Exploring occupational health care nurses' perceptions of systems to enhance their own resilience, hardiness and well-being

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DECLARATION

I hereby declare that this research with the title: *Exploring occupational health care nurses' perceptions of systems to enhance their own resilience, hardiness and well-being, is* my own work. This study has not been submitted before for any other degree or examination at any other university. All the sources used in this study are indicated in the reference list.

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Phil 4:13. “I can do all things through Christ who strengthens me”.

Phil 4: 6. “Do not worry about anything INSTEAD pray about everything”.

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ABSTRACT

Occupational health care (OHC) nurse practitioners experience numerous stressful situations on a daily basis in their different working environments. Studies done in the government sector in South Africa showed that increased nursing dissatisfaction and compromised well-being are due to staff shortages, high work-load and unsatisfactory negative working environments. The resilience, hardiness and well-being of OHC nurses are the important aspects examined.

The study followed an interpretive, descriptive qualitative design with the purpose of exploring and describing occupational health care nurses' perceptions of current support systems utilised within a private organisation, with a view to enhancing their resilience, hardiness and well-being. To achieve this aim, the following objectives were set and reached:

To explore and describe the perceptions of occupational health care nurses about the adequacy of current occupational health care support systems, utilised within a private organisation, with particular reference to their well-being.

To explore and describe occupational health care nurses' perceptions of how these support systems effectively enhance resilience, hardiness and well-being.

Approval for this study was obtained from the Human Health Research Ethics Committee of the North-West University, Ethics number: NWU – 00129-18 – A1 as well as from the vice-president, senior manager and direct manager of the private organisation.

The target population in this study was the staff of two medical centres, comprising occupational health practitioners from a private organisation in a petrochemical industry situated in the Free State and Mpumalanga provinces of South Africa. A purposive sampling strategy was employed. This strategy was chosen as it allowed the researcher to select the most appropriate participants towards achieving the overall purpose of the research. Purposive sampling was used moreover to ensure consistency and unbiased representation. The researcher involved all nursing staff from two medical centres as the sample. This included a total of 26 nurses. The selected method was used to ensure that

only nursing staff from the specific private petrochemical organisation who complied with the inclusion criteria would participate after voluntary signing of consent.

The data collection method in this study centred on focus group discussions by means of a semi-structured interview guide. Data was analysed by making use of a revised qualitative data analysis approach and utilising the ATLAS.ti program, co-coded as a measure to ensure trustworthiness of the data.

Main and sub-themes were identified as follows: 1) Occupational health care nurses' perception of current support services; effective services promote personal and professional growth and well-being; salary package benefits are perceived as services. 2) Promoting nurse's well-being; improving constructive internal communication and acknowledging nurses' professional contributions.

In conclusion, OHC nurses perceived support systems as aiding them in some respects to enhance resilience, hardiness and well-being, but several limitations were indicated that need consideration and should engender recommendations for improvement. Limitations of the study were presented and recommendations were made for nursing practise, nursing education and nursing research. These recommendations have the potential to equip nurses and management by improving resilience building skills such as determination, communication, building work relationships, problem solving and organisational skills.

The knowledge that was engendered by this study could be utilised to enhance the resilience, hardiness and general well-being of nurses. It could also improve their working environment, which would lead to greater job satisfaction.

Keywords: nurses, resilience, hardiness, well-being, support systems

OPSOMMING

Beroepsgesondheidsverpleegkundige praktisyns (BGPs) ervaar verskeie stresvolle situasies op 'n daaglikse basis in hul verskillende werkomgewings. As gevolg hiervan, kan hulle ondersteuning benodig. Aspekte wat belangrik is om te oorweeg is die veerkragtigheid, innerlike krag en welsyn van hierdie verpleegkundiges. Studies wat in die openbare sektor in Suid-Afrika gedoen is, het ook getoon dat daar toenemende ontevredenheid en gekompromitteerde welstand bestaan as gevolg van personeeltekort, hoë werkslading en onbevredigende, negatiewe werksomstandighede.

Hierdie studie het 'n vertolkende, beskrywende kwalitatiewe ontwerp gevolg met die doel om Beroepsgesondheidsverpleegkundige praktisyns se ervarings te verken en te beskryf oor die huidige inhoud van beroepsgesondheids ondersteuningstelsels wat in 'n privaat organisasie gebruik word om die veerkragtigheid, taaiheid en welsyn van Beroepsgesondheidsverpleegkundiges te verbeter.

Goedkeuring vir hierdie studie is verkry van die menslike Gesondheidsnavorsingsetiekkomitee van die Noordwes-Universiteit, asook van die visie-president, senior bestuurder en direkte bestuurder van die privaat organisasie.

Die teiken populasie in hierdie studie was die personeel van die twee mediese sentrums, bestaande uit Beroepsgesondheidsverpleegkundige praktisyns wat werksaam was by hierdie private organisasie in 'n petrochemiese bedryf, geleë in die Vrystaat en Mpumalanga provinsies van Suid-Afrika. 'n Doelgerigte-steekproefstrategie is gebruik. Hierdie strategie is gekies, aangesien dit die navorser toelaat om die mees toepaslike deelnemers te kies om die oorkoepelende doel van die navorsing te bereik. Die doelgerigte-steekproef is gebruik om konsekwentheid en onbevooroordeelde verteenwoordiging te verseker. Die navorser het ten doel gehad om alle verpleegpersoneel van die twee mediese sentrums te betrek, omdat die bevolking betreklik klein was. Dit het 26 verpleegsters ingesluit. Die geselekteerde metode is gebruik om te verseker dat slegs verpleegpersoneel van die spesifieke private Petro chemiese organisasie wat aan die insluiting kriteria voldoen, sal deelneem na vrywillige ondertekening van toestemming.

Die data-versamelingsmetode het die vorm aangeneem van fokusgroepbesprekings aan die hand van 'n semi-gestruktureerde onderhoudshandleiding. Data is geanaliseer deur gebruik te maak van ‘n hersiene kwalitatiewe data-analise benadering wat gebruik maak van die ATLAS.ti program. Ontleding van versamelde data is met die hulp van 'n mede-kodeerder gemaak.

Hoof-en sub-temas is soos volg geïdentifiseer: 1) Beroepsgesondheidsverpleegkundige praktisyns se persepsie van huidige steundienste; effektiewe dienste bevorder persoonlike en professionele groei en, salarispakket voordele word beskou as dienste. 2) Die bevordering van die verpleegkundige se welstand; die verbetering van konstruktiewe interne kommunikasie en die erkenning van verpleegkundiges se professionele samewerking.

Ten slotte is gevind dat ondersteuningstelsels deur Beroepsgesondheidsverpleegkundige praktisyns ervaar word as ondersteuning om sommige aspekte om veerkragtigheid, taaiheid en welstand te verbeter, maar dat daar verskeie beperkings was wat oorweging en aanbevelings benodig met die oog op verbetering. Beperkings van die studie is aangebied en aanbevelings is gemaak vir die verpleegpraktyk, verpleegonderrig en verpleegnavorsing. Hierdie aanbevelings het die potensiaal om verpleegