participate in deployment and utilization of personnel in the unit	11	2.91	0.94
Application of decision making following a decision making process	11	3.36	0.67
Application of conflict management and problem solving skills	11	3.45	0.69

Application of stress management skills	11	3.27	0.65
Application of critical thinking and clinical judgment skills	11	3.45	0.69
OVERALL MEAN (RATING)		3.51	

The overall mean rating for operational (Unit) management and leadership was 3.51. Even though these results reflect that participants were competent, the researcher suggests that the score could have been higher if they were given opportunities to take charge and run the ward during community service. This suggestion is based on the results of this study manuscripts 1 (PNs' perceptions regarding CSNs clinical competence), 2 (CSNs' experiences regarding their clinical competence) and 3 (convergence results through world café) as well as those of the previous studies in manuscript 4 (literature review) where CSNs showed lack of confidence in management and leadership roles.

Table 9: Contextual Clinical & Technical Competence (Matlhaba, Pienaar & Sehularo, 2019)

Scale: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert	N	Mean	Standard Deviation
Contextual Clinical & Technical Competence			
Assessment of a healthcare user on admission	11	4.09	0.83

Formulation of nursing care plan	11	4.18	1.08
Providing emotional and psychological support for the healthcare user and family	11	3.91	0.70
Knowledge of medication, schedule drugs control & administration procedure/ protocol	11	4.18	0.40
Administration of intravenous medications	11	4.45	0.69
Administration of intramuscular medications	11	4.45	0.52
Performing subcutaneous injection	10	4.60	0.52
Administration of oral medications	10	4.70	0.48
Administration of blood transfusion	10	4.30	0.82
Management of healthcare user receiving blood transfusion	10	4.00	1.05

Performing sterile techniques	10	4.10	0.88

Performing postural drainage and percussion, and oxygen therapy	11	3.55	0.82
Performing upper airway suction	11	3.45	1.44
Performing tracheotomy care	11	2.91	1.22
Performing chest tube care with underwater seal management	11	3.00	1.34
Removal of sutures, clips and staples	11	4.09	0.94
Performing wound dressing care	11	4.45	0.69
Performing venipuncture	11	3.55	1.57
Preparation of lumber puncture trolley	11	3.45	1.13
Management of healthcare user after a lumber puncture	11	3.91	1.22
Managing emergency cases e.g. cardio pulmonary resuscitation	11	3.45	1.13
Management of a healthcare user on traction	11	3.45	1.37

Management of a healthcare user with Plaster of Paris	11	4.18	0.75
Performing nasogastric tube feeding and care	11	4.18	0.60

Insertion of indwelling of male and female urinary catheter	11	4.64	0.50
Administration of fleet enema	11	4.00	1.00
Basic Operating theatre nursing Adhering to the legal aspects of the consent form	11	4.27	0.65
Receiving of a healthcare user from ward staff	11	4.45	0.69
Prevention of medico-legal hazards in operating theatre	11	4.09	0.54
Care of a healthcare user in recovery room	11	4.00	0.77
Handing over healthcare user to the ward staff	11	4.09	0.83
Assessment of psychiatric health care user (History taking and Mental Status Examination)	11	3.45	0.69

Management of mental healthcare user following Mental Health Act (Mental Health Care Act 17 of 2002)	11	3.55	0.52
Provide emotional support (de-escalation of emotions) and counselling using the therapeutic self	11	3.45	0.82
Facilitate activity group interaction with mental healthcare users	11	3.18	1.17
Create a therapeutic environment by applying the principles of a therapeutic environment	11	3.45	1.04

Design and maintain a daily/weekly therapeutic programme for mental healthcare users	11	2.91	1.04
Provide health education to the healthcare user and families during hospitalization and on discharge	11	3.45	1.13
Provide psychoeducational support for the healthcare user and families	11	3.18	0.87
Antenatal care History taking and physical examination during visit	11	4.27	0.90

Ability to diagnose pregnancy	11	4.27	0.79
Assess and interpret the results of the screening tests	11	4.09	0.70
Identify risks (low, intermediate and high risk pregnancies)	11	4.00	0.77
Plan and provide antenatal care which is problem orientated	11	4.00	0.77
Identify specific complications during the first trimester	11	3.73	0.90
Provide health education during antenatal visits	11	3.82	0.87
On admission Adhering to labour ward admission policies	11	3.91	0.94
Perform routine assessment of foetal well-being on	11	3.91	0.83
labour admission			
Perform digital vaginal examination for low–risk women	11	3.82	1.08

Perform continuous cardiotocography during labour	10	4.10	0.88
Perform intermittent heart rate auscultation during labour	11	3.91	0.83
Administer analgesia for pain relief (opioid analgesia)	11	4.18	0.75
Encourage relaxation techniques for pain management (muscle relaxation or breathing techniques)	11	4.27	0.79
Perform manual techniques for pain management (massage or application of warm packs)	11	3.82	0.98
Encourage maternal mobility and position	11	3.91	0.83
Encourage proper method of pushing	11	4.27	0.79
Use techniques for prevention of perineal trauma	11	4.09	0.83
Adhering to episiotomy policy	11	3.73	0.79
Application of fundal pressure	11	2.45	1.13
Administer prescribed medicine (prophylactic uterotonics) to prevent postpartum haemorrhage (PPH)	11	4.09	0.83
Ensure delayed umbilical cord clamping	11	4.36	0.81

Perform uterine massage	10	3.90	0.88
Intrapartum care Ensure respectful maternity care	11	4.00	0.77
Ensure effective communication	11	3.82	0.60
Ensure companionship during labour and childbirth	10	3.70	1.06
Ensure continuity of care	11	4.18	0.75
Assess progress of the first stage of labour	11	4.18	0.75
Managing prolonged labour	11	3.91	0.94
Managing poor labour progress	11	3.82	0.98
Managing emergencies during labour Management of foetal distress	10	3.90	0.88
Management of cord prolapse	10	3.60	0.97
Management of shoulder dystocia	10	3.10	0.88

Management of retained placenta	10	3.20	0.92
Care of the new-born Perform routine nasal or oral suction	10	3.70	1.34
Encourage skin-to-skin contact to prevent hypothermia and promote breastfeeding	10	4.10	0.88
Administer prophylaxis (vitamin K) intramuscularly to prevent haemorrhage disease	10	4.40	0.97
Perform bathing and other immediate postnatal care of the new-born	10	4.00	0.94
Management of the woman after birth Perform uterine tonus assessment	10	3.90	0.88
Administer antibiotics for uncomplicated vaginal birth	10	4.20	0.79
Perform routine postpartum maternal assessment	11	4.27	0.79
Perform postnatal discharge following uncomplicated birth	11	4.09	0.94

OVERALL MEAN (RATING)		3.90	

The overall mean rating for contextual clinical and technical competence rated was 3.90. It should be noted that this section of the CCET comprises of three sub-sections, namely Med/Surgical Nursing, Midwifery as well as Mental Health Nursing. The level of competence for CSNs is dependent on the length of time they spend in a particular unit/ward. In this instance, medical/surgical nursing items rated high scores followed by postpartum care. This was also evident in the previous manuscripts.

Table 10: Therapeutic Environment (Matlhaba, Pienaar & Sehularo, 2019)

Scale: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert	**N**	**Mean**	**Standard Deviation**
Therapeutic Environment			
Identify and prevention of medico-legal hazards to healthcare user	11	3.82	0.87
Identification and prevention of medico–legal hazards to yourself, healthcare users, families and communities	11	4.09	0.83
Identify and prevent healthcare users' complications	11	4.18	0.75
Listening to a healthcare user and showing empathy	11	4.18	0.60
Use of precise and appropriate terminology in a timely manner with healthcare users and families	11	4.36	0.67

Use of precise and appropriate terminology in a timely manner with healthcare professionals	11	4.09	0.83
Team work and collaboration (Supporting group goals)	11	4.18	0.75
Provide appropriate heath education to healthcare user and families with disease-related care knowledge	10	4.30	0.67
Create Nurse-Healthcare user relationships	11	4.00	0.63
OVERALL MEAN (RATING)		4.13	

The overall mean rating for therapeutic environment was 4.13, which is a reflection that the participants where proficient in creating a healthy and safe environment for self, health care users, families and colleagues. These results are in contrast with the results in manuscripts 1 and 3 of this study. In Manuscript 1, PNs raised some concerns with regard to CSNs' inability to communicate effectively and their lack of teamwork and collaboration. Whereas in manuscript 3, PNs rated CSNs as novice and advanced beginners with these skills.

Table 11: Quality Nursing Care (Matlhaba, Pienaar & Sehularo, 2019)

Scale: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert	**N**	**Mean**	**Standard Deviation**
Quality Nursing Care			
Needs analysis and holistic patient care (Hygiene, comfort, nutrition and elimination)	10	4.30	0.67
Application of the nursing process	11	4.36	0.67
Infection control standards	11	4.00	0.89
Notification and management of disease outbreaks in the unit	11	3.91	1.22
Prioritizing and improvising care in resource limited	11	3.82	1.17
context			
Charting and recording on healthcare user's file	11	4.55	0.52
OVERALL MEAN (RATING)		4.16	

The overall mean rating for quality nursing care was 4.16, which reflects a high level of competence. This results proves that participants have the ability to provide comprehensive/excellent nursing care for the health care user under their care

Scale: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert

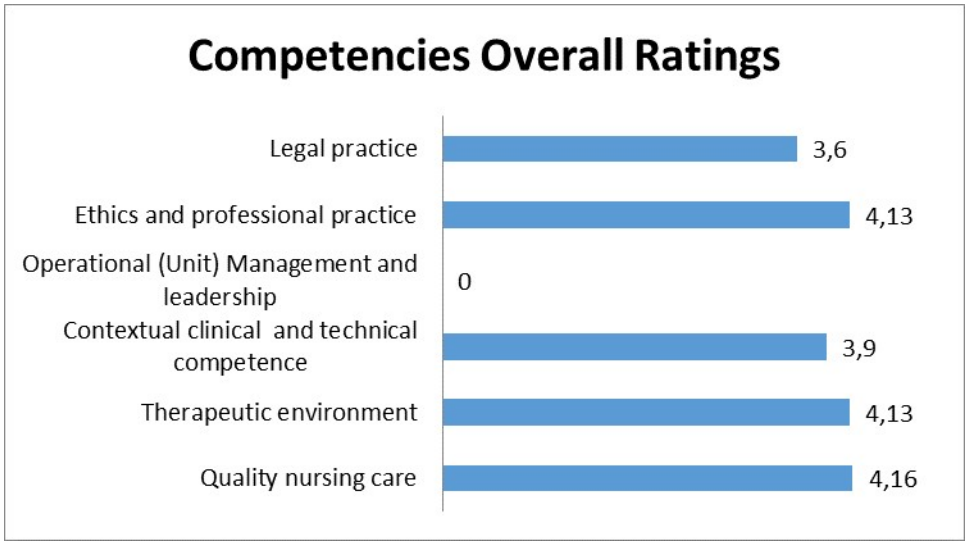

Figure 8: Graphical Display of Competencies Overall Ratings (Means) (Matlhaba, Pienaar & Sehularo, 2019)

Descriptive statistics refers to the statistics used to describe and summarize data (e.g. mean and percentage) (Polit & Beck, 2012:742).

Section D: Correlation Analysis

Spearman's rank rho test

This test is concerned with the correlation between two ranked variables (X and Y). The Correlation is statistically significant if the p-value is less than 0.05 level of significance.

The coefficient of Spearman's rank correlation is given by

$$r = 1 - \frac{6\sum D^2}{N(N_2 - 1)}$$

where

D = differences of ranks of corresponding values of X and Y

N = number of paired values in the data

$-1 \leq r \leq 1$

Table 12: Correlations among the clinical competencies (Matlhaba, Pienaar & Sehularo, 2019)

		Legal	Ethics	Operational	Contextual	Therapeutic	Quality
Legal	Correlation Coefficient	1	0.492	0.478	0.536	0.575	0.221
	p-value	.	0.124	0.137	0.089	0.064	0.514
	N	11	11	11	11	11	11
Ethics	Correlation Coefficient	0.492	1	-0.199	0.419	0.431	-0.124
	p-value	0.124	.	0.558	0.199	0.186	0.715
	N	11	11	11	11	11	11
Operational	Correlation Coefficient	0.478	-0.199	1	0.569	-0.253	-0.175
	p-value	0.137	0.558	.	0.067	0.452	0.607
	N	11	11	11	11	11	11

Contextual	Correlation Coefficient	0.536	0.419	0.569	1	0.092	-0.046
	p-value	0.089	0.199	0.067	.	0.788	0.893
	N	11	11	11	11	11	11
Therapeutic	Correlation Coefficient	0.575	0.431	-0.253	0.092	1	0.488
	p-value	0.064	0.186	0.452	0.788	.	0.127
	N	11	11	11	11	11	11
Quality	Correlation Coefficient	0.221	-0.124	-0.175	-0.046	0.488	1
	p-value	0.514	0.715	0.607	0.893	0.127	.
	N	11	11	11	11	11	11

The table above summarises the correlations between the six (6) competencies of the CCET. Correlations are associations or bonds between variables and the correlation coefficient refers to an index summarising the degree of relationship between variables (Polit & Beck, 2012:724). When there is an association between two variables, the average value of one variable changes as the value of the other variable is changed (Bracken, 2014:324). A correlation coefficient ranging from + 1.00 indicates a perfect positive relationship, through 0.0 there is no relationship and to -1.00 there is a perfect negative relationship (Polit & Beck, 2012:742). Since all the p-values (probability values) in Table 13 above are greater than 0.05 (5%) level of significance, then the CCET competencies are not significantly correlated. Each variable is independent in its own nature and does not influence the impact of another.

Discussions

The developed tool was piloted to measure its reliability. This means that the tool was not exposed to the full complement of participants, but rather a site of data-collection was piloted. Reliability is the degree of consistency or precision with which an instrument measures an attribute (Polit & Beck, 2008:471). According to Polit and Beck (2008:471), the higher the reliability of an instrument, the lower the error in obtained scores.

The tool was positively approved by the CSNs who participated in the pilot study. Even though some experts regarded the tool to be quite long, this aspect was not mentioned by the CSNs. Instead, it allows the evaluation of a comprehensive amount of aspects regarding the provision of quality nursing care that is expected from the CSNs during their placement in different disciplines. Furthermore, the tool provides the opportunity for remedial actions for those CSNs who were deemed not competent by their mentors during their first meeting.

From the results of this study, it can be noted that the CSNs rated themselves very high scores in Ethics and Professional practice (4.13), Therapeutic environment (4.13) as well Quality nursing care (4.16). This is however considered contradictory that Ethics and Professional practice rated high scores (between Competent,

Proficient & Expert) in comparison to the results of the world café (manuscript 3) where CSNs themselves and professional nurses (PNs) rated Ethics and Professional practice low scores (between Novice & Advanced beginner). As this might represent the Hawthorne-effect when quantitative data is measured a follow-up intervention as prescribed by the tool, such as case studies on ethics will produce more reliable results.

From the reliability test, three other competencies scored below 4.0 on the competencies overall ratings. However, this is not surprising when comparing this to the results of this study's objective 3 which merged the results of objectives 1 and 2 (manuscripts 3). These results confirmed that the CSNs were either novice or advanced beginners for legal practice, operational management and leadership as well as contextual clinical and technical competence (particularly maternity and neonatal care as well as mental health nursing). It should be borne in mind that a rating of 4.0 reflected a positive and significant correlation of the cited variables. These results could lead to the understanding that experience is needed in the development of a competent practitioner.

In this instance, experience could only be achieved through exposure during clinical learning. It is therefore believed that if CSNs were given opportunity to manage the wards and provided with adequate rotation during their years of training, the scoring would have been different. In this study, lack or insufficient exposure to different disciplines before and during community service was mentioned in all of the above-mentioned objectives that were presented in their respective manuscripts. These results are supporting statements by Benner (1982:407). The author stated that "experience becomes a requirement for competence. It does not refer to the mere passage of time or longevity. Rather, it is the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory" (Benner, 1982:407).

Limitations

Limitations of the study are those characteristics of design or methodology that affected or influenced the interpretation of the results; including constraints on

generalisability, applications to practice, and/or utility of results (Bloemberg & Volpe, 2019: 207). In this manuscript, two limitations were noted with respect to the validity and reliability testing of CCET and are discussed below.

- Length of the developed tool

Some of the experts noted the developed tool to be quite long during the validation process. Hence, this is regarded as a limitation in this study. Therefore, further research can be conducted where the focus can be on specific disciplines of the nursing profession including midwifery and mental health nursing.

- Time constraints

The developed tool was piloted to measure its reliability. This means that the tool was not exposed to the full complement of the participants, but a site of data-collection was piloted.

Therefore, this is a limitation and an opportunity for further research.

Summary

The aim of this manuscript was to develop and validate a clinical competence evaluation tool for CSNs in North West Province, South Africa. This manuscript consists of the development and validation phases. In the development phase, the tool was developed from the results of the empirical phase, which consists of published and unpublished manuscripts. In the validation phase, quantitative data presentation, analysis and interpretation was done. These results include that of the content validity index, content validity ratio and the Cronbach alpha, which represent the validity and reliability measures. This is data obtained from the experts for tool validation and pilot study with the CSNs for tool reliability. From the above-mentioned statements, a clinical competence evaluation tool (CCET) for CSNs in the NWP, SA was refined.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Author contributions

K.L.M. was responsible for finalisation of data analysis and writing the manuscript. L.A.S. was responsible for conceptualization and proof reading of the manuscript, A.J.P. made conceptual contributions and finalisation of the whole manuscript.

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4. SECTION FOUR: CONCLUSIONS, CONTRIBUTIONS, LIMITATIONS AND RECOMMENDATIONS

4.1. Introduction

In the previous section, the researcher presented manuscripts that have been submitted and those that will be submitted as well that any in the process of being published in journals accredited by the Department of Higher Education South Africa. In this section, the researcher synthesises and draws conclusions from the three phases of this research.

Furthermore, in addition to the developed tool, which is the researcher's contribution to the body of knowledge and the nursing profession, recommendations for nursing education, practice and research are presented in this section, including the limitations experienced throughout the research process.

Before presenting the contents for this section, the researcher considers it important to describe the various phases of the research and the specific objectives they address. Phase one compromised of the empirical phase which addressed objectives one (1) to five (5). Objectives one (1) and two (2) aimed at exploring the perceptions of PNs as well as the experiences of CSNs, while objective three (3) merged the results from objectives one (1) and two (2). Objective four (4) reviewed existing literature in order to describe the legislation, regulations and policies governing clinical competence of CSNs in the community service, while objective five (5) explored the existing clinical competence evaluation tools for CSNs. In Phase two (2), the development phase of this study addressed objective six (6) where a baseline tool to evaluate clinical competence of the CSNs during their community service placement was developed.

The third phase, the validation phase of this study, addressed objectives seven (7) and eight (8) which intended to validate and refine the developed tool through the use of expert validation and to perform a pilot study to assess the efficiency of the

developed evaluation tool. The aforementioned phases were designed to achieve the overall purpose of this research which was to develop and validate a clinical competence evaluation tool (CCET) in order to measure the competence of the CSNs in the NWP, SA.

4.2. Conclusions drawn from Phase One

4.2.1. Conclusions drawn from the experiences of CSNs' regarding clinical competence during placement in selected hospitals in North West Province, South Africa

The study confirms that CSNs are confronted with both facilitative and unhelpful experiences that effect their clinical competence during the 12-months of community service in the NWP, SA. The majority of the challenges reported in this study are in agreement with the outcomes of previous studies, despite a variety of initiatives or strategies being introduced nationally and internationally which are intending to prepare new graduates nurses for their transition into the professional working environment. However, from this study, most the majority of the challenges raised are as a result of the shortage of human resources which is having a negative impact on the effectiveness of community service. These qualitative results then add to the body of knowledge surrounding the clinical competence of CSNs during their community service placement. These results contributed to the development of a clinical competency evaluation tool for CSNs in the NWP, South Africa.

4.2.2. Conclusions drawn from professional nurses' perceptions regarding clinical competence of CSNs in North West Province, South Africa

This study focused on investigation and description of the perceptions of professional nurses with respect to the clinical competence of CSNs in the NWP. From this three main themes were extracted from the study results which included perceptions of clinical competence, challenges affecting clinical competence and

suggestions to improve the clinical competence of CSNs during their placement. These qualitative results add important information to the body of knowledge in the nursing education and clinical practice, something which would not have been achieved had other approaches been used. These results have contributed to the development of a clinical competence evaluation tool for CSNs in the NWP of South Africa.

4.2.3. Convergence of the results of the experiences of CSNs as well as the perceptions of professional nurses regarding the clinical competence of CSNs during community service

This section reports on the convergence of the results that occurred because of similarities identified from the results of the World Café of the perceptions of professional nurses and CSNs experiences concerning clinical competence during community service placement. Utilisation of the World Café method, allowed for real conversations around mutual topics of interest and the rich data collected is a true reflection of the participants' perceptions and experiences. The participants fully participated in the data analysis therefore authenticating the findings, as this is a form of member checking. The World Café yielded meaningful data that will contribute to the development of a tool to evaluate clinical competence of CSNs in the NWP, South Africa.

4.2.4. Conclusions drawn from the review of legislation, regulations and policies that govern community service for nurses

After reviewing legislation, regulations and policies that govern the nursing profession, it became clear that clinical competence in community service is comprised of several factors. An outstanding finding in this review was the lack of structures and systems to support the community service (see section three, manuscript four). It can therefore be deduced that there is limited stakeholder involvement in ensuring the successful professionalisation of CSNs. Hence, there is a need for all stakeholders to partake in the setting out policies and regulations,

especially at the provincial and institutional level. This will have a positive effect on the clinical competence of CSNs.

4.2.5. Conclusions drawn from the desk review on assessment tools for clinical competence of CSNs

Despite all the available competencies across the globe, it was found that there are a wide range of concepts used for the descriptions of competencies by each county. However, all the competencies are built up from the skills, knowledge, attitudes and values, which are the main components in quality care for the patients. The most common descriptions include, but are not limited to, professional practice, ethics and legal practice, leadership and management, teamwork and collaboration as well as communication competencies. Therefore, there is still a need, specifically in NWP of South Africa, for specific competencies for CSNs. Whilst experiencing the rapid growth of the economy, rapid advances in the development of nursing science and technology as well as living standards and the increase in demand for access to a high quality health care service, CSNs still have to maintain and increase their competence to meet these requirements of change. An ongoing clinical competence assessment will allow CSNs to self-monitor, intensify nurses' strengths, ameliorate weaknesses, and determine their abilities to uphold a high standard of nursing practices. The result of assessment will provide a foundation for the development of a clinical competence assessment tool for CSN in the NWP, South Africa

4.3. Conclusions drawn from the convergence of phases one, two and three results

To meet the aim of this research, which was to develop and validate an evaluation tool for clinical competence in order to measure the competence of the CSNs, a mixed method with multiphase design was utilised. Polit and Beck (2012:734) describe mixed methods research as research "in which both qualitative and quantitative data are collected", analysed and integrated in a single study or a longitudinal programme of inquiry. The researcher followed a pragmatic approach as this was seen as the paradigm that provided the underlying philosophical structure

for mixed-methods research. In realising this mixedmethod research, this study was further divided into three phases.

Phase 1 focused on exploring the perceptions of PNs and the experiences of CSNs and further reviewed existing literature in order to describe the legislation, regulations and policies governing clinical competence of CSNs in community service. Phases two and three focused on the development and validation of the baseline tool to evaluate clinical competence of the CSNs was developed respectively.

CSNs face several challenges that impede their successful professionalisation into the practice after completion of their 12-month's community service. This was supported by the results, which indicated that during the community service placement, CSNs find themselves expected to cope without adequate preparation, guidance or assistance. Furthermore, CSNs had to become familiar with the requirements of the nursing profession in unfavourable working conditions which included shortage of human and material resources and role confusion owing to the unavailability of job description and scope of practice (see section three, manuscript two). In addition, although the PNs perceived CSNs to be competent they felt that they still required some supervision. PNs also mentioned the challenges faced by CSNs which were seen have a negative impact on their clinical competence. Those challenges include shortage of human resources, unclarified roles, unprofessional conduct, and apprehension of responsibilities as well as negative attitudes from both CSNs and PNs as their supervisors (see section three, manuscript one). Hence, after reviewing legislative frameworks that govern community service for nurses, the researcher found that there is a need for a clearly defined programme. The stakeholders need to participate in the setting out of policies and regulations especially at the provincial and institutional level.

4.4. Contributory statements about the tool

4.4.1 A CCET was developed and validated. This CCET will assist with developing CSNs' job descriptions and scope of practice.

4.4.2. Preliminary scope of practice of the CSN with clear mentoring strategies

4.4.3 Contribution of the research.

4.4.4 The clinical competence evaluation tool (refer to annexure A)

Description: This is a clinical competence evaluation tool (CCET) for CSNs in NWP, South Africa.

Purpose: This tool will be used to evaluate and facilitate the clinical competence of CSNs during their 12-months of community service in NWP public health care facilities.

Application in practice: This tool will be used to reinforce and improve the clinical competence of CSNs with the intention of preparing them for their roles as professional nurses. As this is not a once off evaluation the process be carried out under the supervision of a mentor and according to intervals as described in the CCET (Annexure A).

Framework of preliminary scope of practice for CSNs

A. To "identify and address legal issues based on critical reflection on the suitability of different legal systems to the nursing and midwifery practice within the legal framework" (SANC).

I. Adhering to the legal standards applicable to the nursing profession

II. Knowledgeable of the regulations related to administration of medicine

B. To "identify and address ethical issues based on critical reflection on the suitability of different ethical value systems to the nursing and midwifery practice within the legal framework" (SANC).

I. Adhering to the ethical and professional conduct of the nursing profession.

II. Demonstrating cultural competence

III. Demonstrating desirable attitudes

IV. Demonstrating self-discipline

C. Management of the unit from shift inception (taking over) to shift ending (handing over).

I. Operational (unit management)

II. Human resource management

III. Leadership and governance

D. Provision of holistic nursing care in different disciplines such as Medical/Surgical; Midwifery and Mental Health and within a Community Nursing or Public health setting.

I. Medical/ surgical nursing

II. Mental health nursing

III. Maternal and Neonatal care

E. Creation and promotion of a safe and clean environment for the health care user under their care.

I. Creating a healthy and safe environment for health care users, families and communities

II. Ensuring effective communication

F. Provision of comprehensive/excellent nursing care for the health care user, family and the community at large.

I. Assessment of health care user and making a nursing diagnosis II. Adhering to disease and treatment guidelines

G. Identification of professional and developmental needs as prescribed by the tool.

I. Identifying and working towards achievement of own professional and developmental needs.

II. Working together with the peer to identify and achieve a variety of professional and developmental needs.

III. Working together with the mentor to identify and achieve a variety of professional and developmental needs.

4.5. Limitations

Limitations of the study are those characteristics of design or methodology that affected or influenced the interpretation of the results, including constraints on generalisability, applications to practice, and/or utility of results (Bloemberg & Volpe, 2019: 207). In this study, three limitations were noted with respect to the validity and reliability testing of CCET and are discussed below:

- ***Potential lack of generalisability***

Even though CSNs are placed across the four regions of NWP for their community service, this study was conducted in only three selected hospitals in the NWP, which may limit generalisability.

- ***Length of the developed tool***

Some of the experts considered that the developed tool was quite long in its validation process, which can be regarded as a limitation in this study. Therefore, further research can be conducted where the focus can be on specific disciplines of the nursing profession, including midwifery and mental health nursing.

- ***Time constraints***

The developed tool was piloted to measure its reliability. Thus, the tool was not exposed to the full complement of the participants, but rather a site of data-collection

was piloted. Therefore, this is considered a limitation but one that provides opportunities for further research.

4.6. Recommendations

Based on the results of this research, the following recommendations for nursing practice, nursing education, policy and research are made:

4.6.1. Recommendations for Nursing Practice

This tool should be used in the practice to refine it further. Formal and appropriate orientation programmes should be developed by the hospitals, with mentors provided for the CSNs as well as strategies implemented that can offer support and improve clinical competence. Realistic expectations should be set by the professional nurses for CSNs allocated to their departments. Ward rotation or allocation is important as this provides the CSNs with the opportunities of exposure to different units. Adequate personnel and the availability of human and material resources should also to be considered to ensure the effectiveness of the programme.

4.6.2. Recommendations for Nursing Education

Stakeholders such as health care facilities, the regulatory body that is SANC and the NEIs should use the results of this study to improve clinical competence of CSNs by developing the scope of practice and job description for these nurses. The hospitals should use these results to improve clinical competence of CSNs by developing effective support systems, which includes proper orientation programmes, in-service training and workshops, and mentoring programmes. PNs should use these results to improve their communication skills and their teaching roles as well as their attitudes towards CSNs. CSNs must use these results to improve their communication skills, which will have a positive impact on their supervision.

4.6.3. Recommendations for Policy

From the existing literature, it is clear that clinical competence in community service is compromised by many factors. It can be concluded that the objectives of the community service can be achieved by having all stakeholders on board and introducing clear policies and regulations especially at provincial and institutional level.

4.6.4. Recommendations for Research

Emanating from this study's results and the developed CCET, more research can be conducted where the focus can be on specialised disciplines that include maternity, mental health and operating theatre and possibly clinical competence evaluation tools for CSNs can be developed specifically for those disciplines.

4.7. Conclusion

This section provided the conclusions derived from the results of this research. Further, it presented the triangulated research results of phases one, two and three. Therefore, a CCET to evaluate clinical competence of CSNs during their community service was developed; validated and pilot study was completed.

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LIST OF ANNEXURES

Annexure 1: Clinical Competence Evaluation Tool (CCET)

Instructions: Please evaluate yourself by completing **Section A and B** of this CSN Clinical Competence Evaluation Tool (CCET). Your input will be used to improve clinical competence of community service nurses (CSNs) during their community service placement for the first six months. This evaluative learning process will further determine if the CSN will practice mainly under direct or indirect supervision for the remaining six months of community service.

Section A: Community Service Nurse Clinical Competence Evaluation Tool

Table 1: Community service nurse clinical competence evaluation tool

Competencies	Domains	Items	Rating/scoring				
			1	2	3	4	5
1. Legal practice	Adhering to the legal standards applicable to the nursing profession	- The Constitution of the Republic of South Africa (RSA), 1996 (Act 108 of 1996)					
		- SANC Nursing Act, No.33 of 2005					
		- National Health Act, No. 61 of 2003					

		- SANC Regulations Related to Performance of Community Service (R. 765)					

		- SANC regulations setting out Acts or Omissions (R. 767)					
		- SANC regulations relating to the conducting of inquiries into alleged unfitness to practice owing to disability or impairment of persons registered in terms of the Nursing Act, 2005 (R. 619)					

		- SANC regulations relating to the institution and conduct of enquiries into alleged unprofessional conduct of persons registered in terms of the Nursing Act, 2005 (R. 1051)					
		- Policy of Community Service					
		for Health Professionals 1997					
		- Adhering to Batho-pele principles					
		- Respecting Healthcare Users' Rights Charter					

	Knowledgeable of the regulations related to administration of medicine	- General regulations made in terms of the Medicines and Related Substances Act, 1965					
		- Medicines and Related Substances Amendment Act, No 72 of 2008					
		- Regulations relating to the Keeping, Supply, Administering or Prescribing of Medicines (R. 1044)					

		- Regulations relating to blood and blood products – (R. 179)					

2. Ethics and Professional practice	Adhering to the ethical and professional conduct of the nursing profession	- Professionalism and advocacy for healthcare users					
		- Maintaining appropriate appearance, attire and conduct					
		- Healthcare user's advocacy (support to get the best care from all healthcare providers in the team)					
		- Time management/ Punctuality					

	Cultural competence	- Demonstrating cultural awareness					
		- Respecting healthcare user's cultural diversity					
		- Respect the healthcare users cultural requests (non-destructive) in all facets of care					
	Desirable attitudes	- Respect towards healthcare users and their families					

		- Respect towards colleagues and other stakeholders					
		- Professional attitudes towards the nursing profession, e.g. protocol and					
		public conduct					
	Self-discipline	- Good interpersonal relation; good intrapersonal relations)					
		- Responsible and accountable to self-actions					
		- Ability to accept constructive criticism					

		- Ability to work independently					
3. Management and Leadership	Operational (unit management)	- Developing demonstrations/ in-service trainings in the unit					
		- Mentoring maximizing opportunities for learning and teaching					
		- Performing shift report (taking over and handing over)					
		- Delegation of duties following the principles of delegation					
		- Developing health educational programme for healthcare users and relatives/ families					

		- Compiling duty roster schedule to ensure ward coverage					
		- Supervision of sub-ordinates					
		- Ordering and control of medication and schedule drugs					
		- Ensuring effective communication channels amongst members of the multidisciplinary team					
		- Plan and adhering to the budget of the unit					

		- Ordering of equipment and supplies for the unit					
		- Disaster management					
	Human resource management	- Participate in the unit policy development and implementation					
		- Participate in Education, Training and Development in the unit					
		- Participate in deployment and utilisation of personnel in the unit					

	Leadership and governance	- Application of decisionmaking following a decisionmaking process					
		- Application of conflict management and problem solving skills					
		- Application of stress management skills					
		- Application of critical thinking and clinical judgement skills					
4. Contextual and clinical technical	Medical/ surgical nursing	- Assessment of a healthcare user on admission					
		- Formulation of nursing care					

competence		plan					
		- Providing emotional and psychological support for the healthcare user and family					
		- Knowledge of medication, schedule drugs control and administration procedure/ protocol					
		- Administration of blood transfusion					
		- Management of healthcare user receiving blood transfusion					
		- Performing sterile techniques					

		- Performing postural drainage					
		and percussion, and oxygen therapy					
		- Performing upper airway suction					
		- Performing tracheotomy care					
		- Performing chest tube care with underwater seal management					
		- Removal of sutures, clips and staples					
		- Performing wound dressing care					

		- Performing venepuncture					
		- Preparation of lumber puncture trolley					
		- Management of healthcare user after a lumber puncture					
		- Managing emergency cases e.g. cardio pulmonary resuscitation					
		- Management of a healthcare user on traction					
		- Management of a healthcare user with Plaster of Paris					

		- Performing nasogastric tube feeding and care					
		- Insertion of indwelling of male & female urinary catheter					

		- Administration of fleet enema					
		Basic Operating theatre nursing - Adhering to the legal aspects of the consent form					
		- Receiving of a healthcare user from ward staff					

		- Prevention of medico-legal hazards in operating theatre					
		- Care of a healthcare user in recovery room					
		- Handing over healthcare user to the ward staff					
	Mental health nursing	- Assessment of psychiatric health care user (History taking and Mental Status Examination)					

		- Management of mental healthcare user following Mental Health Act (Mental health Care Act 17 of 2002)					
		- Provide emotional support (de-escalation of emotions) and counselling using the therapeutic self					
		- Facilitate activity group interaction with mental healthcare users					
		- Create a therapeutic environment by applying the principles of a therapeutic environment					

		- Design and maintain a daily/weekly therapeutic programme for mental healthcare users					
		- Provide health education to the healthcare user and families during hospitalisation and on discharge					
		- Provide psychoeducational support for the healthcare user and families					
	Maternal and Neonatal care	Antenatal care - History taking and physical examination during visit					

		- Ability to diagnose pregnancy					
		- Assess and interpret the results of the screening tests					
		- Identify risks (low, intermediate and high risk pregnancies)					
		- Plan and provide antenatal care which is problem orientated					
		- Identify specific complications during the first trimester					

		- Provide health education during antenatal visits					
		□ On admission					

		- Adhering to labour ward admission policies					
		- Perform routing assessment of foetal well-being on labour admission					
		- Perform digital vaginal examination for low–risk women					

		- Perform continuous cardiotocography during labour					
		- Perform intermittent heart rate auscultation during labour					
		- Administer analgesia for pain					

		relieve (opioid analgesia)					
		- Encourages relaxation techniques for pain management (muscle relaxation or breathing techniques)					

		- Perform manual techniques for pain management (massage or application of warm packs)					
		- Encourage maternal mobility and position					
		- Encourage proper method of pushing					
		- Use techniques for preventing perineal trauma					

		- Adhering to episiotomy policy					
		- Application of fundal pressure					

		- Administer prescribed medicine (prophylactic uterotonics) to prevent postpartum haemorrhage (PPH)					
		- Ensure delayed umbilical cord clamping					
		- Perform uterine massage					
		Intrapartum care - naternity Ensure respectful care					
		- Ensure effective					

		communication					
		- Ensure companionship during labor and childbirth					
		- Ensure continuity of care					
		- Assess progress of the first stage of labor					
		- Managing prolonged labor					
		- Managing poor labor progress					
		Managing emergencies during labour - Management of foetal distress					

		- Management of cord prolapse					
		- Management of shoulder dystocia					
		- Management of retained placenta					
		Care of the newborn - Perform routine nasal or oral suction					

		- Encourage skin-to-skin contact to prevent hypothermia and promote breastfeeding					
		- Administer prophylaxis (vitamin K) intramuscularly to prevent hemorrhage disease					
		- Perform bathing and other immediate postnatal care of the newborn					
		Management of the woman after birth - Perform uterine tonus assessment					

		- Administer antibiotics for uncomplicated vaginal birth					
		- Perform routine postpartum maternal assessment					
		- Perform postnatal discharge following uncomplicated birth					

5. Therapeutic environment	Creating a healthy and safe environment for self, health care users, families and communities	- Identify and prevention of medico-legal hazards to healthcare user					
		- Identification and prevention of medico – legal hazards to yourself, healthcare users, families and communities					

		- Identify and prevent healthcare users' complications					
	Ensuring effective communication	- Listening to a healthcare user and showing empathy					
		- Use of precise and appropriate terminology in a timely manner with healthcare users and families					

		- Use of precise and appropriate terminology in a timely manner with healthcare professionals					

		- Team work and collaboration (Supporting group goals)					
		- Provide appropriate heath education to healthcare user and families with diseaserelated care knowledge					
		- Create nurse-healthcare user relationship					
6. Quality nursing care	Assessment of health care user and making a nursing diagnosis	- Needs analysis and holistic patient care (hygiene, comfort, nutrition and elimination)					

		- Application of the nursing process					
	Adhering to disease and treatment guidelines	- Infection control standards					
		- Notification and management of disease outbreaks in the unit					
		- Prioritising and improvising care in resource limited context					
	Adhering to the principles of record keeping	- Charting and recording on healthcare user's file					

Section B: Self-Evaluation tool

(To be completed by the CSN her/himself) **Definition of**

concepts:

Case study: Polit and Beck (2017:721) define a case study as a method involving a thorough in-depth analysis of an individual, group or other social unit. According to Creswell and Creswell (2018:14), case studies are a design of inquiry found in many fields, especially evaluation, in which the researcher develops an in-depth analysis of a case, often a program, event, activity, process or one of more individuals. Creswell and Poth (2018:321) stated that, a case study involves the study of a specific case within a real-life, contemporary context or setting. According to Bonney (2015), case studies facilitate development of the higher levels of Bloom's taxonomy of cognitive learning; moving beyond recall of knowledge to analysis, evaluation, and application. Within this research, a mentor will use a case study to evaluate the CSN's ability to analyse, evaluate and apply their knowledge skills and attitudes to solve the health care users' identified health issues or problems.

Observation: According to Cant, McKenna and Cooper (2013), observation of performance is one of the common approach identified from the literature to evaluate nursing competencies. Franklin and Melville (2015) stated that evaluation of performance through observation can be done either by direct observation in the clinical environment. In this study, observation of CSNs during performance will be used to measure the level of competence for a specific competence, domain or items according to the CCET.

Reflective learning discussion: According to Reljić *et al.,* (2017) reflection is important because nurses need to think critically and reflection develops responsibility in clinical practice. In this study, CSNs will be evaluated using their reflective learning discussion to measure their clinical competence.

Simulation: is defined as a method used to replace or amplify real experiences with guided experiences that evoke or replace substantial aspects of the real world in a fully interactive manner (Levett-Jones & Lapkin, 2014). In addition, Hall and Tori (2016) define simulation as techniques that uses real life experiences that are often immersive in nature that makes them more realistic. According to Lavoie and Clark (2017), simulation provides opportunities to replicate both rare and recurrent clinical occasions in a realistic manner as often as needed. For the purpose of this developed clinical competence evaluation tool (CCET), simulation refers to method to evaluate CSNs using real life healthcare users under their care.

Demonstration: According to Yanhua and Watson (2012), not only do competence evaluation tools need to be able to reflect 'real life' clinical practice but they also need to be able to demonstrate content validity. Franklin and Melville (2015) stated that behaviours and attitudes that are fundamental to nursing including critical thinking; reflective practice; nursing perception; intuition and caring are demonstrated. In this study, demonstration refers to the ability of the CSNs to demonstrate any of the competencies, domains or items according to CCET.

Clinical Records (exhibits): are defined as the record, made at the time, of clinical examinations, treatments and advice given, complete with dates, names of individuals concerned and drugs or tests used. The record is desirable for evaluating the patient's progress, and essential from the legal point of view if arguments should arise about competence or justness of charges made (https://medical-dictionary.thefreedictionary.com/clinical+record, 2019). In this study, clinical records refers to the CSNs ability to use the health care users records found at the bedside of the health care users according to the health care facility policies.

- This form must be completed within one week after commencement of community service by a CSN.

Table all your learning needs as identified in Section A, e.g. Section A 1 Nursing Act, No.33 of 2005 (This can also be highlighted in Section A)

What are your leaning outcomes aligned to the learning needs identified in Section B 1?

Which support strategies are in place to achieve your learning outcomes? E.g. In-service Training; Ward Conference

Work out your own-/self-learning pathway to improve your competence? E.g., Study the Nursing Act 33 of 2005 and answer application questions as stipulated within a month.

NB: The learning pathway must obtain the outcome; learning process and assessment (including assessment date and time)

Section C: Peer Evaluation (To be

completed by a fellow CSN)

Instructions:

- Please evaluate your fellow CSN by completing **Section A** of the Clinical Competence Evaluation Tool (CCET). The evaluation can be done through observation or simulation.
- This form must be completed within five weeks after the CSN commenced with community Service.
- Your input will be used to improve clinical competence of CSNs during their community service placement in the NWP.

 Please complete Section A as part of this report

Table all your peer's learning needs as identified in Section A

What leaning outcomes aligned to the learning needs identified in Section C 1 are you suggesting?

Which support strategies are in place to achieve the learning outcomes? E.g. In-service Training; Ward Conference; etc.

Work out a learning pathway to improve your peer's competence? E.g. Study the Nursing Act 33 of 2005 and answer application questions as stipulated within a month (possibly a case study).

NB: The learning pathway must obtain the outcome; learning process and assessment of each learning need (including assessment date and time)

Pathways:

Suggestions/ Recommendations

Signature ……/ SANC No._____ Date…….

(CSN)

Signature ……/ SANC No._____ Date……..

(Peer)

Section D: Mentor Evaluation

(To be completed by the CSN with the Mentor who is a professional nurse with two-year's experience)

Instructions:

- Please evaluate the CSN under your supervision by completing **Section A and B** of this Clinical Competence Evaluation Tool (CCET).
- The evaluation ***must*** be done during the ***first week after the commencement of community service***; ***Two months*** (eight weeks) after the commencement of community service; ***Four months (16 weeks)*** and ***six months*** after the commencement of community service.

Submission date: Three weeks after commencement of Community Service

Three months after commencement of Community Service

Five Months after commencement of Community Service

Final Report: Seven Months after commencement of Community Service

- Please note that four sets of reports must be submitted well-timed to the District Nursing Manager and Deputy Director: Nursing in the Department of Health.
- The evaluation can be done through case studies; Observation; reflective learning discussions; simulations; demonstrations.
- All exhibits must be attached to the final report for perusal by the District Nursing Manager and the Deputy Director: Department of Health.
- Your support will be used to assess the improvement and level of clinical competence of CSNs during their community service placement.

First meeting

During the first meeting, the CSN and the mentor enter into an agreement on how the evaluation would be conducted. The agreement includes a plan on how clinical competence can be achieved by formulating a ***learning contract consisting of learning needs, outcomes/ goals and strategies to be used.***

Table all the CSN's learning needs as identified in Section A

What learning outcomes aligned to the learning needs identified in Section D 1 are you planning?

Which support strategies are in place to achieve the learning outcomes? E.g. In-service Training; Ward Conference; etc.

Work out a learning pathway to improve the CSN's competence? E.g. Study the Nursing Act, 2005 and answer application questions as stipulated within a month (possibly a case study).

NB: The learning pathway must obtain the outcome, learning process and assessment of each learning need (including assessment date and time)

Suggestions/ Recommendations

Signature ……./SANC No._____ Date…….

(CSN)

Signature ……/SANC No._____ Date…….

(Mentor)

Qualifications of Mentor:……**Second Meeting**

Progress Comments (Use section A as a guideline):

Signature ……. /SANC No._____ Date…….

(CSN)

Signature ……/SANC No._____ Date…….

(Mentor)

Qualifications of Mentor:……

Third Meeting (with another mentor as witness)

Progress Comments (Use section A as a guideline):

Signature ……/ SANC No._____ Date……

(CSN)

Signature ……/SANC No._____ Date…….

(Mentor- witness)

Qualifications of Mentor-witness:……

Signature ……/SANC No._____ Date…….

(Mentor)

Qualifications of Mentor:……

Fourth (Final) meeting (After comprehensive assessment of at least a week) The final meeting where the CSN would be deemed Competent or Not Yet Competent and the *CSN will be extended to work under direct mentor supervision*

Level of current Competence	
Not Yet Competent	

If a CSN is deemed Not Yet Competent, the mentor needs to specify competencies/ domains/ items not achieved and recommended remedial actions.

Comments/ Recommended remedial actions:

Signature ……/ SANC No._____ Date……

(CSN)

Signature ……/SANC No._____ Date…….

(Mentor- witness)

Qualifications of Mentor-witness:……

Signature ……/SANC No._____ Date…….

(Mentor)

Qualifications of Mentor:……

Section E: Self-Learning Assessment during first six months of community service

Instructions: This must be completed in the fifth month of community service

Knowledge

As you are about to complete your community service, what do you know now that you did not know before commencement of community service?

Skills

What are your three strengths when performing skills?

What are your three weaknesses when performing skills?

Which areas of competencies have you identified for professional development?

Attitudes

What was your attitude before commencement of community service?

- Healthcare user

Novice	Advanced beginner	Competent	Proficient	Expert

 Colleagues

Novice	Advanced beginner	Competent	Proficient	Expert

- Nursing profession

Novice	Advanced beginner	Competent	Proficient	Expert

What is your attitude now?

- Healthcare user

Novice	Advanced beginner	Competent	Proficient	Expert

 Colleagues

Novice	Advanced	Competent	Proficient	Expert
	beginner			

 Nursing profession

Novice	Advanced beginner	Competent	Proficient	Expert

Overall experience

What is your overall experience regarding clinical competence as a CSN?

Novice	Advanced beginner	Competent	Proficient	Expert

What are your highlights of community service?

What are your lowest points or disappointments of community service?

Suggestions/ Recommendations

What are your suggestions or recommendations to improve your clinical competence as a community service nurse?

Signature ……./ SANC No._____ Date…….

(CSN)

Thank you for participating in the evaluation of CSNs. Your comments and suggestions are appreciated.

Annexure 2: Ethics Clearance Certificate

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom,
South Africa, 2520
Tel: (018) 299-4900
Faks: (018) 299-4910
Web: http://www.nwu.ac.za

Research Ethics Regulatory Committee
Tel: +27 18 299 4849
Email: Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by the **Health Science Ethics Committee (FAST-HSEC) on 03/03/2018** after being reviewed at the meeting held on **27/02/2018**, the North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby **approves** your project as indicated below. This implies that the NWU-RERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Development of an evaluation tool for clinical competence of community service nurses' in North West province

Project Leader: Prof AJ Pienaar, Dr L Sehularo & Dr TM Bock
Student: M Matlhaba

Ethics number: N W U - 0 0 2 3 0 - 1 8 - A 9

Application Type: Single study
Commencement date: 2018-03-01 **Expiry date**: 2021-03-31 **Risk:** Minimal

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HSEC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HSEC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The project leader (principle investigator) must report in the prescribed format to the NWU-RERC via HSEC:*
  - *annually (or as otherwise requested) on the progress of the project, and upon completion of the project*
  - *without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.*
  - *Annually a number of projects may be randomly selected for an external audit.*
- *The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the HSEC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-RERC via HSEC and new approval received before or on the expiry date.*
- *In the interest of ethical responsibility the NWU-RERC and HSEC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the project;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.*
  - *withdraw or postpone approval if:*
    any unethical principles or practices of the project are revealed or suspected,
    it becomes apparent that any relevant information was withheld from the HSEC or that information has been false or misrepresented,
    the required annual report and reporting of adverse events was not done timely and accurately,
    new institutional rules, national legislation or international conventions deem it necessary.
- *HSEC can be contacted for further information via or 018 299 2598.*

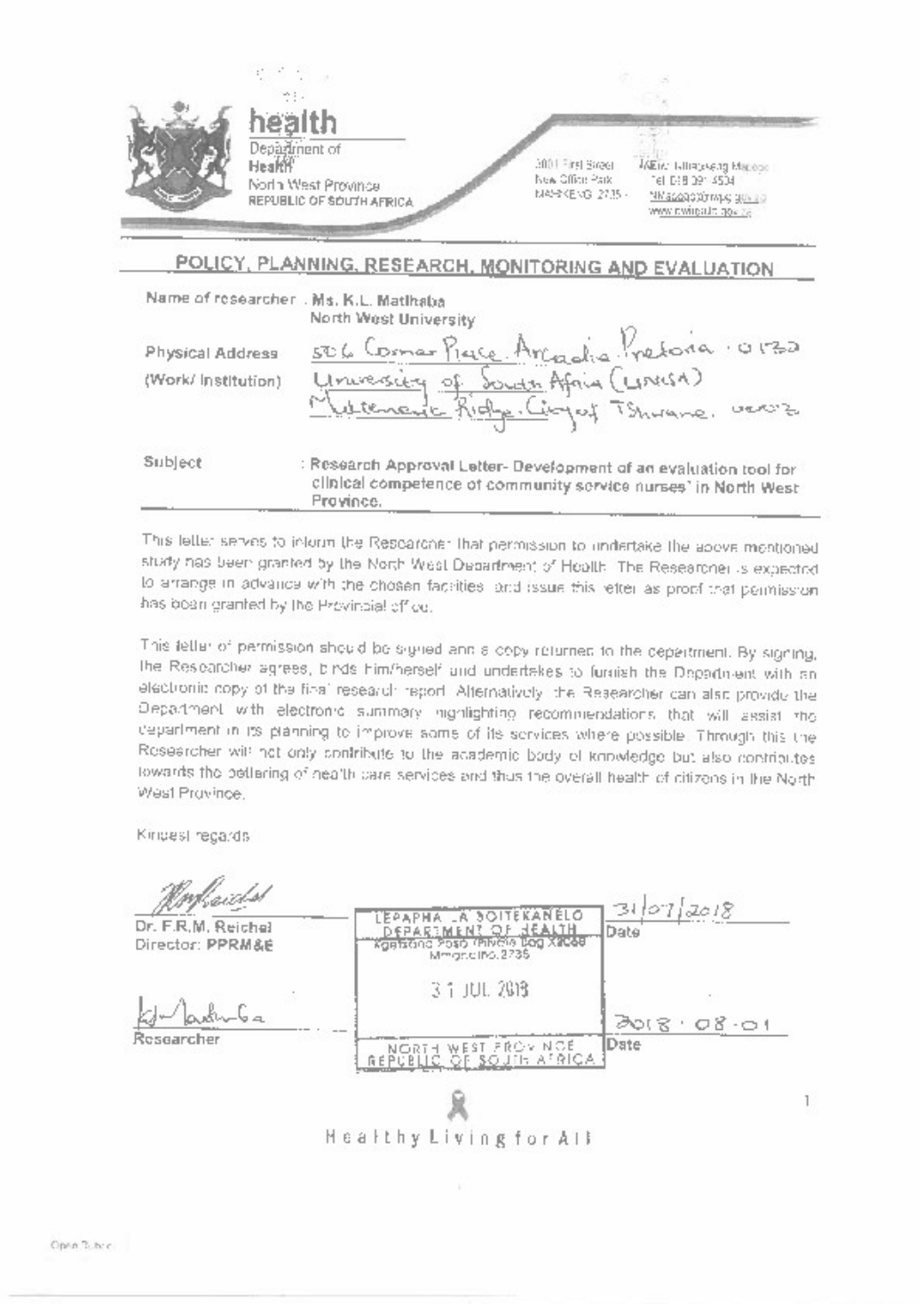
The RERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the RERC or HSEC for any further enquiries or requests for assistance.

Yours sincerely

Prof Refilwe Phaswana-Mafuya
Chair NWU Research Ethics Regulatory Committee (RERC)

Annexure 3: Request & permission letters

3a: North West Department of Health



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

3001 First Street
Iwa Office Park
MAHIKENG 2735

Tel: 018 391 5534

www.nwpg.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms. K.L. Matlhaba
North West University

Physical Address (Work/ Institution) : 536 Corner Place, Arcadia, Pretoria, 0132
University of South Africa (UNISA)
Muckleneuk Ridge, City of Tshwane, 0002

Subject : **Research Approval Letter- Development of an evaluation tool for clinical competence of community service nurses' in North West Province.**

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds Him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

Dr. F.R.M. Reichel
Director: PPRM&E

31/07/2018
Date

LEPAPHA LA BOITEKANELO
DEPARTMENT OF HEALTH
Agriculture Road Private Bag X1208
Mmabatho 2735
31 JUL 2018
NORTH WEST PROVINCE
REPUBLIC OF SOUTH AFRICA

Researcher

2018-08-01
Date

Healthy Living for All

3b: Letter of request to the hospitals: Joe Morolong Hospital

REQUEST FOR PERMISSION

ENQUIRY: K.L. MATLHABA (Ms.)
Tel: 012 429 2073
Cell: 078 247 6009

The Chief Executive Officer
Joe Morolong Hospital
Vryburg
8601

Dear Sir/Madam

APPLICATION TO CONDUCT RESEARCH STUDY ON COMM SERVE NURSES AND PROFESSIONAL NURSES AT YOUR FACILITY.

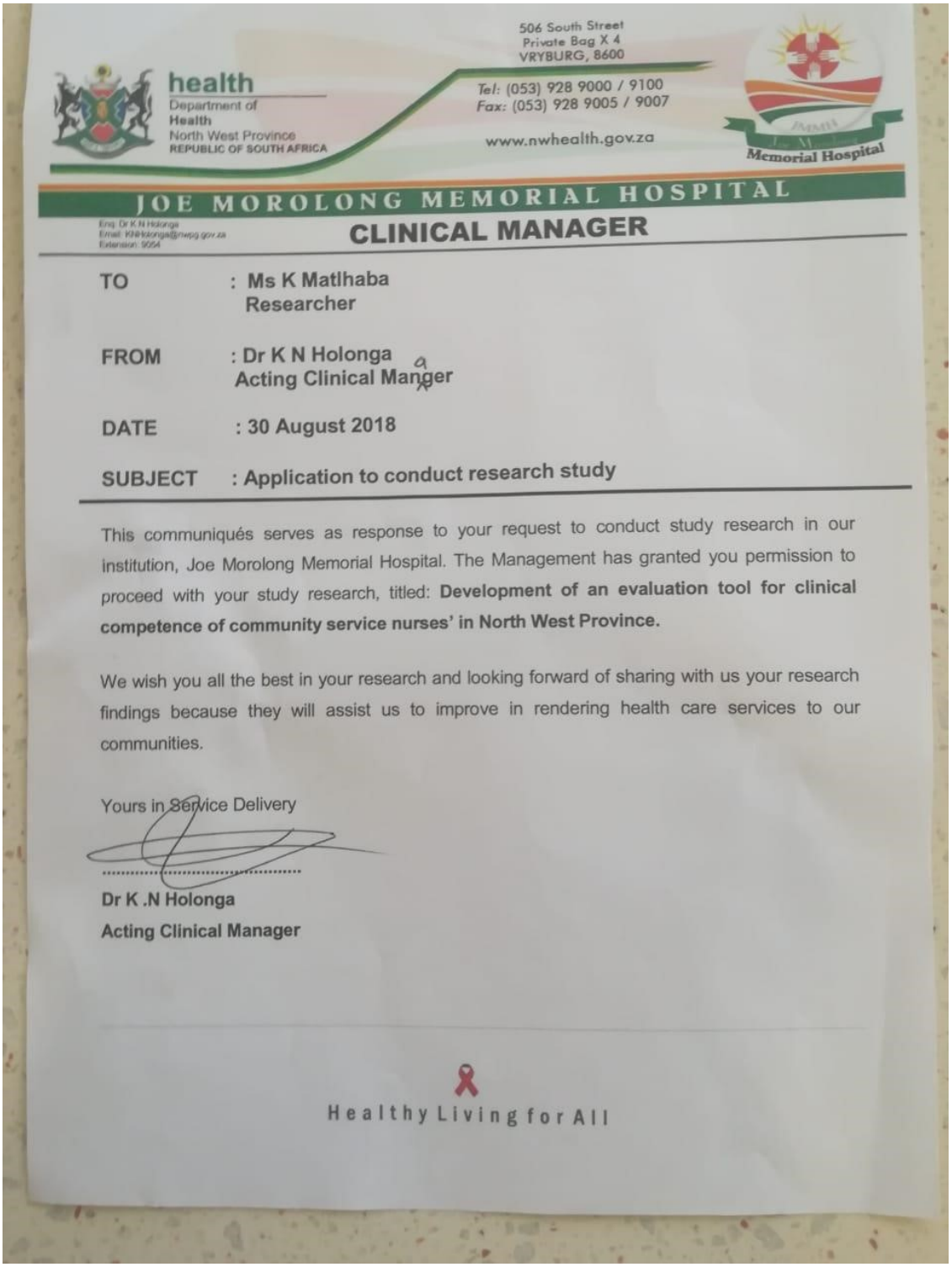
I hereby request to conduct research on Comm Serve Nurses and professional nurses at your facility. I am a PhD candidate at the University of North West and my promoter is Professor A.J. Pienaar, and co-promoters are Drs' L.A Sehularo and T. Bock. The topic of my research study is "Development of an evaluation tool for clinical competence of Community Service Nurses' in the North West Province"

The aim of this research is to develop and validate an evaluation tool for clinical competence in order to measure the competence of the Community Service Nurses.

With your permission, data will be obtained by questionnaires, individual interviews and focus group discussion and with the use of audiotapes from the Community Service Nurses and professional nurses who are eligible in the inclusion criteria at the health care facilities at the district.

The researcher will ensure that the right to privacy and confidentiality are maintained, i.e. the identity of the participants will be protected, as their names will not be mentioned during the interview sessions.

3c: Approval Letter of request to the hospitals: Joe Morolong Hospital



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

506 South Street
Private Bag X 4
VRYBURG, 8600
Tel: (053) 928 9000 / 9100
Fax: (053) 928 9005 / 9007
www.nwhealth.gov.za

Memorial Hospital

JOE MOROLONG MEMORIAL HOSPITAL

Enq: Dr K N Holonga
Email: KNHolonga@nwpg.gov.za
Extension: 9054

CLINICAL MANAGER

TO : Ms K Matlhaba
Researcher

FROM : Dr K N Holonga
Acting Clinical Manager

DATE : 30 August 2018

SUBJECT : Application to conduct research study

This communiqués serves as response to your request to conduct study research in our institution, Joe Morolong Memorial Hospital. The Management has granted you permission to proceed with your study research, titled: **Development of an evaluation tool for clinical competence of community service nurses' in North West Province.**

We wish you all the best in your research and looking forward of sharing with us your research findings because they will assist us to improve in rendering health care services to our communities.

Yours in Service Delivery

.....

Dr K .N Holonga
Acting Clinical Manager

Healthy Living for All

3d: Approval Letter of request to the hospitals: Joe Morolong Hospital

REQUEST FOR PERMISSION

ENQUIRY: K.L. MATLHABA (Ms.)
Tel: 012 429 2073
Cell: 078 247 6009

The Chief Executive Officer
Potchefstroom Hospital
Potchefstroom
2520

Dear Sir/Madam

APPLICATION TO CONDUCT RESEARCH STUDY ON COMM SERVE NURSES AND PROFESSIONAL NURSES AT YOUR FACILITY.

I hereby request to conduct research on Comm Serve Nurses and professional nurses at your facility. I am a PhD candidate at the University of North West and my promoter is Professor A.J. Pienaar, and co-promoters are Drs' L.A Sehularo and T. Bock. The topic of my research study is "Development of an evaluation tool for clinical competence of Community Service Nurses' in the North West Province"

The aim of this research is to develop and validate an evaluation tool for clinical competence in order to measure the competence of the Community Service Nurses.

With your permission, data will be obtained by questionnaires, individual interviews and focus group discussion and with the use of audiotapes from the Community Service Nurses and professional nurses who are eligible in
the inclusion criteria at the health care facilities at the district.

3e: Approval Letter of request to the hospital: Potchefstroom Hospital

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Dr. Chris Hani
Knox Street
Private Bag X 938
Potchefstroom
2520
Tel: (018) 293 4416

POTCHEFSTROOM HOSPITAL

2030 NDP

OFFICE OF THE CLINICAL MANAGER

03 September 2018

REF NO: RS/23/08/2018

TO: Ms Kholofelo Matlhabe

FROM: Dr. JMM Shakung
Clinical Manager
Potchefstroom Hospital

Dear Ms Matlhabe

This is to inform you that the Potchefstroom Hospital Patient Safety Group (PSG) that sat on 14/08/2018 has given you permission to proceed with your research titled: **Development of an evaluation too for Clinical competence of Community Service Nurses in the North West province.**

We wish you all the best with your study and look forward to sharing in the results of your findings.

Yours sincerely,

Dr. JMM Shakung
Clinical Manager
Potchefstroom Hospital

OFFICE OF THE CLINICAL MANAGER
POTCHEFSTROOM HOSPITAL
2018 -09- 03
PRIVATE BAG X 938
POTCHEFSTROOM 2520

Healthy Living for All

1

3f: Letter of request to the hospitals: Brits Hospital

The participants will participate at their own free will. Should they wish to withdraw from the study, they will not face any penalty.

The researcher is committed to honour participants and no biasness will be made. The research results will be made available, should you request to have them. Should you have any queries regarding this project, I will be pleased to answer them.

I hope that my request will be taken into consideration.

Thanking you in advance

Yours Sincerely

_____ Date: _____ Researcher

Annexure 4: Request for participation

TOPIC: DEVELOPMENT OF AN EVALUATION TOOL FOR CLINICAL COMPETENCE OF COMMUNITY SERVICE NURSES' IN THE NORTH WEST PROVINCE

RESEACHER: KHOLOFELO LORRAINE MATLHABA

With reference to the above mentioned topic, I hereby inviting you to participate in a research study on Development of an evaluation tool for clinical competence of Community Service Nurses' in the North West Province"

The aim of this research is to develop and validate an evaluation tool for clinical competence in order to measure the competence of the Community Service Nurses.

The proposed study may also benefit the nursing profession as the findings will identify gaps in the educational preparation of professional nurses and arears to be addressed during training which will improve the Community Service Nurses' level of competence.

As far as your participation is requested, there will be no risks or discomfort of some sort to you. In the process of participation, you will meet with me and other participants as the interview will be done in a form of group discussion, and you are requested to allow me to use audiotape record information obtained from you.

As a researcher, I will ensure the safe keeping of the audiotapes used in an interview as well as the transcription of those tapes. I want to assure you that your name will not be mentioned on the audiotape, even on the transcription of those tapes. The reason behind this is that all the information you will supplied, will not be linked with your name. All data that you will give will be kept safe and no one except the research team will have access to it. Your identity will not be exposed when the study is published.

If you have any questions or queries regarding study or about being a participator in this project, please feel free to contact me, Kholofelo Matlhaba on the following numbers: 078 427 6009 (mobile) or 012 429 2073 (work), matlhkl@unisa.ac.za (email address) or my promoter Professor A.J. Pienaar at abel.pienaar.gmail.com.

Your participation in this research project is completely voluntary and you are under no

obligation to take part. You have a right to withdraw at any time if you wish to, there will be no penalty posed to you, even in an on-going process of interviews.

The research study and its procedures have been approved by relevant people and appropriate research committees of North West University (Mahikeng Campus) and the department of Health (North West Province)

The above points will be communicated to the participants. I have a positive mind that the participants will understand the benefits and the obligation included in participating in this research project.

Researcher Date

---------- ----------

I confirm that I have read and understand the information given in the informed consent for the abovementioned study.

I understand that participating in this study is voluntary and that I may freely decline to participate or withdraw my consent and stop taking part at any time without giving any reason and no penalties will be posed against me.

I understand that the data gathered from this study will be accessible to other researchers at the North-West University and that the results will be published.

I hereby freely consent to participate in this research study.

_____ _____ _____

Signature of participant Signature of witness Date

Annexure 5: Request for tool adjustment & permission

REQUEST FOR COPYRIGHT PERMISSION

Ms. K.L. Matlhaba (PhDc)

University of South Africa

Department of Health Studies

Preller Street, Muckleuneck

PRETORIA

South Africa

0002

Email: matlhkl@unisa.ac.za

Ching-Yu Cheng

Chang Gung University of Science and Technology (Chayi Campus)

School of Nursing

2 Chiapu Rd, West Sec. Putz, Chiayi

Taiwan

Email: chingyuus@gmail.com

Dear Sir/ Madam

I am a PhD candidate at the North West University (Mafikeng campus), South Africa and my promoters are Professors A.J. Pienaar and L.A. Sehularo. I am writing this letter to request copyright permission for the research material titled **Developing and validating the Clinical Competence Questionnaire: A self- assessment instrument for upcoming baccalaureate nursing graduates** that I am using as a guide for my research project titled as follows:

Project title: **Development of an evaluation tool for clinical competence of community service nurses in North West province.**

Ethics number: **NWU 00230 – 18 – A9**

1

This tool is intended to assist in developing the scope of practice and job description for community service nurses in the North West province of South Africa. I would be grateful to receive permission without a fee. Copyright statement including proper acknowledgement of authors, title, source and copyright date will be attached.

Please indicate your permission in the table below:
Permission granted X

Permission granted with the following restrictions

Permission denied

Compiled by:

Name: Ms. K.L. Matlhaba (PhDc)

Signature: Date: 2019.05.30

Approved by:

Name: Professor A.J. Pienaar (Promoter)

Signature: Abel J Pienaar Date: 2019.05.30

Seconded by:

Name: Professor L.A. Sehularo (Co-Promoter)

Signature: Date: 30 May 2019

Annexure 6: Adjusted tool

Clinical Competence Questionnaire

Please use the following response categories to mark the number that most closely indicates your current condition in performing clinical behaviors.

1. Do not have a clue;
2. Know in theory, but not confident at all in practice;
3. Know in theory, can perform some parts in practice independently, and needs supervision to be readily available; 4. Know in theory, competent in practice, need contactable sources of supervision; 5. Know in theory, competent in practice without supervision.

	1	2	3	4	5
1. Following health and safety precautions……..	☐	☐	☐	☐	☐
2. Taking appropriate measures to prevent or minimize risk of injury to self……	☐	☐	☐	☐	☐
3. Taking appropriate measures to prevent or minimize risk of injury to patients……..	☐	☐	☐	☐	☐
4. Preventing patients from problem occurrence……	☐	☐	☐	☐	☐
5. Adhering to the regulation of patients' and families' confidentiality…	☐	☐	☐	☐	☐
6. Demonstrating cultural competence……	☐	☐	☐	☐	☐
7. Adhering to ethical and legal standards of practice…….. 8. Maintaining appropriate appearance, attire, and conduct……	☐	☐	☐	☐	☐
9. Understanding patient rights……	☐	☐	☐	☐	☐
10. Recognizing and maximizing opportunity for learning……	☐	☐	☐	☐	☐
11. Applying appropriate measures and resources to solve problems……	☐	☐	☐	☐	☐
12. Applying or accepting constructive criticism……..	☐	☐	☐	☐	☐
13. Applying critical thinking to patient cares……..	☐	☐	☐	☐	☐
14. Communicating verbally with precise and appropriate terminology in a timely manner with patients and families……	☐	☐	☐	☐	☐
15. Communicating verbally with precise and appropriate terminology in a timely manner with healthcare professionals……..	☐	☐	☐	☐	☐
16. Understanding and supporting group goals……	☐	☐	☐	☐	☐
17. Taking a history for new admissions……	☐	☐	☐	☐	☐
18. Performing and documenting patient health assessment……...	☐	☐	☐	☐	☐
19. Answering questions for patients or families……..	☐	☐	☐	☐	☐
20. Educating patients or families with disease-related care knowledge…...	☐	☐	☐	☐	☐
21. Charting and documentation…….	☐	☐	☐	☐	☐
22. Developing care plan for patients……. 23. Performing shift report……..	☐	☐	☐	☐	☐
24. Performing hygiene and daily care routines……	☐	☐	☐	☐	☐
25. Providing rest and comfort measures……...	☐	☐	☐	☐	☐
26. Assessing nutrition and fluid balance……...	☐	☐	☐	☐	☐
27. Assessing elimination…….	☐	☐	☐	☐	☐
28. Assisting activities and mobility, and changing position……..	☐	☐	☐	☐	☐
29. Providing emotional and psychosocial support……..	☐	☐	☐	☐	☐
30. Performing venipuncture……	☐	☐	☐	☐	☐
31. Starting intravenous injections……...					
32. Changing intravenous fluid bottle or bag……..……....					

33. Administering intravenous medications (or into intravenous bags)……. 34. Administering intramuscular medications……...
35. Performing subcutaneous (or intracutaneous) injection…….
36. Administering oral medications…….
37. Administering blood transfusion……...
38. Performing urinary catheter insertion and care……...
39. Performing sterile techniques……

Annexure 7: Request for expert validation

ENQUIRY: K.L. MATLHABA (Ms)
Tel: 012 429 2073
Cell: 078 247 6009

Dear Sir/ Madam

REQUEST TO VALIDATE THE DEVELOPED TOOL

I am a PhD candidate at Northwest University and my promoter is Professor A.J. Pienaar, and co-promoter is Professor L.A Sehularo. The title of my research is

"Development of an evaluation tool for clinical competence of Community Service Nurses in the North West Province, South Africa"

The aim of this research is to develop and validate an evaluation tool for clinical competence in order to measure the competence of the Community Service Nurses.

With your expertise, I hereby kindly request you to participate in validation of the tool I am developing.

This tool will be submitted to you in the last week of August 2019, and you will be granted two weeks to assess the tool and provide input.

I hope that my request will be taken into consideration.

Thanking you in advance

Yours Sincerely

Date: 2019.08.30

Researcher

Annexure 8: Instructions to experts

A. Demographic information

Please make a tick/ cross against any of the options where necessary and fill blank spaces where they are provided

1. Gender:

No.	Gender	Tick/ Cross
1.	Male	
2.	Female	

2. Age:

No.	Years	Tick/ Cross
1.	Below 30	
2.	31 - 35	
3.	36 - 40	
4.	41 - 45	
5.	Above 45	

3. Qualifications:

No.	Highest qualification	Tick/ Cross
1.	Degree	
2.	Honours	

3.	Masters	
4.	PhD	

4. Work experience:

No.	Years of experience	Tick/ Cross
1.	Less than 10 years	
2.	10 – 20 years	
3.	21 – 30 years	
4.	Above 30 years	

5. Area of speciality:

No.	Area of speciality	Tick/ Cross
1.	Academics	
2.	Governance	
3.	Government	
4.	Labour movement	
5.	Professional association	

B. The tool

Please rate each of the items of features in this tool.

1. For each competence, rate whether the competence itself, domains and items measured in the tool is:

a. Essential—requires a great deal of cognitive work by the CSNs (yes, no)

b. Useful—displays the competence needed for a competent practitioner after completion of community service (yes, no)

c. Not necessary—as it is either below or above the capability of the CSNs (yes, no)

2. For each competence, rate whether the domain and items are very likely or unlikely to form part of the tool.

0 = Unlikely to be utilised in evaluating clinical competence of CSNs

1 = Somewhat likely to be utilised in evaluating clinical competence of CSNs

2 = Likely that to be utilised in evaluating clinical competence of CSNs

3 = Very likely that it must be included in the tool for evaluation of clinical competence of CSNs

What would you like to add on the tool and why?

Annexure D: Submitted; intention to submit and published manuscripts

Annexure 9: Manuscripts editing certificates

NORTH-WEST UNIVERSITY
NOORDWES-UNIVERSITEIT
UNIBESITI YA BOKONE-BOPHIRIMA

Office: 0183892451

FACULTY OF EDUCATION **Cell: 0729116600**

Date: 16 January, 2019

TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

I, Muchativugwa Liberty Hove, confirm and certify that I have read and edited the entire article**, Community service nurses' experiences regarding their clinical competence ,** submitted to your journal for consideration towards publication and wider circulation**.**

I hold a PhD in English Language and Literature in English and am qualified to edit such an academic article for cohesion and coherence. The views expressed herein, however, remain those of the researcher/s. Yours sincerely

Dr M.L.Hove (PhD, MA, PGDE, PGCE, BA Honours – English)

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NOORDWES-UNIVERSITEIT
UNIBESITI YA BOKONE-BOPHIRIMA

NORTH-WEST UNIVERSITY
NOORDWES-UNIVERSITEIT
UNIBESITI YA BOKONE-BOPHIRIMA

Office: 0183892451

FACULTY OF EDUCATION **Cell: 0729116600**

Date: 16 January, 2019

TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

I, Muchativugwa Liberty Hove, confirm and certify that I have read and edited the entire article**, Professional nurses' perceptions regarding clinical competence of community service nurses in North West Province, South Africa,** submitted to your journal for consideration towards publication and wider circulation**.**

I hold a PhD in English Language and Literature in English and am qualified to edit such an academic article for cohesion and coherence. The views expressed herein, however, remain those of the researcher/s. Yours sincerely

Dr M.L.Hove (PhD, MA, PGDE, PGCE, BA Honours – English)

NORTH-WEST UNIVERSITY
NOORDWES-UNIVERSITEIT
UNIBESITI YA BOKONE-BOPHIRIMA

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

14 January 2019

TO WHOM IT MAY CONCERN

This certificate serves to confirm that I have edited and proofread K Matlhaba's article entitled, **"LEGISLATION, POLICY AND REGULATION GOVERNING COMMUNITY SERVICE PROGRAMME FOR NURSES IN SOUTH AFRICA: A LITERATURE REVIEW".**

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31 October 2019

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This certificate serves to confirm that I have edited and proofread KL Matlhaba's thesis entitled, **"Development of an evaluation tool for clinical competence of community service nurses in North West Province, South Africa".**

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language, which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

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28 November 2019

TO WHOM IT MAY CONCERN

This serves to confirm that the thesis for: Doctor of Philosophy in Nursing Science.

By: **Kholofelo Lorraine Matlhaba** - Faculty of Health Sciences, Mafikeng Campus of the North-West University

Entitled: ***Development of an evaluation tool for clinical competence of community service nurses in North West Province, South Africa.***

has been edited by one of our accredited language editors. The accuracy of the final work is still the student's own responsibility.

A & M Steyn

Scribing, Proof-reading and Editing Services

Annexure 9: Proof of manuscript submission to the journal

Manuscript 1:

CURATIONIS Submission 2045 - Confirmation and acknowledgement of receipt

Ref. No.: 2045

Manuscript title: Professional nurses' perceptions regarding clinical competence of community service nurses in North West Province, South Africa

Journal: Curationis

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Manuscript title: Community service nurses’ experiences regarding their clinical competence

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Annexure 10: Proof of published manuscripts

Community service nurses' experiences regarding their clinical competence

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Background: In South Africa, it is mandatory for nurses who have qualified as a nurse (general, psychiatric and community) and midwifery, leading to registrati

Background: In South Africa, it is mandatory for nurses who have qualified as a nurse (general, psychiatric and community) and midwifery, leading to registration in Government Gazette Notice No. R425 of 22 February 1985, to perform 12-months' compulsory community service after completion of training at a College of Nursing. Community service affords new graduate nurses the opportunity to improve their clinical skills and knowledge while nurturing professional behavioural patterns and critical thinking consistent with the profession.

Aim: To explore and describe the experiences of community service nurses (CSNs) regarding clinical competence during their placement in three selected hospitals.

Setting: The study setting was North West Province (NWP), South Africa.

Method: This study followed a qualitative, exploratory, descriptive and contextual research design. A cluster sampling technique was used and 17 CSNs participated in the study. Three focus group discussions framed by semi-structured questions were conducted with five to six participants per group. All discussions were recorded using a digital voice recorder and transcribed. Data were analysed using Pienaar's four steps of qualitative thematic analysis.

Results: Four themes emerged from this study: facilitative experiences, defacilitative experiences, challenges confronted during placement and suggestions to improve clinical competence.

Conclusion: Clinical competence of CSNs could be improved if all the stakeholders, including professional nurses and CSNs themselves, hospital management and the regulatory body, the South African Nursing Council, collaborate. More importantly, this study's results were used to develop a clinical competence evaluation tool in the NWP, South Africa.

competence; community service; community service nurse; experiences; placement.

Introduction

In many countries around the world, new nurses are associated with underpreparednes s and a low level of clinical competence, which lead to their inability to provide quality nursing care (Duchscher 2009). This is a concern around the world where either the nursing education institutions (NEIs) or the government resorts to introducing measures that seek to improve the competencies of newly qualified nurses (Duchscher 2009). According to Andre and Barnes (2010), many hospitals offer a 12-month noncompulsory graduate nursing programme designed to support and build the confidence and competence of graduate nurses as they develop professionally. This is perceived to assist and support graduate nurses in their transition into the working environment (Andre & Barnes 2010). In the United States, The Institute of Medicine (IOM) (2011) has determined that nursing graduates need to enhance competencies in the basic areas of nursing care (IOM 2011). Institute of Medicine suggests that to ensure that its members are well prepared, the profession should institute residency training for nurses (IOM 2011). Furthermore, according to Theisen and Sandau (2013), many health organisations use orientation programmes or nurse residency programmes to ensure that new graduates are both confident and competent

Annexure 11: Transcripts

E1: Focus Group Discussions with professional nurses

Interviewer Let start by welcoming you, colleagues. Thanks very much for being here, and thanks very much for completing the…or for signing the consent form. So, as I've mentioned, the question that I'm just…I'll be asking you is what is your perception on clinical competence of CSNs? Just a reminder that don't use your name, or the facility name, just use the number and feel free to give as much information as you can. Thank you

PN 7 *Nna* from my experience since 2015 *neh* ..i can say 60% *neh* of the commservers, they need lesser guidance. Most of them they have the confidence, 'cause of usual they are based where there are no supervision, from my experience, I was placed in gyne ward in 2015. So I didn't work under supervision, I was only given orientation for a week. So, most of the commserver here they will come with good communication whereby they can communicate with patient based on Bathopele where they can give patient information. I think they are trying. They just need minimal guidance on the communication, they can advocate for the patient whereby they translate, if there is something that should be done on the patient, they are able to communicate between the doctor and the patient, they can translate to the patient what the doctor's saying, 'cause, most of them, maybe they don't understand. So for communication, yes they are trying. For ethical behaviour, they know what is good and what is right based on the policy and regulations that are provided by the institution. So, professional behaviour, at least they are trying to wear uniform and the distinguishing devices and, so. For management, I think, yes, they are also trying, but then they need guidance and supervision whereby the sisters and they can be left in the ward whereby they have to make sure that medication are ordered, let me say at surgical ward, we order on Thursday. So, they can do drug ordering, do ward stock ordering, they can do off-duty books, they can delegate, they can supervise from seven to seven at the…in the evening. So, from both North West MMACON and Excelsius commservers, they're trying their best. Out of hundred, I could give them at least 80%.

Interviewer Can you give others chance first, then we'll move to the next one. And, if you have any other information maybe that you want to add, you are welcome.

PN 2 Professional nurse number two. I don't know how to put this. I think, in general, they are competent in general. As much as we have specialised units and general units, in specialist units there's always a challenge, and I think the only way of correcting it, like they would be allocated maybe in a specialised unit, and they will be for coverage. So, we don't

get enough time to…to try and guide them, enough time to try and improve their skill where they lack.

Interviewer Ma'am, how are we going to correct that? Because we have to have time in order for them to be competent.

PN 2 I think a period of twelve months, it's okay, but we need to allocate them not as workforce, to allocate them as part of the team. They are still learning in the specialised area but in general units they are just doing fine.

Interviewer Specialized area, do you mind giving me example?

PN 2 Like theatre, high care, and even with Obstets they still need to practice deliveries.

Interviewer So, they need supervision, but the challenge is you are busy.

PN 2 Yes, the challenge is we are trying but we cannot accomplish what we need to accomplish.

PN 6 Professional nurse number six. I think I'm just going to add like in special areas like maternity, there they need supervision. They are trying we have to be there for them.
Even though, actually, we don't have time, but we must try to have time with them, we must guide them. We don't have time and there is a shortage of staff there because they are allocated maybe one with two of the commserves u see? We have to guide them. In maternity *nna* alone, I don't trust them alone.

Interviewer Then how do they function, because you don't trust them? Are you with them all the time? When are you going to trust them?

PN 6 It's not going to be all the time.
Interviewer When are you going to trust them, if I may ask? Because, next year, they will be professional nurses because now we preparing them [SKIP] to this role and you don't have you don't have time. Then what are we doing?

PN 7 can I try to assist. The problem with commservers ……

Interviewer That is professional nurse number?

PN 7 PN number seven. The reason why most of the commservers are not trusted in

maternity like sister said, you will find that is only 1 advanced sister for maternity and the whole staff are assistant nurse and the staff nurses and two commservers. I will say the best way to make sure that they can trust them, then you can leave whole duty with them, maybe we can make a tool neh whereby you assess them. 'Cause, usually, nna when I was a commserve, I don't remember being assessed, I don't remember that. At least in two weeks or so. If I'm going to stay at maternity for a whole year, for one month, maybe we can make a tool whereby they assess me. First week, they can check if I am able to deliver, do I know normal labour for whatever, whatever? So, every Friday, maybe sister will come and say let me check if you do manage to do this u know, maybe we can have a tool to where you assess comserver, especially at special unit, especially maternity or high care, just to write a tool, you check if so and so be able to do…did you manage to do so?
Or you can give me a tool whereby you say I'm going to use this tool by the end of this week so that you accompany this. That thing will give me a motivation so I can gain confidence on what I'm doing. But then, if there's no…that supervision or that tool, I will never gain a confidence or motivation. U understand?

Interviewer Thanks very much ma'am on that note, but now, remember, you can do it in the ward or maybe tell us how do you do it in your ward because that is a good recommendation for specialised area or maternity. And then, in your ward, how do you ensure their competency, CSNs? There is a good one and it will be one of the recommendations for specialised area. In your ward, how do you ensure that their competency is improved? You have CSNs in your ward, isn't it?

Group Yes.

Interviewer How do you ensure their competence?
PN 7 Usually what we do *akere* when she start we give them orientation and everything. We tell everything. We orientate her on surgical ward then at least on a Friday but usually is done by the operational managers, our sister. Sometimes she call them in the office and something like…it's not an assessment per se…is just to tell that person where can you achieve? You are still struggling with this, are you comfortable doing this? Are you getting okay with the dressing and the other things?

Interviewer Ok based on your routine, are you saying they are competent, ready to be professional nurses? Are you saying they still need supervision?

PN 7 …they just need minimal supervision. They are coping. But they just need minimal

supervision.

Interviewer When you're saying they are coping, are they coping because they are not competent? They have to cope?

PN 7 They are coping because they are competent. They have confidence to do what they are doing.

PN 6 Professional nurse number six. I think it doesn't mean they are not competent. When they are working, they don't know what they are doing. They know, but they need supervision "*letlhako le le ncha le agelwa go la bogololo".* They need those who are having experience just to guide. It doesn't mean they don't know.

PN 4 As it has been mentioned that but there are the specialist units, like they have been working in theatre, theatre is there other unit that need more…. When new students they are coming they need more lay out of the ward. I know when you are at the school, we just go to theatre but just for the practicals and come back. So when we came in the hospitals, then they put you in theatre. So the only thing that you need to do, as I'm working in theatre, our unit manager, they orientate student in theatre….

Interviewer …the commserve or student?

PN 4 Commserves. Commserves in the unit because in theatre, we've got recovery, we've got reception, we have got CSSD, So these commserves when they in there, the unit manager must show them according to how theatre is divided. And after that, the unit manager usually in our unit with the in-service training for those new ones so that they must start to know because there we are using the instrument, chemicals, the machine that we are using there, they need to know those things, how you use them. So I think they need more when they are in theatre as the sisters that they've been there for many years, they have to take them. it takes long because it's a long process for them.

Interviewer Ma'am I hear you talking, and professional nurse seven, most of you, you're mentioning unit manager, the unit manager is doing that. Why are we saying…shifting now everything to unit manager? The unit manager, is she the one who is with them on the ground?

Group No.

Interviewer The professional nurse, the one who is with them, so what is your responsibility?

PN 4 So, my responsibility when there is a new –

Interviewer Or your role.

PN 4 My role as a professional, when there is a new commserve, this person I have to take and introduce het in the unit. Then, after that, I have to take rounds in the unit to sure her where we put our stuff, where we put our stock, wat is happening in theatre even if to do, to prepare for the cases, I have to go with this person to show here we are putting our stuff and put them in there, in the theatre, they prepare for the cases things like that.
Cases that we're supposed to do this person must be next to me so I must show her how we do things. Even if I am going to scrub, this person must be next to me and show her how we scrub, how we open the packs, things like that, *kore* everything you have to show her.

Interviewer Are you doing it? Let's talk the reality? You're mentioning what you're supposed to do, but you're having the commserves in the ward. Are you doing it? Are you saying they are competent? You are assisting to improve their competence? That is what we are trying achieve.

PN 4 They are competent according to my assessment because they are committed to what you are teaching them. Because, if someone is committed, you will always be asking questions, Sister what is this? How is this done? or you'll be always after you to know more about what you are trying to teach.

PN 1 Professional nurse number one. …clearing throat….. *nna* my comment will differ. *Akere yanong* it depends on the unit that you are working with. So, with other units you won't have that experience. I will just comment on the experience that I have in maternity.
I don't know gore is this …kore I don't know what to call it. There is this perception, maybe is because nursing where it comes from, it was initially general. You will be doing a general nursing. And then it will be compulsory that you do midwifery, and then the other will depend *gore wena* you have interest in Psych or community. So the government came with the proposal of tackling everything in one area so that if you go to the clinics or where you are stationed, you can have the ability to deliver in all spheres of nursing. So....I don't know what actually is it whether nursing right now, is it a calling or a passion to do it, or is it just that is one of the profession you have to follow. So you will sometimes just wonder if that person is here with the heart of being a nurse or what? *Kore* you just become puzzled. Because, for everything, there must be initiative and an interest. So, like the sisters have been saying

gore , you'll show a person something and then that person will have that that eagerness of wanting to know and follow you. My experience in maternity I don't know is because most of the people, they don't like being in maternity. I don't know whether is because maternity is an area that is perceived as litigation is something like very much or work maternity is different from other wards like for instance if a mother or a baby dies, there is a research going on *gore* how did it come about and what happened. So most of the people, when they come to maternity, they've got that fear. It's rare that … is one out of five, or two out of …. When see gore out of this people is ready. With communication, if you want to know something or if you are eager to know something, you perceive or you instil that feeling *ya gore* I want to know or I want to see. So, it will be like you'll be just doing it just to go to pass through maternity because even other they state *gore* if I can just see three months past, just for me to get out of here. So, sometimes you become so heartbroken gore but when are we going to have midwives? So, the communication part of it is not like *gore* I want this or I want this. So, somewhere, somehow, you'll be just pushing, pushing, pushing and then there the eagerness of wanting to know or *eng* won't get too much of questions or too much of saying I want this to know this and that. Wena you will be just following up and asking have you seen this? …just like that. So, we always, during the rounds or whenever, give that information, or sometimes we the health education, or we present the topics, and then give information but you will be just expecting for you must get too much more from because you are still from school and we say *akere jaanong* like sister said, "*letlhako le le gologolo …le le ncha le loine le tlatsa le le golo"* because wena you will be full of the past and then they come with the new. So, you'll have that *gore* why can't me this? So, just tell me this. How are you doing it? Where have you seen this? Can you give more where you are from or where have you practiced? Come with it, that is positive and give to the ward, but it will be less, and then you'll be expecting more so that *le wena* you can give. So this of one of the ethical perception [sic]. *Akere* it was entailing Bathopele principles and patients' rights , *le yone* you'll be expecting more because they are new …. *Wena* you will be having this on … what in theory. So, you are expecting them to give you more of the new, or maybe to express those things to the patients, but, most of the time, it's lacking. Most of the time *kore* they don't spend too much time with the patients. In our olden days, every hour or every minute that was passing by, you'll be next to the patient. *Akere* patients they are there for you to give them more information or to lighten them up. So, really, it will be not hundred percent, or you'll be expecting more, more, more, but…or you'll be following them up, can you please do one, two, three, four? *Kore* it's not like that full eagerness. Every time, you have to remind or, every time, you have to instil that, or do this, do this, do this, and I

understand *gore* if you are maybe orientated or inducted, you are inducted or orientated so that you can go on, not to expect *gore* every time you must be followed up.
So…. Sometimes, you'll become like frustrated. You want to instil that, and you want that to happen, but it's not happening as you are expecting or is not happening as you wish it to happen or *wena* you want to instil that, but it's not like well accepted.

Interviewer Ok…still on that, you're talking more of your expectations from them and you see them as people. Yes, you're saying they are not eager, but, when they're doing certain procedures, are you quite sure that they're doing it right? Is there any, maybe, specific procedures that you're saying, yes, these ones I can say they're doing well or they are interested in doing that specific procedures or is just the whole maternity?

PN 1 Procedurally, so *kore* I cannot say they are not doing it right because, sometimes when … ha *o tsena mo ntlung ya motho o fihlela motho a…* maybe *o tlare ha o tsena ko roma o fihlela seo baroma ba se dirang* …. I'm expecting if maybe they come in and [VERNACULAR] they see *gore* we are doing something but it's not the correct way that they were taught, or it's supposed to be done. They have to come with the change. Sometimes a change is not there. You'll be say, no, but *lo santse lo le bantsha* come with the new things and let's practice. We are doing this, but not hundred percent correctly because of time. At least we've got extra hands or what, so let's do the correct thing. Because, sometimes, *rona akere* due to shortage of staff, sometimes you just do things double up, you don't just follow the whole protocol or procedures. So, if you are with them, you expecting *gore* they'll say, no, sister, but this is wrongly done, let's do as we know.
But, most of the time, we don't get that.

Interviewer But now, if you are aware that you're doing things wrong, how do you expect them to correct you?

PN 1 That is what I'm saying *gore wena* you will be trying to say let's do the right, because now we did this because of shortage of staff, so now, because you are here as extra, let's follow the correct route but it's not followed kore…like…yoh…they don't give you that hope *gore* because now you've got extra hands, now we are going to follow this. So, I was thinking, with this professionally…professional behaviour, I don't know whether maybe we'll be expecting more, or maybe…we are not…even at home, you cannot expect your children to behave the way you behaved at your time, and, even now, we cannot expect professional nursing profession to be like the way it was before. We have this tendency of knowing a

senior, whoever or what, *kore* you give that respect and what. *Kore nna* what I have realised, their professional behaviour is…it has gone cause we were expecting maybe like *bo* delegation, or maybe reprimanding or what, everything will be taken personally. Rona we knew *gore* according to profession, if you have done something wrong or …you correct or do whatever, but now you even fear to reprimand, or maybe to call to order, say you just ask yourself gore maybe I am outdated or maybe I am not making people to feel free where they are.

Interviewer but how are we going to correct this? How are we going to? Because we cannot just leave it the way it is. We need to come up…because, at the end of the day, we are not going to be able to show them the correct way because we'll be thinking they will take it personally, but, at the same time, that patient is the one who's going to suffer, and we are not going to have competent practitioners. What can we do? Or what are you doing, in your instant, in your ward, if you come up with situation like?

PN 1 We normally address it, we talk about it, and we delegate, and then we follow up *gore* whether the delegation is done. We keep on talking and even referring *gore rona* in our past we…. we give them the information about our past*. Nna* I always tell them, I always say to them gore this and that… I see something wrong I call them gore not this way, like follow up, w aba *cheka.* So, this one of managing –

Interviewer It is fine. While you are still thinking, maybe we can check somebody else.

PN 3 Number three. From my perspective, the CSNs are doing well. And they…. Not 100% but you know most of the times because of the shortage, they are mostly utilized but they really pull their weight. Coming to communication, they are doing well. Ethical behaviour? There are elements of we need to really improve on them as they are Novice in the nursing field, we are having protocols, we are having policies, and then, this, when we talk about ethical behaviour, we are talking to the ethics of nursing. We need to polish them in their career of nursing. We do have the material that we need to…even though we cannot read the whole book, but we need the most important things. Every time, you just remind them, guys, this and this and this regarding this, let's just come around, let's…when they are free, you just call them and address some of the things that you need… like according to this, you need to do this, to do it like this, to do it like this. And the professional behaviour as well. Every profession has got its etiquette and whatever, and, at times, we assume that people know what they are supposed to do whereas we don't know because what we should do is they are here, we know they are professionals, but let's just assume they don't know

anything. Just we are not going to go in details because at least they do have the basics and this just try to round up whatever they need to do, because, every time they are here with us, we do see that this one, the element of professionalism, he is or she is lacking this. This one is most of the time on the phone when she's supposed to be at the patient's bedside, or maybe the patient talks to him, he's having the headsets on. You call the person and just address it with the person that phones, when you are at work, you should put…switch…your phone off, and the you will attend to your phone during tea break or lunch break because you are not going to …at times, there are things…when you are on duty, there are things that you need to open your eyes and ears. Now, when you are having these things and then you are just doing whatever, there are things that you might miss, and that can cause the life of a person.

Maybe somebody calling out and you don't hear what the person is… So, we need to be hundred percent concentrated and try to remove all the distraction. And then the managing diversity, managing is a bit controversial to them because these people, they are just newly qualified, and they are not sure…they don't have the confidence, but, if we instil the confidence in them, we delegate to them, and we just leave them to lead, give them a chance to lead that this is…I've delegated you to do this, to do this, so you are going to do this with the help of these other people. So, run with it. And then you check as to that project as to how she manages or he manages it and whatever. For example, you are weekend off, this person is on weekend in, and then he or she is leading a shift. Then you know that it will be the schedules for daily routines, and there will be specific things that need to be done, and then, because you will be expecting something, you are having the roster there that this should be done, and then you give the person the accountability to say, because this was supposed to be done, sister, I couldn't do this, I couldn't do this. This was supposed to be done, I couldn't do this because of one, two, three. That person will know that, for a fact, I'm encountering problems. She understands. And then support and say I do understand, but the importance of this to be done over the weekend is because we do not get the chance to do it during the week. And then, from there, at least…and try and encourage the person to try and do things that are supposed to be done, because, at times, you'll find that things are not done that were supposed to be done, not because there was no time, but because people were just listening to the music because of this technology. Most of the time, they are just on their phones chatting.

Interviewer You've mentioned that sometimes you are weekend off and this commserve is alone or leading the shift, are we trusting them to run the ward? We're leaving them with

the ward? Reason behind that being?

PN 3 For example, there are two. There is this one, the senior one, and this one, and then you say *wena* the commserve, you are going to do this.

Interviewer So, you're allocating them?
PN 3 Because they work under supervision.

Interviewer You're delegating specific task, then you follow up on that.

PN 3 Yes.

Interviewer Thank you.

PN 2 I just want to be open with this one of commserves. There are instances where the commserves were left to lead to the shift. That's what I'm saying, in high care, we are working two/two. So, you will be with a commserve and you'll be four professional nurse per shift with two staff nurses. So, somehow, during the course of time, we let them lead the shift.

Interviewer so does this mean we trust in them? We believe that they will run the ward, especially in a specialised area.

PN 2 Specialised area like that. That's what I'm saying. It's quite a challenge for us. It's quite a challenge. We are doing it and we are not even having enough time to work with them step by step. So, you are just given the skeleton staff to run the unit.

Interviewer But don't you think we're leading them to failure?

PN 2 That's what I'm saying. That's why I said my…this thing, my…what can be done is to allocate them not as workforce. Let's allocate them, help them, supervise them, but as commserves, but not as professional nurses. At least for that year or at least as time goes by, they will improve and be able to run the ward.

PN 6 Like in maternity, these wards, they differ. Professional nurse number six. You cannot, and you will never, leave the commserves alone. We cannot say I'm leaving them to lead the shift or so. Now, we are all here. What if eclampsia comes there, what if shoulder distortia or whatever? It's not fine. I don't mean it's only commserve. There is a professional nurse there, *maar* she's still new also. So, in that ward, you will never say I am leaving the commserve alone, we don't do that, but there is a lot of shortage here. But we

don't do it, but there's a shortage.

Interviewer And that shortage is actually –
PN 6 Because of that, and we don't even have lunch and everything because of that. I guess, sometimes, we are alone with commserves or a new professional nurse.

Interviewer But, now, are we saying that new professional nurse who just underwent the community service, is she competent?

PN 6 We can say, yes, she's competent, but there are those, even we cannot manage alone in maternity. Shoulder distortia, can you manage? We are only one with commserves.

PN 6 I was asking are you a professional nurse or?

Interviewer Yes I'm a nurse by profession

Interviewer That is why I am able to probe to ask these questions. When you're saying specialised area, you're leaving them, that is why I want to know [CROSSTALK].

PN 1 like the sisters are saying, there are instances like you can say …through observation, you can see those instances and *nna* I experienced a lot. Like I was saying gore it goes with passion. And then you are a commserve, you undergo training. Through your training, there is this core thing that is going to burn in you. But when you complete your profession and what, and you cannot select or save yourself, no, I'm not going to go there and there. You have go through the programme of the… national programme or the hospital programme. So if you are commserve, you are going to work in this ward, this what you gain the experience. But there will be that burning issue in you, burning issue of midwifery, burning issue of surgical, burning issue of medical or what, so if I can tell you there are those in the ward, as a commserve, but you'll be shocked and amazed gore really when you compare with that and you cannot compare, because in life you cannot compare because every individual is unique. There are others that you will just sometimes just relax and forget yourself or that person is a commserve. When you realise, you just say…but, when you come, she has passed the…*kore* you will become so shocked *gore* this one did everything *kore* it just depend. And then there are those who will meet this milestone a lot, milestone a lot, they differ. An individual is unique. So, sometimes, others, you become *gore* no even if…but you're not saying *gore* you leave her, because, even it's me, it's sister, we have been long in this profession, but when there is a delivery or what, I can't just say I'm going somewhere, or

I don't help, I can just say I leave there because I know gore she will ….. Mm-mm. When there is a delivery, I have to be in here because anything can happen. So, even with them, even if you can be sure whether they are competent enough, you cannot just relax and say, no, they are competent, I'm going to be far, or I can just let her, and then you intervene where there is a need, but there is achievement you compliment.

Interviewer ok so…looks like they are competent based on specific areas.

PN 1 Where there's a burning thing within you *gore* she like this. Even when…she can even be in maternity, and then you see this reluctance gore she is having fear. When she goes to medical or wherever and then you come to contact the sister, and the sister tell you [sic] this is an asset. It just depends.

Interviewer So, the rotation, is it assisting?

PN 1 It's assisting because the person will identify –

Interviewer Will identified.

PN 1 …*gore* what is my capability? What is my burning thing? Because it will be through experience *gore* here *gone* I can do one, two, three.

Interviewer So, we can say the rotation –

PN 1 Rotation is important.

Interviewer …will improve also their competent, because people will see where they are competent.

PN 1 Yes. So, I was thinking, maybe to curb this *akere* at their training, they've got these competency books or manuals, let them carry that throughout. *Kore* for instance, they complete the training, let there be maybe a…I don't know, what do you call it? That very same book that they carry when they are still at *ntho*…., that one. Maybe that one we can call it post-what training module. They come along with it in the wards so that we go through it, like sister was saying gore, we can formulate what…to make competency checklist. If maybe this is done, it would be something that is uniform, and then they carry it and take it medical, surgical, maternity, or whatever and then what are the pre-requisite or things that they can say now we are competent when you have reached this and then we go through it when they are in the ward, and then, every time when you are with them, you just check

what is it that I have to check in, and then you assess her and then you tick. And, even in the hospitals, if maybe there can be somewhere where they can be called, a clinical area, whereby, now, during maybe spare time or whatever, they go there, individually, or maybe they schedule or maybe from this ward, one who must come, and it will be different clinical things. For instance, the olden days, you couldn't just come in the ward…even now, come in the ward and start working, using the trolley or what without damp dusting it or carbolising it. Sometimes they just look at me and say, sister, what are you saying? I say like that. I cannot just come in and do something without them dusting or what. So, they sometimes become shocked gore damp dusting? I say yes as a nurse irrespective of category you have to make sure the environment we are working at, before everything, you clean. So, if maybe you have the clinical area just to show …. *Kore* I was sometimes shocked what we see registered nurse*, rona* in the olden days, when you dilute the ampule for injection, you use a pink needle, and then, thereafter, you remove it, you take green to inject. You become shocked. The very same pink needle that was…goes straight again to…uh-uh, sister, ….. And then you become shocked *gore* but this person was…she undergone [sic] a training. Has she forgotten or what? So, if we can have that clinical, because sometimes you'll just say, no, I know she can give injection, then you don't supervise it. Then everything will just happen like this and this. You'll just realise when you are there…and, sometimes, when you are there, it seems as now you are stalking people. No, don't do that. *Okare* you are now after her, like not this way, this way. So, if there's a clinical area, I know *gore* we can *rona* try to say we can do it in the ward, but, due to shortage, lack of time and what, sometimes you want to do that, but you cannot reach, but, if there's a clinical area somewhere in the hospital, you will have that time to go there with somebody else there who is not…or, if maybe, I don't know……..

Interviewer Allocated person for the [CROSSTALK].

PN 1 For the clinical area.

Interviewer Still on that, with the evaluation tool or the manual that you've mentioned, that will improve their [CROSSTALK] –

PN 1 Their competency.

Interviewer And who must tick that?

PN 1 The one who's in the –

Interviewer The supervisor.

PN 1 *Akere yanong* you will be in the ward. And then, if she knows *gore* what I'm doing, I have to follow this, and sister is here in. Following that, it will dwell in the mind *gore* even if somebody's not here to supervise me, I have to do the right thing. Even the dressing, you go, time and again, supervise and then you check when she's a…or she's still not yet, and then you intervene.

PN 6 Professional nurse number six *neh….hhhmmmm*…. I don't know. I think maybe, for them to gain confidence sometimes, even if you are there as a supervisor, give them a chance. Like maybe she's delivering a woman in a delivery sometime, *akere* you are always there with them. Sometimes, just be somewhere but watching *kore wena* you will be aware *gore wa bona?* but she must be there alone, maybe with assistance nurse or staff nurse, so that she can be confident *gore* I can do it alone, not always to be after her or him.

Interviewer So, we also need to improve their confidence by giving them that opportunity to practice.

PN 6 Yes. But you'll be somewhere, knowing that she's delivering there, opening eyes and ears for in case if something happens.

Interviewer ok. Anything else?

PN 3 I was on this issue of this tool. I wanted to talk about it but sister has mentioned it. Because….clear throat….I was in the UK. When you are arriving in a ward, you are assigned a mentor. And then that mentor, you are having that, just like a student. They know that you are a qualified person, but this person is supporting you in there, and ten you go through that.

Interviewer That will assist.
PN 3 That will assist.

Interviewer Then will we have time in the ward? Because we're always talking of not having time. Will we be able to say today you've done one, two, three?

PN 3 Yes, we will have time because these people are doing these things on daily basis. So, every time when she is doing it, you will assess that ok she has done this, and then she needed assistance with this and I must support in this.

PN 1 Professional nurse number one. If that tool is there *akere* this person now will be

trained *gore* basically, I'm expected *gore* the duration is a month or what, maybe in this ward. So, I am expected or I…if this month ends or what, or this day ends, I will have accomplished one, two, three four, because *akere* if you come back, maybe it will be the patient, she'll have to write the patient's name gore in that … what the procedure have I done. So, in that way also, it will also assist us in this thing of delegation *akere* there will be a delegation book, but sometimes you'll be just moving around in the ward aimlessly. When you check at the end of the day, things are not done. *Kore wena* you will be as a mentor, or whoever, we'll say there is a delegation, I know things are happening, and then, as a manager or a senior nurse, you'll be concentrated on something. *Le wena* you want to finish. So, when now comes a time for you to come and review or when the other shift comes, it's then that I know you are going to be alerted by complaints. Sister but one two three is not done, then you will be shocked gore how good people but *mos* I had people here and I had that confidence. I couldn't go back and see whether it was done because I know that they are going to do it, so you become shocked. So, now, if there is this one book, it will instil that thing *ya gore* I have to do because, now, here's a thing that I've recorded that I've done this to this patient. If something is not done, I'm not going to generalise. Yes….

PN 1 …*gore* so-and-so is on duty. It will be sister A or B. But now you have recorded here *gore* you have done one, two, but, now, what they say is not done. So, that one will keep you busy, it will minimise this, the very same thing what sister's saying *gore* sometimes a person will forget herself. They say now there is no work in the ward and then chatting one, two, three. They'll be inspired and say *gore* at the end of the day, if something is not done, then I have to account, so if that book is not there, the person who is supervising is not doing anything to see *gore* you'll be having that thing, like sister was saying, *gore* give them that confidence *gore*, yes, I can do it and say, no, she's going to do it, but, at the end of the day, there's a complaint, *gore* this is not done, this is not done, and *wena* you want to…not to say you didn't want to go and recheck. You were busy with something that hooked you *le wena* until that you didn't have a time to go back and check.

Interviewer Anything else from somebody else? So we are confident to say they are competent in basic nursing.

Group Yes.

PN 1 Only that they need people who can take them further, but those people are overwhelmed, they are overworked, and they are …. *kore* sometimes you just want to or *eng,* but you cannot reach them in totality. *Kore* some other things they will just have to see

themselves along.

PN 2 No… *nna* I'm just emphasising that there are instances that ……..

PN 6 Number? sister number?

PN 2 Professional nurse number two. There are instances where the commserves are left alone in the unit. So, we are somehow overburdening them and frustrating them

[CROSSTALK] group in agreement

Interviewer But how can we improve that?

PN 7 Can I say something? *Nna* I was a commserve 2015, whereby I was left with a staff nurse and the assistant nurse on night duty. It was my first night. We didn't get a orientation. I was working in medical ward. So I had a rape case between a psychotic patient with a bedridden patient, so, I didn't have that enough support as a commserve you know. Things were not done accordingly. So I didn't have that support whereby I lost my confidence 'cause I know that I wanted to do nursing. I didn't come for nursing because of the salary, and I didn't have another choice. I had another choice but then I chose nursing. So, it was frustrating. I didn't get the support, so I lost…somehow, somewhere, I lost my confident and till one of the sister [cancel me. You know she was trying to be there for me. So I went to other ward. So, that's where I gained my confidence back like sister said we need supervision. We cannot leave a commserve alone. Sometimes a commserve need that moral support not only to teach him on how to put a drip, but then just to support physically, emotionally …….

[CROSSTALK]….

PN 7 …psychologically. So, *nna* as the commserve I think, as I was a commserve on that year on that year, I didn't get enough…. And it affected me a lot.

Interviewer So ma'am with that your bad experience, what are you doing to ensure that your experience doesn't happen to someone?

[CROSSTALK]

PN 7 …to another person. For instance neh, it was not a commserve, it was a staff nurse. Like I observed her. She was from medical, then she went to surgical ward. She was not

…. she was dodging, always on the phone, not taking responsibilities. So, I didn't have the confidence to tell her face to face but then I called her afterhours Iwas like, soand-so, nna as a nurse I think you should do this and this, because other people are watching you and the only person who is going to suffer is a patient. As a friend and as your colleague and as your senior, I think you should do this. Be accountable, be in charge, especially when there are procedures that ……. You can engage yourself when doctors are doing procedures. Don't wait for me as a professional nurse to come and call you to come in the procedure. Be interest on…even though I didn't have the confidence to tell her face to face, but now she's improving, she's improved a lot. She even came to me. She was like, sister, thank you. At least I'm trying, you know

Interviewer Thanks very much ….your experience actually taught you that I don't want to see another person going through the same [CROSSTALK].

PN 7 'Cause people were talking around as if like I was not…I didn't [CROSSTALK], I was not advocating for the patient. I was sleeping, or I was eating. So, I don't want this thing to happen to other people.

PN 6 Professional nurse number six. I think this thing of allocating commserves alone is not good *neh*…. And is caused by shortage of staff, we are using them as if we cannot [CROSSTALK] we are using them, they are already professional nurses. If you allocate them alone, it means they are no longer commserves *mos* because they still need supervision, that's true.

Interviewer And now the question is …..

PN 6 It's because of shortage of staff.

Interviewer …are you allocating them because they are competent, or are you allocating them because you don't have a choice? But, at the same time, what are we doing to them?

PN 6 *Nna* I think it's because there is no choice. Since she was still new and then she was just allocated, they didn't know how she…is she competent enough or not? They didn't know her, but she was allocated alone.

Interviewer But we need to do something about it because it's like we're killing them.

PN 4 Professional number four. I think this thing of allocating commserves I think is better

when you allocate her with someone who was already worked long in that unit. Like for example in our unit we don't allocate them alone. Always, you allocate them with someone who has been working there for many years who can support them.

PN 1 From experience of sister… what sister had gone through….all of us we agreeing that this thing of shortage of staff…. I think, during that time, there was no night super, like recently now, there's been a practice now that there is a night super. But people has got another perception about night super, I don't know. Like you will be just going through the wards checking some who didn't come on duty or checking gore this and this has been done, you are allocated some activities. Are drugs checked? Is the emergency trolley done? Is this and this in a correct place whatever …. but *nna* I was thinking if maybe is one way of cubbing this… If maybe, during that time, sister was new and there is this night super, the night super will be like concentrating on areas where there are commserves. And the he will be knowing gore this, the commserve she is still new due to shortage of staff, she's placed there but she doesn't have someone who's got an experience. So, during my time of the night, I will be more or dwell much in that area. During treatment out taking or what, I will be with her and then and supporting her, and then check the risks and whatever, and then check with her gore how are you going to do…or I foresee this and how are you going to do to see that this doesn't happen. For instance, is a psychotic patient there with bedridden patient, maybe as an experienced sister, unless it's at night, I know gore this patient is placed there. So, maybe now, let's place her nearer to the ward where maybe we are …. every time we are having access to the ward so that each and every now and then we frequent that ward and check. Or we allocate a minutes or what gore you do an overall checking and check the very psychotic patient because, actually, it's an open space here. Even if the patient is…you're saying this patient has been given treatment and now he's stabilised, he cannot *…... nna* what I was taught or what I know about psychiatric patient is unreliable. You cannot say now because she has been on treatment and what, so she cannot do, always have *gore* anything can happen, she can change at any time or maybe she will be well sound but she'll use her in this as an excuse and do things that she knows that is not supposed to can do. So the night super will be concentrating on areas where the commserves are, and then, in other wards where there are experienced nurses, just go and overall checking but most of the time be with this one, the commserve areas

Interviewer So if I get you right you say they can be left alone (commseves) But under supervision of the night super.

PN 1 …[CROSSTALK] or day overall in charge. Every time, when he's doubtful of something and then they will be able to come, not to say I'm busy, I cannot come to you, but that person must be accessible and be available at all times.

PN 7 So, to ensure that these commserver *neh* they are competent enough, I think *rona* as seniors we should work on our attitude. Our attitude can help them to improve, to grow kore to be like …to perform well in communication and professional behaviour. Rona as seniors we should improve on …. attitude *ya rona*. Sister mentioned something about junior respecting senior. How can I respect my senior If she doesn't respect me? respect come from both sides. And again *rona* as professional nurses we should use our management skills you know, whereby I know how to solve problems like in the unit how to….like conflict management, problem solving, you can teach them on how to do these things. I think that's where they going to improve. Communication, information, we can give them in-service training every day.

PN 6 And also their behaviour. They must also have behaviours is like … even nowadays is like nursing have changed.

Interviewer That is professional nurse number six.

PN 6 Number six. *Kore* is like this etiquette or something, it's like it's no longer there *maan*. It's like nursing have [sic] changed with the new people who are coming from school.

Interviewer Isn't it maybe with, as supervisors, we don't…because we're always saying we don't have time, we're always saying shortage of staff. Isn't it like we're just neglecting them –

[CROSSTALK]

Interviewer As you've mentioned that we assume that they know, but I think the attitude of us, as supervisors, has to be maybe changed so that we give them the opportunity.

Mumbling in agreement…

PN 1 likwe what sister is saying and the very same … information the sister is giving ...respects comes from both. It's unlikely that nursing…I don't know whether…I haven't checked in other professions, but I think nursing is most profession that, most of the time, people are always are always together. If you check with the clerk, she will be having her own office, I can check the social worker, she is having her own office….. I can name them,

but I think nursing is the most *ntho* that has got people that are working together. So, a place where there is a group of people, always there are things that will depart people, that will make people to be not united. If it can come to the census of nurses say, when I wake up or when I dress and say I am going on duty, I'm going to my profession, if everything in my house or where I stay land then I will collect it back when I come. Kore… attitude, like sister's saying, just…if we can just take what we have learn [sic] form school and practice it at work I think we will have hamonous work and see commserves that we are talking about and other nurses where the perceive themselves as one, and a s a family, and if we can take this into consideration that where we are going in the wards is not for the benefit of who, who, is for the benefit of the patient, and it's for my benefit that, when I knock off there and come and sleep or enjoy, everything that I have worked for, that person that I was dedicated to her, I've done hundred percent or I have tried. Even if you cannot do it but I've tried, this one will help us in a sense that you come on duty, I didn't know sister, or maybe I know her, I was training with her or I come from the same place with her, or I don't know sister, we just meet here, but I'll just look at sister or listen to her or and then see something or and then I conclude to myself that this one is one, two, three, four. If we can leave or do away with judgement of each other, I think we will go somewhere. If I can just concentrate on *gore* we are here for a patient, whether the behaviour a one is sweet, the behaviour one is sour, the behaviour one is bitter or what, let's just leave that one and concentrate on doing our job …and let's leave away this judgement of grapevines and gossips. Let's just concentrate on the patient. If we see *gore* like the sister was saying, *gore* dodging we…an individual is unique. There will be those who are lazy *[nyana],* dodging, don't want to do or pull up socks and what in, and then there is this other one who is moderate, and this one is high. *Kore* If we can just complement each other, we can go somewhere. The very one who is dodging every time, just pull, *kore* like joking this, I know, but let it be with a good spirit, not like now you'll go to some like *mmabobodu, a bo o mmone gore eng*….. No, just, like she said, she confronted the very same person, and then the person will know *gore ohh*, this one, I know even if I can stay somewhere, she will just go and look for me, but in a nice or a polite way, not *gore* she has labelled me or what, and then she will just pull up herself and say, okay, no… and the very same issue, like I'm saying, this thing of if I say something to her *gore* and then we take it personally. So, let's leave that. Let me just say, okay, no, actually, even if sister can just cremate me or do *…. nna* what I know is that now my work I've done it or I'm doing it for the patient. I'm going to do it gore now I want her to love me or I want her to…. praise. No, you do the job for your sake to do the job, but not to be praised

or to be loved.

Interviewer So, what you're saying is that the attitude of the supervisors need to change. PN

1 Yes. And not only the supervisor –

PN 6 And the junior.

Interviewer And the junior.

PN 1 The supervisor can be one, two, three, four, but, if me, a junior or whoever, *gore le nna eng eng*……. I want to be on top of her, I want to show her what, that won't help. Let's complement each other. Let us not compete but let us complete each other. Where we have lacked, let me intervene and complete. Where we have lacked *le wena* because there is no master of…. The know all…. or even if you can have experience or what, you can be shocked *gore* a junior or somebody whom you were undermining can take you out of a very critical *ntho e leng gore* it can happen to you. So, even if you know *gore wena* you can excel, or you know everything amongst other people, don't show them, or don't undermine them openly so.

Interviewer You must just keep in mind we are on commserves, clinical competency, on their competence, because now it's like we're talking general.

PN 1 *Kera* the very same *rona* you experienced once. Just embrace the what the commserve have, whether bad or good, just try to…but, bit by bit, not…Rome was not built in one day. Even if that person can be lacking behind or coming slowly but, one day, he or she will also reach the goal.

PN 2 Its just an addition, I'm supporting that issue that there must be a tool, evaluation tool. So, in our unit, we've developed the orientation programme, and we are really doing the orientation. We have the induction tool, so whereby there are procedures that this individual must learn and there are conditions because we are admitting certain [CROSSTALK] –

Interviewer Critical patients.

PN 2 So, we go by this. Every time when you've done something for him and we demand feedback, it is helping, but the only challenge is that you don't have enough.

Interviewer That was professional nurse number?

PN 7 Number seven. ….. in the clinical facility from…I attended North West university, I think they did but then for them to make sure that a new commserve their competence *neh*… the duration for clinical practice are not enough as compared to MMACON in Mafikeng.

Interviewer With the colleges, so, the university and the colleges.

PN 7 Yes. So, the time given for a student is not enough 'cause maybe Monday and Friday, and then the rest it's theory. So, most of the commserve from North West University there are still lacking information. They're only good in theory part, but practical so, they are not.

Interviewer So, what you're saying is that it's actually building up from the training.

PN 7 Yes.

Interviewer Thank you very much, colleagues, I think you have shared enough information and I would like to take this opportunity to thank you…..yes I will come back and give feedback. Thank you

--- END OF AUDIO….

Annexure 12: Focus Group Discussions with CSNs

Interviewer Morning, colleagues.

Group Morning, Sister.

Interviewer My name is Kholofelo Matlhaba, I'm the researcher, as I've mentioned.
Thanks very much for giving me the opportunity to interview you. As I've mentioned, I'm here from North West University, and the topic for my research is development of an evaluation tool for clinical competency of CSNs in the North West Province. Then my promoters are Professor Abel Pienaar and Professor Leepile Sahularo. So, feel free to participate and you give information as much as you can. And thanks very much for signing the consent. Remember, by signing the consent, you're giving me the permission to use the information that you provided. And, just to remind you that no names will be mentioned and please don't mention your name or the facility name, but feel free to give me all the information that you're having. If there's anything that you don't understand, then I am willing to assist you with that. And also to remind you that this interview, there will be no actually harm or injuries to you, so feel free to participate. So, the first topic or question is: what is your experience regarding clinical competency during your placement as a community service nurse?

Comserve 4 Please elaborate on clinical competency.

Interviewer Clinical competency is when you feel you are actually good in doing something. Clinical, we're looking at what is happening in the clinical area. It can be the procedures, it can be the communication with your colleagues, your mentors, or everybody else, and it can be in a form of professionalism where we're going to look at the way you are dressing yourself, the way you're carrying yourself as a professional nurse-to-be, and it can be in a way of ethical consideration where you're going to be…your interaction with the patient, how do you interact with the patient? Do you find it difficult? Do you know the Batho-pele principles? If yes, how do you apply that to your patients? For example, when you were doing OSCE, there were procedures that you were doing, and they were saying you are competent or not yet competent, so which means you passed, you're good in that.
But you must just keep in mind that there's always room for improvement.
Comserve 4 What I will say is what I feel is you get into…maybe you are placed in a ward and you get there, you are orientated for a week two. In our facility, they will be saying we are going to help you through the way, throughout when you are still learning, but manager

can say, whatever you need, ask, but now, when you get to the actual asking, then you get different responses from different professional nurses who are now your supervisors who must help you through the way. Some will be supportive, but most of them are really not supportive, the reason that they are giving being that they don't have time to teach us because they are overworked. Taking time for them to show you something means they are getting behind on the job that they have to do and, yet, they will have to go back and do their own job and they are pressed for time, so they become irritated, they are shorttempered. You try to understand why they are doing that but, still, you need their help, so you become frustrated because you cannot really get help. But they also have their reasons why they are not offering you that help that you need, that is what we experience in our facility.

Interviewer Please you're free to talk. Then, if there's anything then I'll come back to you maybe if I need more information. Maybe, before we talk, you can just say number one.
So, that was number four.

Commserve 4 Yes, number four.

Commserve 5 Number five. According to my experience of…from two wards that I have worked at, I'm now having a different view from what she said actually 'cause, for me, where I have been working, all the staff there have been so supportive to me, they have been taking me through all the procedures, especially those that are new to me, and, also, they have been taking me through all the things that are done in the ward, you see, so… They have been supportive to me. I don't know if it's only me, but that's what I've been receiving at the wards that I've been working at. So, I never encountered anything negative from the ward.

Commserve 1 Once again, like she mentioned, it's a personal thing. Obviously the wards differ, and I think I know that he started in a ward where it's more routine, it's more…I can't even remember where number four started, now to think of it, but I think it just depends on personalities and how the ward…if there's time to thoroughly orientate. But I also actually started where number five started, and I must actually…I don't want to say disagree, but actually orientate me. And, so, for me, it was also a bit difficult to adjust at the beginning. I don't know if it was because we were…we started at the beginning of the year and…I don't know.

Interviewer What you're saying is that your experience is actually different from –

Commserve 1 Number five.

Interviewer …number five. The two of you were allocated at the same ward.

Commserve 1 Yes. But he started…I know number five started a bit later than I did. So, I remember I was already there for a few months when he came in.

Interviewer So different experiences?

Commserve 1 A bit different.

Interviewer …different. Do you want to tell me that with regards also to clinical…to the competence you felt you were actually thrown there in the deep end? You can elaborate on that.

Commserve 1 So, the one thing that really got to me was…this is a very stupid example, but something…writing something like a nursing care plan, they say but you're *mos* new, fresh out of the books, you can write them. You understand? So, I feel like sometimes they expect like we just know everything, and I know we're supposed to be fresh out of our books, but I do feel like the past…and I don't know how all of your degrees…I'm not sure how exactly it works, but where we studied, it was, in your third year, you did your midwifery. So, in your whole third year, it was basically midwifery and so in your whole midwifery and all those things, but it was midwifery, and then you finished in you fourth year, in May you finished with midwifery, and then you went to psyche, you worked in the Witrand for long. So, for us, when I got into the ward, I didn't…I started in surgical ward. So, that was quite like, oh, my goodness, I can't remember all the wounds,
I can't remember the ward routines, all the diseases that you…the conditions you face in surgical ward isn't something I've worked with a recently. So, in two years, you can forget lot….laughs…... So, I don't know.

Interviewer So, how did you manage that? Because the last time you were with patients on conditions, different conditions, was two years ago. Now you are here in the surgical ward where you have now to show your competence. How did you manage that?

Commserve 1 I think, really, it was like…at a stage, you obviously build a relationship with some of the staff members, and then they really do guide you. Like I know the staff is very nice, I really…I do like them, but it had to…I had to get to know them, they had to get to know me, and then there was a few that I was willing to ask…..laughs…, but the others are

not….laughs.

Interviewer Number five, you said your experience was different. Please tell me more about the procedures that you feel competent enough to say I know these procedures?

Commserve 5 Ok….clearing throat…..Number five. Like I said, my experience there was very, very superb. *Yah*…they did take me through the procedures, especially those that I couldn't remember well, they took me through all them, and *yah*, so far, I can say, most of them, I'm very competent on them. And it was easy for me to easily adjust to those procedures 'cause, back there at school, I worked surgical so many times, and almost all the placement that was done, I was working surgical, surgical. So, I use to remember all the procedures that was done there, so it was easy for me to easily adjust.

Interviewer So your experience is actually different in any….. maybe procedure, or are there any procedures that you felt you were not competent with and you were actually expected to perform?

Comserve 4 In ward …. which, when I remember I was not exposed that much to. I was working a lot in surgical ward. I even wanted to query but, at the college, even when you try to show the lecturer that you are allocating me a lot in surgical ward, I don't have experience in other .. they say if you can just come and see how I struggle when I'm making an allocation, then you won't be complaining. Just accept where I'm putting you and you must just go there. So, I had a lot of experience in surgical ward, but, when I started, I was in medical ward. So, the conditions the patients were presenting with, they were, let me say, too much for me. I couldn't handle seeing that much sick patients. Sometimes I was even afraid to go and touch. There's an IC drain, and I don't even know how to handle this patient with an IC drain. Maybe it's hurting him or it's getting out of position. I don't know, when they are putting it, where are they putting it exactly? When I have to maybe to bath the patient or take off the clothes, what is really going to happen when I help that patient? So, for me, it was a challenge of conditions what is happening here and how much I intervene? But, when it comes to a procedure, like the ward routine, then that I can do because I know that I have to come in, I have to do the doctor's rounds, give medication. That, I'm used to doing. But now these patients are so sick, and they are really scaring me, and I don't even know who to ask. When you ask somebody, no, I don't know. The doctors knows. So, you end up doing things that you are not even sure whether I'm doing the right thing or what, and then you just say, as long as I did my best, hope your best is good

enough, but you are really not sure if it's good enough or not.

Commserve 2 I supported number and number one. It really depends where you are allocated and I luckily get nice team. But everyone was asking me can we help you, can we help you, can we help. It was a chance to me and I thought maybe it's like that everywhere. But, when I changed team, the same unit, it was a disaster. I felt where I am now, where are those ones who were asking can we help you? No, I'm fine. I'm fine. No, those being fine, now they're over. I'm not fine. I need help and there's no-one.
Everything. Even if got those degree but we are…this is our first year … like we are working, but we did need a help from professional nurses with kindly hearts who has willing to teach, not like, oh, you were here for three months, you are still asking this, you have a degree, maybe let's come to staff, they will tell you, no, you have a degree, we don't have, no. And they know everything. I felt in a dirty and I was like I wish to quit, and I wish to quit this team ….laughs…. and go to my old one. And, when I changed to other unit, I really felt that they are busy, busy, busy. You are just thrown there, you have to found your way, and you have to save life. Fortunately, they all say, when you meet someone, and they make you…you did something wrong, that something wrong teach you a lot we learn from them. So, when I was allocated now in medical, but I was like no-one was training me. So *yah* ….You are thrown in a…like jungle of lion and you're having to find your way and do that thing. And clinical, I think, where I am, I can't say I'm not competent, I'm really competent at where I am, but, when it comes to in the ward, like doctors round, like following patient, let's say blood transfusion, I know how to do this. Whatever I'm doing with a patient, I try my best, even if I'm busy, busy, but I try. But, when it comes to other thing that's really regarding you as a commserve, you are near to do interview, that, but it's like I don't know what I'm gonna answer because they're gonna consider that I wrote those forms and what. Those file in the office, no time for that. And always say, okay, come when, when I come, you are busy, and we need those files to know what's wrong, what is about them, because, when we do interview with interview about those files they have in their office. when you like are caring for patient, you have to know, because someone is in office for that, and, when it comes to contact with the family, because I don't know what they're gonna tell them, I ask, and now it's three months left, I'm still asking, sister, can you come and…because she knows the policy and what, she's the one to come, but, at this level, if you were guided or oriented, you should be able to face anything.

Interviewer Number two, you've mentioned your qualification, your level of qualification, or had some actually negative impact. Do you really think you were treated fairly or that maybe

affected your performance? Especially if you were classified as the person who's having higher qualification and people forgetting that you are just coming from school, you need guidance. How did that affect your performance?

Commserve 2 It didn't affect me. Emotionally, it affected me because, if I ask you can you help me? So, emotionally, I'm shocked. And, on the other side, there was like, if maybe there were many PN, I should to that one, I should choose, have a chance to choose, but, because of shortage, there's no chance to choose. But it depend who you are, working together. I really had angel team. If I didn't have that team, I could have ….

Comserve 1 Quit.

Comserve 2 I couldn't with that angel team. We are dearest friends.

Comserve 1 Can I give an example with regarding to number two. With shortage of staff, there is nothing that you can do or help with, but an example where I fit in. So, we are used to, in your fourth year as well, even with delivery, you have someone that is…you have another sister that's standing with you, checking if everything's okay, and I know, even in private, you're not allowed to do a delivery one only. You have to have someone for mom, you have to have someone for baby, but, currently, I know you…..laughs…the first baby I delivered in the hospital was on the floor at seven o'clock in the morning, and he was there quickly trying to open a pack for me just to…but I was so like, oh, my goodness. So, now, it's going from you have three people, it's a controlled situation, it's fine, and there you go, bam, alone. Go, there's a patient, *nou gat jy diep kant, swem*. So, that's not nice. I think it's scary. For me it was.

Interviewer Number three and number six, your experiences.

Comserve 6 With me…number six. I've been only here for two months, since July. Over the past two months, I think I've learnt a lot because, fortunately, the team I'm working with, some of them are so kind and good. They take their time to show you. I can say thirty percent of them, they'll show you how to do this, then they'll say, the next time, I'll watch you do it, correct you. So, my competence I think is improving. But the other thing I've seen…because we are in the same ward with number four, but he's been here I think six months before me. So, with the patients, sometimes I feel that the other team members, they like…because I take my time to assist them, so they're like, hey, you, you're spoiling these people. So, I feel like…so, I'm saying it's maybe it's because I'm comserve, maybe

when after comserve I'll be like them, but I don't wanna be like them because I think, as a nurse, we are there for the patient, we advocate for them, you must assist them. You must have our time because, when I'm here, I'm at work, so I must have time to help them, whatever she needs or he needs. If you say help me to the toilet, if I'm not busy, I must take him or her to the…so they say, hey, you, man, this. So, I feel like they regard me as a traitor sometimes….laughing….. That's my experience so far. But I'm learning. But I am learning a lot.

Interviewer So, for them to regard you as a traitor, does it happen with other procedures like maybe giving medication or doctors rounds, or there's a specifically or a particularly procedures, for example, when you're assisting a patient with maybe bed bath?

Comserve 6 Yes. It's some of the procedures, they feel that I shouldn't do this.

Interviewer And how does that make you feel, as a commserve who is actually in this programme? As one of the objectives of this programme is to equip you with competency so that, when you're done with this programme, you are a competent practitioner.

Comserve 6 I don't have any negative feeling. It's just that I told myself that I'll do what I think is right, what I was taught at school, and I'll also ask. Because sometimes I feel I'm a pain in the flesh to some of them because I always ask them because I don't wanna do mistake, especially the ward I'm in, it's accident and emergency, so you can imagine…or I don't wanna make a mistake. So, whatever I do, I ask before if I'm not sure. Even my colleague here, because she's been here.

Interviewer So, you want to tell us that you're relying on your senior commserve?

Comserve 6 Yes…..laughs…...

Comserve 4 If I can add on that. This is number four. I started in medical ward of the three months that they said we are going to rotate, and, in that period, I was working with number three. It was so difficult that, some days, most of the days, we will be found…because medical ward is divided in female medical and male medical …myself I'll be in male medical, she'll be in female medical, nobody is supervising us, we have juniors only, and we will be relying on each other. When she has a problem in female, she will be coming to me and say please help me with this, we are only two with our juniors, they have experience, they will be assisting wherever they can, but sometimes they will say, sister, now you are the sister, how do we go around this? And it's only the two of us, and we have to ask each other, and we

are commserves …..laughs….. So, now I'm in casualty with him, he came after me, but he came in July, I also went to casualty in July, but at least, for the two weeks that he was still in orientation, they were showing me some things.

So, when he comes, he knows that I've been in the institution for six months, but I'm in that unit for two weeks prior to him, but, when you ask somebody and they don't give you that assistance, he will come to me and we will see what we can do, the two of us. And, with the thing of being traitors, casualty, they will be saying this is an accident and emergency unit. So, now the doctors assess the patient, they see they need to admit, they admit the patient. When we call the wards, there are no beds in the wards, so we are stuck with the patient who is admitted. This patient needs to be fed, be given treatment, whether it's TDS or it's QID, and then the senior staff will be saying this is accident and emergency, we are not going to do the routine of the ward. So, we will have to do that. We will be standing on our feet the whole day because we want these patients to be fed, we want them to be taken to the bathroom if they need. If they need to be put on nappies, we will have to do that because *bona* they don't feel that they must do that because their department is accident and emergency. So, your conscience will be telling you I have to do this, even if it's an accident and emergency, but these patients are admitted, they don't have beds upstairs, but you must do that. You will see a patient admitted for three days with not giving medication because, according to them, it's not a routine for accident and emergency ……

Comserve 6 It's not their patient.

Comserve 4 …to give treatment. Sometimes it's not there, but you must make an effort.

Take that file, go to pharmacy, explain to them that this patient is admitted, we don't have this medication in casualty, but the patient needs medication. So, what is happening, they throw you in the deep end and then they leave you, and then, when you do your efforts, they still criticise, you are going to get tired because you are doing something…they are not doing anything, so, when you do, they will just give you negative, negative all the way.

You are going to be tired. Come and sit. You don't have to do that. And then they are sitting there. So, that's what we are experiencing.

Comserve 6 It's the challenge we are facing.

Comserve 4 And, because you don't have a scope of practice, but you are a nurse. Whether the scope of practice, whether there's something written, but you are a nurse, you are taught the basics of nursing, the basics of humanity, just humanity. You cannot let a patient be soaked in a wet nappy for two days only because there are no beds in the ward,

and then you are not going to change the nappies. This is accident and emergency. But now it's going to be on your shoulders. You will feel that now I'm dragging myself because I have to.

Interviewer …you are lucky you are together.

Comserve 3 For me, number three, regarding clinical competency, I felt like I did my four years' nursing, fairly competent in general, community, midwifery, psychology, all the real world. Now, all of a sudden, I'm HR, I'm the cleaner, I'm the doctor, and it feels like the thing that I'm actually is lacking. My….like … when I don't know how to do HR stuff or how to fill in something stupid like a leave form, like that. So, somebody can add on that.

Interviewer So, for you, number three, it's a total different world now. You come in now to the reality.

Comserve 3 Yah. It's stupid stuff like with family, the family comes in, I have to deal with the family. I'm not taught how to counsel, counsellor as well. And it's stuff like that. You actually feel really small 'cause I'm a nurse, I'm supposed to be the patient's advocate, and now I don't know how to do stuff like that 'cause they didn't teach me in school how to tell the family. I know they said don't tell the family he went to greener pastures 'cause then they think he went to Transkei or somewhere….laughs ……., but…so, it's stuff like that that, really, it makes my competence go a little bit down.

Interviewer because now, the family, when they come to you, they see you as a professional nurse who has been taking care of their loved ones, and they're expecting you to say something. That is now we're going to talk about ethics. How are you treating this patient family? But how did you treat them or deal with them if you're not competent, if you don't know what to do or what to say well? And have you ever maybe tried to reach out to maybe the professional nurses with regard to that? Because that is a serious…thing Comserve 3 I know when I was working as well, it was so difficult for me because you have to…for example I have to phone the family. Firstly, they don't speak English, so I don't understand them. Language barrier. And now I have to tell them that somebody demised. So, it will always be like I don't understand what's really going on. So, then I really… It's something you have to learn. So, sometimes I could go to the senior sister and like my number one, and then I will go to her and say, sister, I really don't know how to do this, I've never told anybody that…you don't get a OSCE where you have to tell the preceptor a situation…I

don't know. We didn't do it. And *yah* stuff like that. I'm not competent.

Interviewer The patients' family is a challenge and especially with regard to the language barrier.

Comserve 1 actually to number six as well. I feel like we, as nurses, I actually read the…I have no idea what…I can't remember what you call it, but that…the ……

Interviewer The oath.

Comserve 6 The oath.

Comserve 1 There we go.
Interviewer That is number one.

Comserve 1 Yes. Sorry, number one. So, I read that the other day 'cause we had to go pay at SANC and all those things and I saw it and I read it again, and, in a public hospital, in a setting like this, like number three said, it's you're the cleaner, you're the porter, you're the…you are everybody because nobody else does…there's a shortage everywhere. I remember one specific day that I was working in…I was the only nurse as well, it was still in surgical ward, and we were short of staff, and it was on a Saturday, and I phoned mortuary from eleven o'clock that afternoon, and I just couldn't…nobody came to fetch this corpse, and the corpse was there 'til that night that I actually luckily…they phoned eventually, I spoke to the matron, and she got a hold of them. So, they came so late and, if you have to….it's like you have to focus on so many other things, you have to call the morgue, or you have to trace this blood because this compact left two days ago and still hasn't arrived and you're struggling to get a hold of the transport, and you're struggling with that and this and this, that you don't have time to…for instance, in maternity, I see, as well, if you work in the postnatal side, where a patient just had a C-section, that's a big operation. So, I'm not gonna tell her, *kom*, you're gonna stand up now, you're gonna take off the blankets. *Nee, kom, kom, kom….clapping hands…..* I don't have time for this. You want to be careful, help her stand up nicely. And I've also done that, and the other sister came in and she's like you're gonna retire early. I'm like that's…what is the…where's the heart of nursing these days? You can't……..

Comserve 3 What does nursing mean?

Comserve 1 And I understand that they lose that because it's such a rush and it's

so…there's not enough staff and it's busy and there's so many other things you have to do. If you tell a cleaner someone spilt something, they'll tell you where the mop is. Literally, yesterday, I was mopping up water and a cleaner showed me how to use the mop thing. I'm like okay. So, I think, in the setting, in public setting, but, once again, it's not something that you personally can change, but, in the public setting, I think that it's very challenging, and I think it just makes it so much worse.

Interviewer Ok…..

Commserve 1 Sorry.

Interviewer No, it's fine. That's the reason why you are here. So, most of you, you are actually having some challenges with maybe procedures or with the routines, some routines. Do you think this programme, the commserve, the twelve months, will actually prepare you or impact on your competency? Because, remember, after twelve months, you are now a professional nurse. I know already you are being left alone, like what they were saying, but, now, after twelve months, do you think this programme will have an impact on you, especially looking at the litigations that are happening around the nursing fraternity? Do you think these twelve months is actually equipping you to be a competent…?

Commserve 2 I don't understand what is really competent. Even the PN have been here for long, but what they do or what they…we can learn, if we just pick up, we can pick up wrong things, and we assume they are competent. I'm number two. So, when it comes to competent, I feel like there are really some who are really competent from maybe when they are born, not even before they got to school, they were competent when they got to school, who have that heart of nursing, who see patient as their nursing is caring for her place?. when it comes to PN, I see, these days, I don't see this competent nursing, or we are forced to be like…let's say like them. Let's say we were trained verbally, you have to do this and this and this, the book tell you this and this and this, and, when you come from school, you feel like I'm going to help helpless people. So, when you come to the field, you found things different. If there's someone who…you will strain yourself, what's gonna be like in five years coming? You will retire early because you are lifting up the patient, you are changing…you are too kind. Really, those words, I don't know this competent…laughs…..

Interviewer So, what you're saying is that you don't actually get the support or the encouragement from your seniors – Commserve 2 Some of them.

Interviewer …and that is actually…...

Commserve 2 They discourage you and they tell you will be like us. That's not the way to tell someone who will come, I come to…I can help ……

[CROSSTALK]

Commserve 2 If you see someone come in your ward and see he can really…he like the job, encourage. Don't just say you will be like that, sit down. Us too, we were like now we are sitting down. I said really? Sitting down, not even giving medication or changing nappy of wet bed. You will be like us. I don't like those words. Really, I don't like it. I want to be who I am.

Commserve 4 I'm number four. I think now I'm left with four months to complete my commserve. I've already been in two units, medical and casualty two months, this is the third month, but I will supposedly be a competent. I feel like I won't be competent enough. I will be like the rest of us who don't even know what they're doing. Because, honestly, if I can give you an example of…for instance, what is happening in the side of a unit manager . I don't know…nobody takes you and say this is what we do. When we say it's month end, we do the statistics, we do like, when it's…I don't know what is happening in that office, but, once you are a professional nurse, then you must know what is happening in there, if I'm not mistaken. You must know. Even when you apply now… because we were supposed to apply so that we can go for interviews and be given professional nurses, we will be going for interviews, and the very same people who are not teaching us what is happening on all these things that needs to be…they will be asking us those questions and try and remind yourself *gore kana* when they said procedures for…maybe a procedure for…what can I say? Schedule drug, administration of scheduled drugs, then you must go to the book and start and do it step by step, because what we are doing is not the right thing. We know the right thing to do, but, if I'm only one PN in the ward, who am I giving the scheduled drug with? So, it means that I will go alone to the drug cupboard, take out…I know the procedure, but I'm not doing the procedure because I'm alone, I'm a commserve, I'm alone, but it's time for medication, I have to give that scheduled drug. So, it means I know the procedure, but I'm not practicing the procedure. So, we know what we are supposed to do, but we cannot do what we are supposed to do. So, how are you going to improve your competence if you know you were supposed to do this but you can't because of some reasons?

Interviewer I'll give you…. So on the managerial, because that is a managerial role. You

spoke about drug…the scheduled drugs, which we know that you have to check it with somebody – [CROSSTALK]

Interviewer Are there any other procedures, for examples, with a duty roster, competent with that because, especially when you're saying it's only…in January, you're going to be a professional nurse, then what?

Comserve 4 Those things, you are not exposed to. Even the delegation because now I'm the only professional nurse, then I will have to delegate to the ward, but, everything else, it's the OPM who's going to be doing that in the office, but there is no time that he can call me and say let me show you this, because one minute she calls me, there is nobody in the ward. Who's going to look after the patents? Who's going to do the doctors rounds? Who's going to talk to the families when they come? Everything. So, for me, I feel like we are here to replace wherever there's shortage, but not to be taught what needs to be taught. When I'm in medical ward and the OPM doesn't have the time to show me because, if she calls me, the first thing she feels like she's going to be wasting time showing me that how do I balance the off-duties? Maybe she knows that she can do that with me, I don't understand here, it's going to take longer for her. So, she's going to avoid calling me because, no, she's going to delay me. And, even if she can call me, then who's going to be out there in the ward? So, we don't get any, any exposure to that.

Comserve 5 Number five. *Eish*…I don't know if I'm the only one who's receiving a good treatment from the staff 'cause like *nna* I'm encounter different things that most of people here are in medical ward where I'm currently working is very good, to an extent that they take you through everything. Administrations, all those of duties delegations, the stats, everything. Even our OPM there, we have implemented this thing that, this week *neh…akere* there's two sides, the males and females. So, this week, the professional nurses at male sides, they will be the one doing the stats the OPM, going through everything, balancing the stats, and everything. Then, the following week, the female sides, you will also go through. So, they put us in. That's the treatment that I'm currently receiving at where I'm working. So, I don't if you [CROSSTALK].

Commserve 2 Which is medical –

Comserve 5 …which is medial ward, yes. So, yes, me also, it happened that, when I was first placed at medical ward, the very first two weeks, it happened that I was alone there, I

was a senior nurse there 'cause, at female side, there was a senior nurse there with another commserve. So, if I was encountering something, I was going to her, asking her how do I go through this and that and that? So, it was not overburdening me or something. So, I don't know if I'm the only one who received that treatment. Maybe I was fortunate.

Interviewer So, what you're saying is that this programme, for you, is actually…you are competent that you can be that professional nurse who will stand?

Comserve 5 Yes. So far, from all those wards that I've worked at, I can say I'm competent and it will and it has helped me a lot, especially…I think it depends on people that you are exposed at 'cause, on our shift, seriously, we are working very well, we collaborate very well.

Comserve 4 With the experience that myself, number four, and number three who worked in medical ward for that long …..

Comserve 2 And number two.

Comserve 4 And number two. I think now the other reason that he is getting what he's getting that we didn't get is the change of OPMs, because, during our six months that we were there, there was another OPM. So, now it's another OPM. Maybe that is why that new OPM is exposing him to those things. With our OPM, it was nothing. And I'm very, very much want to get in and do things, and I will go to her and she will be telling me I'm overworked. I will use this Setswana name….she will say *keimetswe*…I can't, that is what she will tell me…laughing….. Yes, I want to help me, but *keimetswe* I can't. And you are always coming, you are insisting that I show you this, but I don't have time *keimetswe*.
That is what she will tell me, always, when I go to her office.

Interviewer your experience on this programme, the impact?
Comserve 6 So far, for me, I can say I'm enjoying it 'cause I'm learning a lot for the past two months I've been here. I just told myself that no-one will stand on my way, I wanna achieve, then I'll always be the pain in their flesh, I ask, if I don't know 'cause I don't wanna end up in trouble. So, so far, I am learning a lot.

Comserve 1 Number one. I think we all are learning a lot, even though there are things that obviously really bothers us and… I'm just very concerned about are we learning the correct things? Because I've seen it so many times. Like you have to do what you have to do with what you have, and doing a dressing without a sterile pack, it's not correct, but you have to do it because that dressing has to be done. And suctioning a tracheotomy in the surgical

ward, which it's actually like a high-care patient, but nobody knew how to suction that patient, it's a sterile procedure, it's supposed to be…I remember that so well because that was the one procedure for OSCE that I was so stressed about it and we did it in one private hospital, so it was…*agh.* So, that sterile procedure, it's not done that way. There's no sterile pack open for it. But we can't open a sterile pack ever every time we have to suction. So, I really…I think we do learn a lot, things you don't learn, if I can say like that, in varsity or university, you don't…I don't know, you had to deal with the whole situation, but, once again…I'm just always so worried about I must just remember the correct procedure because, if you ever end up in a private hospital, or a new student or whatever comes and asks you how is this supposed to be done, are you gonna be able to show them the correct way? 'Cause I even remember there were…we had procedures for bed bathing. I mean….laughs…. And then the students come, oh, no, sister, just sign here, we washed all these patients, and I'm like can you show me how you washed them? But, Yah.

Comserve 2 and what we do in the wards, we are good in that. …but the problem is the office. The office –

Interviewer …administration.

Comserve 2 …administration –

[CROSSTALK]

Comserve 2 We are behind because of shortage of staff.
Interviewer Next year, you have to do that.

Comserve 2 Yes.

Interviewer So, that part, you are not competent.

Comserve 6 We are not.

Comserve 2 [CROSSTALK] the ward, I think, everyone is [CROSSTALK].

Interviewer So, basic nursing care, you guys are fine with it?

Group Yes.

Interviewer Except the fact that you are not sure because of shortage of equipments [sic],

resources. When it comes to the managerial or administration is where the challenge is.

Group Yes.

Comserve 2 That was number two.

Interviewer If there's something that you remember, then we can get back to it. And I know I've asked you this question to say specific practice, do you think you are clinically competent? And, as you have mentioned, the administration part is a problem.

[CROSSTALK]…laughing…..

Interviewer So, with the basic nursing care, you are fine.

Group Yes.

Comserve 3 If there's something we don't know in the nursing care, we go read medicines, generic names, and I get into the medical ward and there's seven hundred names I couldn't remember from pharmacology. So, I read it up, but, admin, where do I go read up South African HR stuff? I don't have a script for that.

Interviewer Ok.. actually your fourth-year books are still assisting, or the college books are still assisting?

Group Yes.

Interviewer Then, with this programme, because the intention, or one of the objectives, of this programme is to equip CSNs with competency so that, when they get to next year, January, they are competent practitioners. What do you think it can be done to improve this programme? Because, with your experience, there are a lot of challenges, I will say. What do you think it can be done to improve this? Maybe we can cluster these things with regard to communication, professional competency, ethics –

Comserve 1 Our OPM apparently, she was the year before …. was more in control of all the commserves and things. She made a little booklet, I think she even gave one to us, a list of procedures with stuff that we…in our fourth year and stuff, you had a booklet and you had procedures and the sisters had to sign it. You had to do them. So, I don't know if it's something like that that's gonna force the OPM or the other sisters…my commserve, me as a OPM, this comMserve of mine, she has to sign off whatever. So, I don't know if that can be a solution to kind of force you, especially with the admin stuff, to even add the admin

stuff, like maybe orientation of all the files, 'cause there's these cupboards of files and policies and all these things, and I, personally, also only saw that
[sic] files…they're like we're gonna read policies today, and I'm where's the policies? Is like I've been here for two months, but okay. So, stuff like that. I don't know if it can be a solution or it can contribute.

Comserve 2 at least three months, three months, three months.

Interviewer training in-service for commserves.

Group Yes.

Comserve 2 The workshop, in different areas, they can have. And, if we were provided with workshop, I think that would good because now we are in the practice. To practice the thing that we learn in two hours, it can be a huge thing, it can help a lot. No one will see us as a commserve, it's a problem. They see us as a PN. Just like you are a PN.

Comserve 1 I agree with everybody's opinion as well. It's so nice to…we're not alone in this and I'm not the only one who feels that way. So, even to just have a meeting, to have a discussion, to sit around a table to discuss, even that, more often, would be…can be good to stay informed because maybe, if Sister ……[SP] or whoever, if they knew how we felt about other staff, maybe there would have…I don't know.

Commserve 3 And, also, number five is very positive and I can get advice why is he getting along with the people so good and why is [sic] things happening so good for him?

Commserve 1 He's just a favourite. I think he's just a favourite.

Group laughing…..

Interviewer That was number three.

Commserve 3 That was number three, *yah.*

Interviewer No challenge. Anyone else? How can this be improved? Because, remember, the intention here is to improve clinical competency.

Commserve 4 Number four. I think, if this thing of shortage of staff can be done away with…because the reason that we are not being exposed to …….within our commserve is because we are busy with the work of two people or the job of three people.

So, there won't be time for you to be able to be taken away from the work and say let's do this. So, I don't know. Everybody's saying good suggestion *gore* let's go for workshops, let's do this, let's do this, but, with my experience…for even now, there's one sister who was the commserve who was supposed to be with us here. She was denied to come here because there's shortage. So, if maybe we ask you to say organise a workshop for us, and then you will gladly do it, but, when it's time for us to leave the unit to come to the workshop that will benefit us so much, we will be told you are not going because there is no-one who is going to be in the unit. That is what we are experiencing. So, I think … is to get the staff so that the commserves, when they come, they are not replacing the short staff, they are given the opportunity to learn from the staff that is already there, that is competent, that is willing to teach you to be competent as well.

Comserve 5 *Yah eish,* serious…clear throat…. Number five. The workshop will do, honestly speaking. Like number four have already mentioned, it will depend on the staff that you're working with, the shortage that they are mentioning if they will release you or what, 'cause that's what they do. Even myself, when I was coming here, they told me that what are we gonna do 'cause we are short staffed? Then I was like Sister this workshop…this meeting is gonna be beneficial for me. So, what about you call the other sister from female side. I'm this side, I'm working female now. Then so…... So, the workshop will do but then it will depend on if they will release you [CROSSTALK].

Commserve 4 It's a struggle –

Commserve 5 It's a struggled.

Commserve 4 …to get commserve out of the ward –

Commserve 6 [CROSSTALK].

Commserve 4 …to go and do something else that will benefit her or him.
Group Yes.

Interviewer Do you have mentors in the ward?

Commserve 4 We don't have mentors.

Commserve 6 We don't have mentors.

Interviewer No mentors.

Commserve 2 I think mentor the commserve had is a sister, the one that she mentioned that who had an induction [CROSSTALK] – Interviewer The coordinator.

Commserve 2 …but now she's on duty, fully, fully worked, she doesn't have time for commserve. I think she's the one who was helping.

Commserve 1 [CROSSTALK].

Commserve 4 But now she's replaced by the one who just organised this,

[CROSSTALK]
Commserve 4 She doesn't even know now who to go to –

[CROSSTALK] group laughing….

Interviewer So, communication is also a problem here?

Group Yes.

Comserve 2 Communication is a problem.

Interviewer Because you should have actually be aware who is responsible for you.

[CROSSTALK]

Commserve 2 I think asked that question –

Commserve 4 And she doesn't know.

Commserve 2 …who is that one for…as commserve, who is…does it……she mean for us? I asked her that question. I know she's AD …….

Commserve 4 And the fact that, in our facility, there are so many acting what-what, acting AD, acting what-what……

Commserve 3 Everybody is an acting…acting OPMs.

Commserve 4 …and it changes maybe three months, you know this person to be

responsible, it changes, and there is no memo written there to say this one is no longer doing this, she's doing this, and then you still know that somebody's responsible for us but now you are surprised she is in the ward now, fully hands on, and you don't know who else, because everything is changing and it's all acting, and then you don't know who's really responsible for you, you don't know who to go to. When you have problems, you really don't know.

Commserve 1 And another thing is the organisation of the management. Nothing against anyone personally, but we still don't know if we are oriented…rotating. Now, for one, I was…I'm worried about…I have leave in the beginning of October, but I might be rotating to another ward. So, my leave is approved currently with maternity, but, if they decide to rotate me, which they still cannot give us a answer on currently, it's the middle of September, so we don't know if we are rotating. So, a friend of ours, I spoke to her the other day, she is working in another hospital, not in the North West, but they knew exactly, three months, three months, three months, three months, and she could go and she could meet the people, she could plan her leaves, she knew, if she wanted to go in that month, she will be working there. With us, all of us have problems with the leave because it's…and, if you trace it back to the root, it's the rotation. If we just knew where we're going, then we…

Interviewer Now, what you are talking about now is answering the next question about the process of placement and everything. So, as you've mentioned that, is there anyone who wants to add your experience?

Group laughing….

Comserve 4 Yes, I want to add, please. *Yoh*…..This is number four. January, we came here and we all asked are we going to rotate or are we going to be in the same unit for the entire twelve months? Because we heard the rumours that other groups stayed in one unit for the whole twelve months, other groups are rotating. So, we wanted to know whether we are going to rotate or not, and then we were told, yes, you are going to rotate, and you don't choose where you are going to be placed. There will be an allocation. Then we were given the allocation. It's January, you go to these wards, to these wards, to these wards, and then, end of March, you'll be given another allocation to say where you are going. Come end of March, some of us are stuck in the same unit, you ask why, they tell you –

Commserve 1 We will place you where we need you. So, you will stay.

Interviewer That's number one.

Group laughing…..

Commserve 1 That's number one. That was the answer to me. I just wanted to quickly add, sorry. Continue, number four.

Commserve 4 And then you…I'm number four, I ask why am I not rotating? And then the answer is, no, I don't want to lose you in this ward, because I was put to the deep end, I had to learn to swim, now I am a good swimmer in that ward, now they don't want to lose me….laughs….. So, when you go back now, it doesn't reflect good to what you were told. Now you are asking yourself: if I don't rotate, and then I was told that you need to move at least four times so that you are used to the other wards, where does that leave me? So, I'm going to be competent in only one ward and then what about the other wards?

Commserve 3 So, that also goes back to the competence. So, you are competent now for six months in one ward, and now you are PN next year, and I know nothing about theatre. I'm not competent, never got the experience in my commserve.

Commserve 1 I was also told in the ward I was in six months that it takes too long to orientate us, and it doesn't work as effectively because we…'cause, currently, we were…I think we were four commsevers on a specifically remember a meeting where I completely lost it, and I told them it's not fair towards us. You want to keep us here now because you are afraid you're gonna lose your four commserves and you only probably gonna get two.
So, currently, it's very nice 'cause we have more staff, but you are…it's not beneficial to us. So, currently, we are replacing permanent staff because there isn't enough staff, while we are actually supposed to…it's not supposed to be a problem for us to rotate because we have to learn, we have to rotate, and we can learn, we can see the wards, but, now, we are basically permanent staff and they're just too afraid to lose us. And their point of view as well or the situation, but it's difficult.

Comserve 5 Number five. *Eish*… I think, also, there's a very huge miscommunication, even amongst the management and all that, 'cause I remember, when I was working surgical, then I had to hear from my colleagues…I was overlapping, I was supposed to be in Saturday, then my colleagues started…we were weekend in, then we started Friday. Then I heard from them that I'm going to medical, I'm starting Monday, and I was like medical?

How? But they didn't tell me at that ward that I'm going to medical. They didn't tell me that I'm rotating or something. Then I had to call the OPM just to get something from her if she knows about this or something. Then, when I called her, she said she doesn't…she was on leave. Then she told me that she doesn't know anything about us rotating and so there's miscommunication even amongst our management. So, I had to call other sisters, those who I was working with at surgical, just to ask them what is happening there, 'cause I was supposed to be on duty Saturday. Then I called them, then they said they would check for me what is happening. They also didn't know. They were not given some sort of pamphlet or allocation for us commserves. They were not given anything. Then they had to go to Peads to find out what is happening and all that. And I was at home. And they did that and they told me that I see you have to go to medical, starting Monday. So, it's a serious issue, this thing, at our institution, this communication is bad.

Interviewer It's actually affecting you.

Comserve 5 It's affecting us.

Comserve 1 It was the same with us –

[CROSSTALK]

Comserve 1 …that rotation the same rotation [CROSSTALK].

Comserve 5 'Cause I feel like you have to be informed as early as possible so that you're also prepared.

Comserve 4 Commseve four. I worked medical six months and I went to casualty. It was supposed to be July, August, September. So, end of July, I continued with my shifts only to receive a call from an OPM in surgical that day when she called me, and she said, sister, are you aware that you were supposed to start working in surgical ward on the twenty-ninth of July? I think that it was now the first week of August. And I said, no, I'm not aware. And then she said I put you on the off-duties since last week because the changeover was last week, so you didn't report to work, and you were marked absent in surgical ward because you didn't come to work. I called casualty and they told me that you are off duty so that you are only coming in today. That is why I'm calling you today to say you are supposed to be in surgical ward. And I said, sister, but nobody told me anything. And then she said didn't your OPMs in casualty tell you? I said, no, nobody told me anything. But, to my surprise, you are the one who made the off-duties. Why didn't you call me to tell me that I'm changing to

surgical and I must start on which date? Because I remember, when I was in medical and I was changing to casualty, the OPM in casualty called me and even asked me should I put you in the orientation or should I put you on the shifts already? Then I said, no, I need orientation first because that's what you need. So, it was like they don't even ask you that…and I know that I have to be in casualty for three months, but only the first month they decide to remove me there, they don't inform me, they put me in the off-duties, they mark me absent for the whole week, and then they tell me that…it's a Friday, I'm supposed to work Friday, Saturday, Sunday, they're telling me that, Monday, I must be in surgical. So, how am I going to work? I'm on the off-duties of casualty for Friday, Saturday, Sunday. Monday I must start at surgical ward. I told her that my mind is now running two hundred and sixty miles per hour. I can't even think. I was like I can't think. I don't know what to say. I'm not being asked, I'm being told. I don't know whether I……. in this facility, what I've learnt, and it's frustrating and it's tiring, you have to fight for everything. For you to get a leave, you must fight, for you to be taken to a certain unit or not to be taken out when they need to take you out, you must fight. You must develop resistance. The other time, in the meeting, I asked them that I'm really developing resistance because, if you don't develop resistance, then you are thrown all over. When they need you to go there, you must just go, and then, when you get there, you are not orientated, you just have to do something. So, I'm developing resistance, I'm arguing a lot, and, after arguing, your whole day is a mess, you cannot even think, you don't know what you are doing the whole day, and you are going to be short-tempered to both the colleagues and the patients because now you are so confused.

Interviewer I hear you, colleagues. Let's look at this tool that I am trying to develop. Do you think it will help have an impact? As we conclude. Can each one of you just mention the procedure that you know you are competent in, or maybe the department that you feel you're comfortable, you're competent, and the one that you're struggling? If there's something like that.

Commserve 1 I think it all depends where you worked the longest.

Interviewer Yes, you can mention that.

Commserve 1 I worked in surgical for six months but like the postnatal side, the babies and the mommies. But I am not competent there. Now, I feel I forgot everything there…everything there but, if somebody tells me now to go work overtime in medical, I will

again be shocked for seven hours and then I will work the next five hours, but *yah.*

Comserve 4 I would say, for me, I'm very competent in medical ward because I've been there the longest. Even the doctors that I was working with in medical, they didn't even believe when I tell them that I'm a commserve there. But, in the first months, it was a struggle, but I gained competency in medical ward, I'm competent in medical ward. As for casualty……

Comserve 2 It's a messed up ward.

Comserve 4 …it's a mess. I've been there for two months, but I don't know what a professional nurse must do in casualty, and I don't feel competent if maybe there's a resus and there are no other professional nurses, I don't feel competent that I will be able to handle a resuscitation because, when there is a resuscitation, there are people who are there, and, when you go to observe, it's like you are overcrowding them. So, you will be standing back because you want to see and to experience what is going on, but, in the meantime, it's like you are overcrowding them, you don't know…when they call for something, you don't know what they want. So, for the resuscitation in casualty, and I'm left with…. I cannot even say I'm only left with three weeks because I'm going on leave and I'm supposed to go to maternity, if we change, because there's also an issue with changing. Maternity staff don't want to orientate commserves, so they want to keep the ones that they have already orientated because, if they go, we are coming, they will have to start from scratch. I really don't know whether we are going to rotate or not. But, when it comes to competency, medical ward, even if you can take me now and take me there, I will handle it like a pro, except for the administration side.

Commserve 6 *Yah* well me, for the two months that I've been there, I think most of the procedures we do there, I can say I'm the resus, I'm also with her there. There's still a lot to learn. The ECG, when we did the ECG at school, we learnt it here in casualty, they showed me, but, surprisingly, I think it was last week, we were doing it with one of my colleague. I ask her…there were two, just to interpret it for me. They said they don't know. And some of more than ten years. So, I made it my homework, I went back to my books, I read it. I was explaining to one of them on Monday…when was it? Monday. When were we off? It was Monday when we were in. She was so surprised. She said *joh.* So, I was teaching……

[CROSSTALK]

Commserve 6 …'cause I went back to the books 'cause I wanted to know…I can't just do a

thing then to see –

[CROSSTALK]

Commserve 6 What if one of the patients ask me I see this; how can I explain it that's in a layman's language? I must just tell him or her, no, you see this, it means that you what-what, your heart's …...

Interviewer That was number six.

Commserve 6 *Yah.* That was number six.

Commserve 5 Number five. In comparing surgical and medical, I am more competent in medical 'cause medical, at times, it can be very busy as opposed to complicated patients where you have to run around, get the resuscitation equipments and all that. So surgical, it was quiet sometimes, it was quiet.

Comserve 1 I think you learn with –

Comserve 5 So, I believe I'm more competent in medical 'cause, there, you can run sometimes.

Comserve 2 Number two. So far, I worked in two unit, casualty and surgical. In the casualty, I was like I wish they don't change me. I had a great thing there, and it become better, afterward when I was doing night shift with another team, I was like I better go away. And I was hoping to go back to that team, and I was surprised to find there. I feel competent in surgical, but not resuscitation, because resuscitation is there are people who must be there. Even if you go there, they will send you, send you, send you [SKIP] see anything. But I feel competent in both except resuscitation and administration. I'm [INDISTINCT – VOICE CLARITY].

Interviewer Would I be correct to say your competency, your clinical competency, actually depend on that maybe the longer in the ward and the type of…and maybe the team?

Comserve 2 Thank you for your time to come to see us as commserve. It's like the thing we are discussing. I think we should have a discussion with someone from this facility.

Comserve 2 They should check on us to see how we are faring, how far we are doing.

Interviewer And the competency because that is the most important thing, especially January, when you are going to be in the ward. I like what she mentioned that the student

nurse will come to you and ask you. Will you be able to explain to that student. And, remember, with a student, as soon as you're struggling to explain, they either gonna undermine you and… And my wish is that to say, these twelve months, actually, as the programme was implemented, it was to equip the CSNs with competence. We need to make sure that it's working. We need to make sure that the objective of this programme is met. Competence all the way. We need competent practitioners. And it's not nice if you know you are not competent, and they allocate you in the ward that you are not…next year, that you know you're not competent, it's gonna be hectic.

Commserve 1 And another, from the beginning of the year, I know we want to be PNs and we are PNs, but …., and, even two weeks ago, rotating and maternity staff not feeling that they should…they can't orientate new staff or new commserves, then she said, no, but you're *mos* professional nurses, you don't need that intense orientation, but we do need that intense orientation 'cause it's so different from when we still studied.

Commserve 6 I think, number six, you must also check with our institutions when it comes to allocation, like she's just said. They don't allocate us to some of these departments. When I spent four years at school, I was never allocated to casualty. I started working casualty here.

Interviewer Number six, so you're referring to the NEIs?

Commserve 6 Yes.

Interviewer So, actually, as a student, you need to be exposed to other [CROSSTALK].

Commserve 6 *Yah*. So that, when we come here, we… That's one.

Interviewer So now, within these twelve months, you are expected to be in that ward and, after, in January, you are…there's a possibility that you will work in that ward as a professional nurse. So, maybe the time that you were in that ward is only one month?

Commserve 4 For example, number four, during my four years of studying, I was in theatre for only two weeks and, in those two weeks, there were, I think, two or three public holidays, so it became shorter. And, in my commserve, I've never been allocated to theatre. So, what happens if I'm a professional nurse and, as professional nurses, we do rotate, and then I'm placed in theatre, and then I tell them I don't know anything?

Because, basically, I don't know anything about theatre. Even the staff, right now, they treat us like you should know, as a commserve, what will they say as a PN telling them that I don't

know? So, the objective of us being equipped within the whole units is not obtained in this one year of commserve?

Interviewer You're saying we need two years of community service?

Comserve 2 No, we need allocation.

Interviewer Allocation –

[CROSSTALK]

Comserve 2 …three months, three months, three months. They have to respect those three months, just to be exposed to everything –

[CROSSTALK]

Interviewer Within the 12-months?

Comserve 2 Mm.

Comserve 4 Within that twelve months, if they say we are going to rotate three months, three months, there must not be an OPM who will say, no, I want to keep this one, and then they agree, because, now, when the allocation comes, and you are not rotated, you cannot say I'm going, because the needs is for the whole year.

Comserve 1 And another thing is I think there's the thing is you, let's take, for instance, step down, surgical, medical. Yes, it is different wards completely, 'cause step down currently is more like your gynae, but it's ward routine?. So, orientation, I really think, should be at least…like casualty and a ward that has the normal routine, the normal doctors rounds. I don't know.

Interviewer So, rotation is very, very important within the twelve months of community service, as well as during the four years because now we need to look at it from there.

Group Yes.

Interviewer Are we doing it correctly from the nursing institutions?

Group Yes.

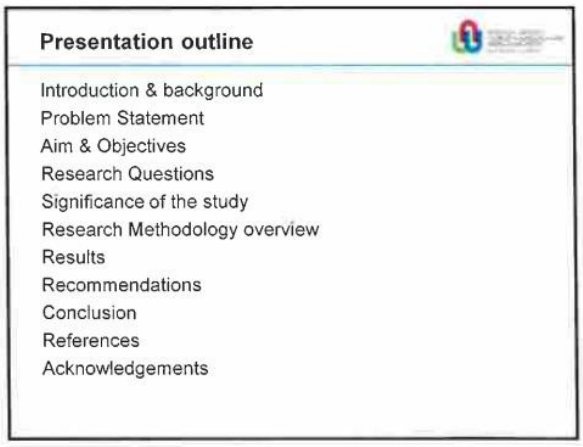
Interviewer Colleagues, thanks very much for your time.

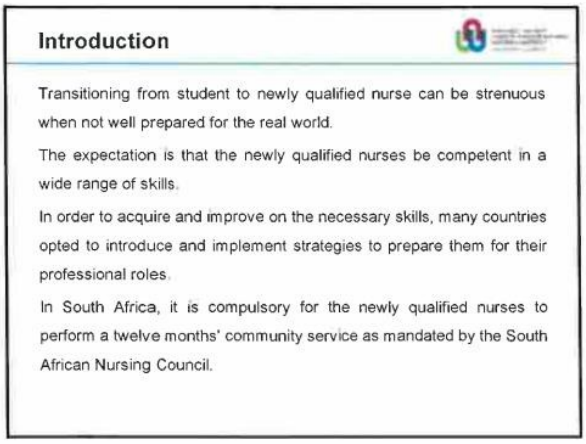
Group Thank you.

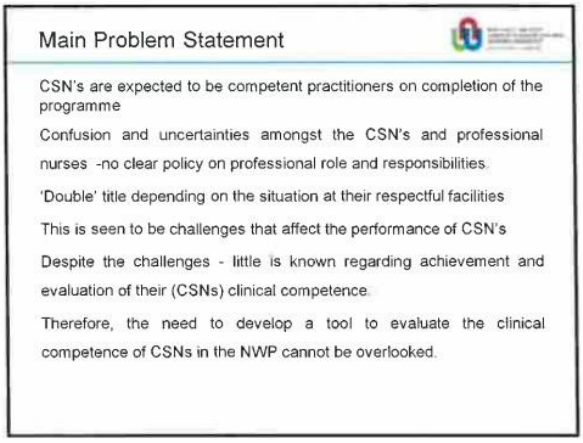
Interviewer Then that is the end of our interview.

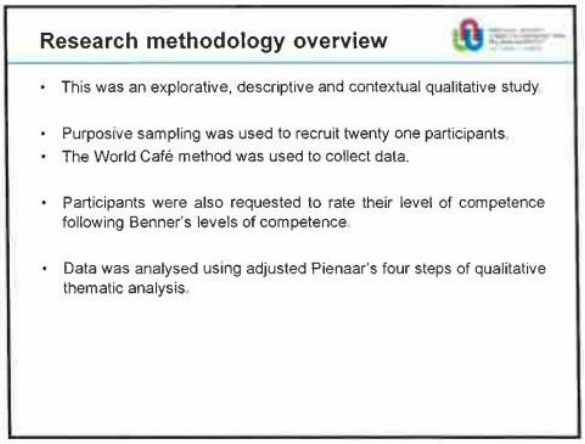
--- END OF AUDIO…..

Annexure 13: Conference presentations









Three tables (Table 1- Q1&Q2; Table 2-Q3; Table 3- Q4&Q5)
World Café Questions for CSNs

- What professional nursing and midwifery competencies are needed for you as CSNs to be regarded as a competent practitioner?
- Which of the mentioned professional nursing and midwifery competencies did you achieve by the end of your training? **(Use rating scale A and motivate)**
- Describe the specific professional nursing and midwifery competencies that you achieved during community service placement?
- Which competencies do you still lack at the end of the Community Service period?
- How can this competence challenge of CSNs be bridged in your own experience?

Three tables (Table 1- Q6&Q7; Table 2-Q8; Table 3- Q9&Q10)
World Café Questions for PNs

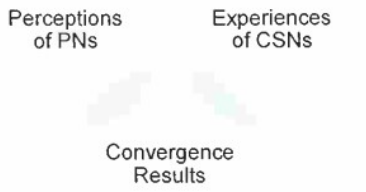
- What professional nursing and midwifery competencies are needed for a CSNs to be regarded as a competent practitioner?
- Which of the mentioned professional nursing and midwifery competencies do CSNs achieve by the end of their training? **(Use rating scale A and motivate)**
- Describe the specific professional nursing and midwifery competencies that CSNs achieve during community service placement?
- Which competencies do CSNs still lack at the end of their Community Service period?
- How can this competence challenge of CSNs be bridged in your own experience?

Results

Three main themes were identified, namely:

- (1) Ethos and Professional practice
- (2) Unit management, governance and leadership
- (3) Contextual clinical and technical competence

Figure 1. Convergence results from perceptions of PNs and experiences of CSN regarding clinical competence during community service.



Theme 1: Ethos & professional practice

- Participants reported that ethos and practice form the basis of the nursing profession.
- Therefore, it was of outmost important the CSNs uphold to the ethical and professional conduct of the nursing profession.
- However, CSNs from both hospitals indicated that they had little or not much clued up with the ethics or professional conducts.
- This was supported by the PNs who stated that CSNs do not uphold to the ethical and professional conduct of the nursing profession particularly with regard to the nursing etiquette.

Theme 2: Unit management, governance and leadership

- CSNs had the ability to manage the unit with minimal supervisor.
- Majority of PNs were in disagreement as some CSNs mentioned that have never come across the situation where they led or managed the unit.
- Therefore, they were not confident with their leadership skills.
- This results concurred with those of several studies contacted in different provinces of South Africa where CSNs where unable to manage conflicts, and fear of taking the lead especially with regard to delegation of duties and other managerial responsibilities (Ndaba & Nkozi, 2015; Roziers, Kyriacos and Ramugondo, 2014).

Theme 3: Contextual clinical and technical competence

- Contextual clinical and technical competence was not satisfactory and depends on the duration of allocation in specific units.
- It was also reported that some CSNs still need supervision on basic procedures including as they did not get enough exposure during their training days.
- This study results concurred with the results of study conducted in Australia by Parker, Giles, Lantry & McMillan (2014).
- The study reported that it was found that new graduate nurses want more support than is given and also suggested that performance of new nurses is negatively affected when they found themselves in unfamiliar workplace.

Recommendations

- Provide clear job descriptions for CSNs/ roles amongst the multidisciplinary team
- Extension or adjustment of community service nursing to six months internship and six month community service nursing or two years community service.
- Support measures including induction and orientation
- Continuous professional development

Limitations of the study

- The researchers acknowledge that this research is limited to only two hospitals and that the findings cannot be generalised.
- However, this article provides valuable information that can be considered by both CSNs and PNs as well as other stake holders including hospital management and NWDoH with regards measures to improve clinical competence of CSNs during their community service placement.
- Furthermore, the results of this article will be used to develop a tool to evaluate clinical competence of CSNs in the NWP.

Conclusion

- By utilizing the World Café method, it allowed for real conversations around mutual topics of interest and the rich data collected is a true reflection of the participants' perceptions and experiences.
- These results will contribute to the development of a tool to evaluate clinical competence of CSNs in the NWP, SA.

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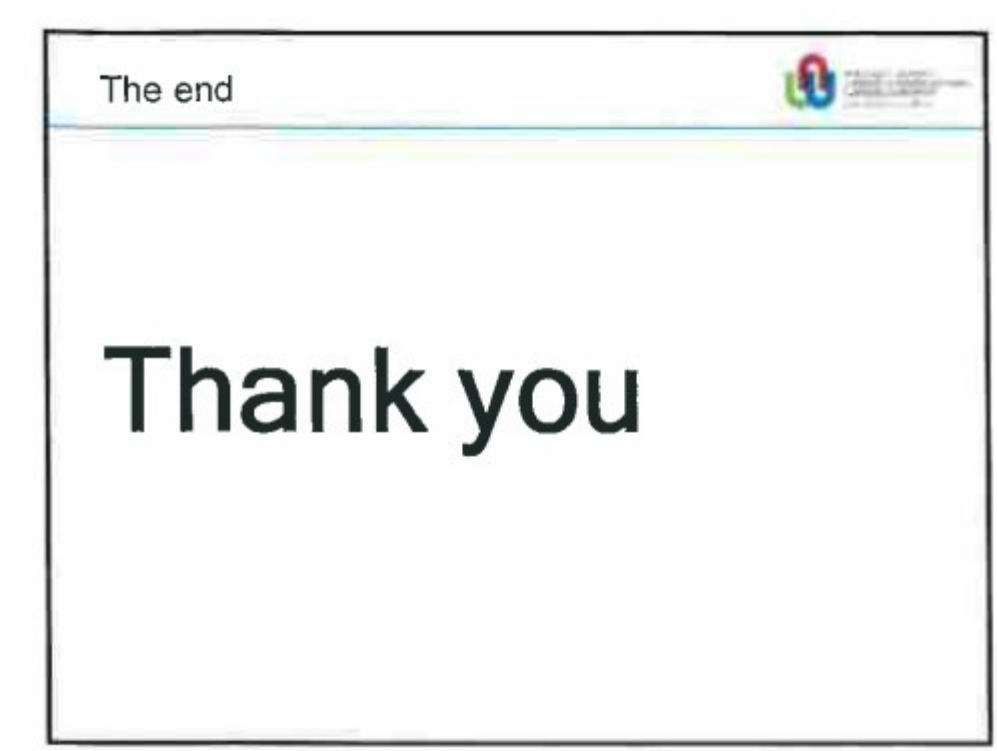
- Hospitals Management & participants
- TIME OFF: University Of South Africa (UNISA)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Thank you

Community service nurses' experiences regarding their clinical competence

Ms. K.L. Matlhaba
PhDc; MCur; BCur; RN

Promotor: Prof A. J. Pienaar
Co-promotor: Prof L. A. Sebularo

Background

- In South Africa it is mandatory for nurses who have qualified as a Nurse (General, Psychiatric and Community) and Midwifery leading to registration in Government Gazette Notice No R425 of 22 February 1985 to perform compulsory 12 months community service after completion of training either at a university or College of Nursing.
- The community service affords new graduate nurses the opportunity to improve on their clinical skills and knowledge while nurturing professional behavioural patterns and critical thinking consistent with the profession.

Research Objective

- To explore and describe the experiences of community service nurses regarding clinical competence during their placement in selected hospitals in North West province, South Africa.

Problem statement

- In the NWP of SA, like other provinces, CSNs perform their 12 months' community service in allocated health care facilities such as clinics and hospitals under the supervision of experienced professional nurses in order to obtain and improve their clinical experience (Department of Health 2011).
- As newly qualified nurses, CSNs require the supervision and support of experienced professional nurses to enhance their clinical competence which would ensure seamless transitioning into the working environment as professional nurses after completion of the mandatory community service (Makhakhe, 2010).
- Therefore, experiences of CSNs in the NWP regarding their clinical competence during placement needs to be investigated. The findings and recommendations of the current study could assist the researcher in the development of an evaluation tool for clinical competence of community service nurses in the NWP, SA.

Methods & Design

Methodology

Qualitative methods

Design

Exploratory, descriptive and contextual

Sampling Technique- Cluster

Population & Setting

CSNs – NWP hospitals

Exclusion Criteria – Newly Qualified Nurses

Data Collection

- 3 x FGDs – 6 participants
- 7 Males & 8 Females
- Semi – structured questions
- Age ranges – 22 – 47 years
- Digital voice recorder
- Fields notes

Questions asked

- "What are your experiences regarding clinical competence during your placement as a CSN?"
- "What suggestions do you have for improving clinical competence of CSNs during placement?"

Data Analysis (Pienaar' s four steps of qualitative thematic analysis (Pienaar, 2017)

Step 1

Basic concepts are derived from the spoken words

Step 2

Group similar concepts together

Step 3

Converged and identified new concepts, themes or clusters (insights)

Step 4

Build the storyline or pattern to form a process

Quality measures

Quality measures

- Authenticity
- Reliability
- Validity
- Trustworthiness

Results (4 Themes & 15 sub-themes)

THEMES

1. Facilitative experiences of CSNs
2. De-facilitative experiences of CSNs
3. Challenges confronted during placement
4. Suggestions to improve clinical competence

Facilitative experiences of CSNs

- *"I think it depends on people that you are exposed to 'cause [because], in our shift, seriously, we are working very well, we collaborate very well with the staff members there." FDG1/P5*
- *"Even the assistant nurses, you just go to them and ask them…listen here help me with this or help me with that… I just had to go to the staff nurses and they showed me." FDG2/P5*
- *"At least they taught me how to do the doctor's rounds, they orientated me very well, to do other stuff, what is it they expected from a commserve." FDG3/P4*

De-facilitative experiences of CSNs

- *"I was the only sister, for the whole weekend, for thirty-six patients. It was expected of me to run the ward. I called the matron and I said to her I can't do this, I'm a commserve." FDG3/P5*
- *"There's an IC drain, and I don't even know how to handle this patient with an IC drain." FDG1/P4*
- *"Sometimes I ask myself what if this patient reacts during transfusion, I don't know what to do, who to call." FDG2/P5*
- *"Absenteeism, it's really a problem, especially of permanent staff because they think, if you're around as the commserve, it's their opportunity to absent themselves and do their duties outside." FDG3/P1*
- *"I'm not competent with maternity. It is just that, I'm not competent with maternity." FDG3/P3*
- *"I agree with you absolutely because I am so depressed working in maternity." FDG3/P5*

Challenges confronted during placement

- *"Like you have to do what you have to do with what you have, and doing a dressing without a sterile pack, it's not correct, but you have to do it because that dressing has to be done." FDG1/P1*
- *"Sometimes they say it takes time. It consumes their time where the in-charge will be the only RN in the ward with 30 patients." FDG2/P1*
- *"....And, because you don't have any scope of practice, but you are a nurse. Whether the scope of practice, whether there's something written, but you are a nurse." FDG1/P4*
- *"It was so difficult that, some days, most of the days, we will be found ...because [the] medical ward is divided into female medical and male medical ....myself I'll be in male medical, she'll be in female medical, nobody is supervising us, we have juniors only, and we will be relying on each other." FDG1/P4*
- *"So, you are competent now for six months in one ward, and now you are PN next year, and I know nothing about theatre. I'm not competent, never got the experience in my commserve." FDG1/P3*

Suggestions to improve clinical competence

- *"I would suggest maybe that they have a....what do you call it? A preceptor or something for us, to guide us, to come visit us in the wards, to make sure that we know what we are doing." FDG3/P5*
- *"So, I think they should at least maybe give two/two for the whole year so that you can get enough experience and then decide at the end of the year where do you want to work" FDG3/P4*
- *"More staff is needed in the ward so that, if the other sister is busy with the rounds, the other sister must be busy with you on medication, to help you." FDG3/P2*
- *"I do think they should get feedback from us, before the end of the year, so that they know what we are experiencing so that they can correct such if there are any things that need to be corrected" FDG3/P4*
- *"If we were provided with workshops continuously, I think that would [be] good because now we are in the practice." FDG1/P2*

Conclusion

- Clinical competence of community service nurses could be improved if all stakeholders, including professional nurses and community service nurses themselves, hospitals and the regulatory body, the South African Nursing Council, collaborate.
- This study results were used to develop a clinical competence evaluation tool in the North West province, South Africa.

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- TIME OFF: University Of South Africa (UNISA)

Thank You!!!

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Legislations, policies and regulations that governs clinical competence in community service programme for Nurses: A literature review

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Promotor: Prof A. J. Pienaar
Co-promoter: Prof. L. A. Sehularo

Presentation outline

Introduction & Background
Problem Statement
Aim & Objectives
Research Questions
Significance of the article
Research gaps
Research Methodology overview
Results
Discussion & Recommendations
References
Acknowledgements

Introduction

- In South Africa (SA), it is mandatory for nurses to complete a 12-months period community service program after successfully completed their four years nursing degree or nursing diploma education (R425) before they can be registered as professional nurses (general, psychiatric, or community) and midwifery (SANC, 2005).
- This requirement has been published in the Government Gazette Notice No. 765 of 24 August 2007, and further details remunerated community service for this category of nurses at the health care facilities.

Cont.

- The main objective of the programme is to ensure improved provision of health services to all the citizens of South Africa by empowering young professionals developing their skills base, enhancement of their knowledge, while inculcating professional behavioral patterns and critical thinking consistent with professional development (SANC, 2007).
- However, since the implementation of this programme in 2008, there has not been much examination of legislation, policy and regulation governing this programme in South Africa.

Problem statement

- Since the implementation of community service programme for nurses in SA in 2008, there has been some noticed challenges which are seen to have a negative impact on the effectiveness of the programme.
- These challenges are both administrative and functional and are been observed across the majority provinces in the country.
- It is evident from the existing literature that there is a gap between the legislation, policy and regulation governing community service programme for nurses and practice in South Africa.

Research gaps

Significant of the research

- The results from this article will contribute in filling both policy and programme gaps in strategies to improve community service nurses programme in SA which will be of benefits to all stakeholders.

Research Objective & Question

Objective

- To determine the impact of the legislation, policy and regulation that govern clinical competence in community service programme for nurses in SA through the existing literature.

Question

- What is the impact of the legislation, policy and regulation that govern clinical competence in community service programme for nurses in SA?

Methods

- A computer-assisted search was conducted in the Cumulative Index of Nursing and Allied Health Literature (CINAHL), the National Library of Medicine PubMed service (PubMed) and Ovid Medline databases using the keywords: Community service nurse, compulsory community service, compulsory rural health service, military service nurse.
- The reviewed literature comprised research conducted globally including the country of the study, South Africa ranging from 2005 to 2017.
- Articles about other health care professionals are excluded as the focus was on nurses.

Results

- Themes were derived from the research studies conducted on community service programme and were analyzed using the adapted Pienaar's steps of data analysis (Pienaar, 2017).
- Themes are discussed separately and are supported by references from authors.
- Relevant literature is cited to ensure that literature control is done.

Table 2: Themes from data extraction

Systems & Structures	• *Ineffective systems and support structures* • *Lack of orientation and mentoring programmes*
Allocation & Rotation	• *Choices with regard to allocation and placement* • Rural placement versus urban placement
Lack of Supervision & Support	• *Shortage of experienced nurses to supervise* • *Negative and Reluctant attitude from seniors*
Role confusion	• *Unavailability of job description and scope of practice* • *Misunderstanding or misinterpretation of CSN programme*

Discussion

- The extent of compulsory service programme for nurses in South Africa' prevalence, requirements, effectiveness and long-term impact has never been studied.
- The legislation, policy and regulation that govern compulsory community service for nurses in South Africa permit further discussion.

Legislation

- Introduction and implementation of compulsory community service for nurses in South Africa is based on Chapter 3 of the Republic of South African Constitution (1996) as indicated earlier in this article.
- However, it seems like this programme's objectives are not and will not completely be met before the mentioned challenges are not addressed.

Cont.

- The inability of the Department of Health to absorb this category of nurses after their completion of the 12 months' compulsory service programme left some bitter taste on the community service nurses themselves, as well as the gap on resources in the health care facilities.
- This is seen as a problem as the shortage of nurses is escalating rapidly and this will lead to poor health care service to the community of South Africa.

Policy

- The policy for compulsory community service programme for nurses is a strategy intended enable government to provide quality health care service to the people of South Africa including those in the geographical areas that are not well served and in communities that are not favored by market forces and health worker preferences.
- However, there are multiple challenges in designing and managing an effective compulsory service programme as is noted from majority of the existing literature.

Cont.

- All these challenges shall be overcome if proper planning with allocation and support of the CSNs can be taken into account.
- The implementation policy for this programme need to be looked at as majority of the stakeholders it intended to benefit are suffering due to poor implementation or lack of clear standards and procedures especially at the institutional level.

Regulation

- The regulation regarding community service is explained in section 40 of the Nursing Act, 2005 (Act No. 33 of 2005) and in the Regulations Relating to Performance of Community Service published in Government Notice No. 765 of 24 August 2007. However, the unavailability of the scope of practice is seen as a challenge to the effectiveness of this programme.
- The nature of support provided to compulsory service nurses during their 12 months in the facilities plays a major role in the successful completion of the programme.
- However, this is seen to be a challenge as senior nurses in the facilities remain confused or unsure as to where to allocate this category of nurses due to unavailability of their scope of practice.

Cont.

- It was learned from the existing literature that this nurses find themselves in the middle of being categorized as 'student nurses' or 'newly qualified' nurses depending on their situation in their facilities.
- This confusion was also seen as a contributory factor to poor support and supervision from the senior qualified nurses. This is also seen to have a negative impact on clinical competence of this category of nurses.

Conclusion and Recommendations

- From the existing literature it is clear that effectiveness of community service programme is compromised by many factors.
- It is concluded that objectives of the community service programme can be achieved by having all stakeholders on board and introducing clear policies and regulations especially at the provincial and institutional level.
- This will have a positive impact on community service programme for nurses which will lead to competent practitioners.

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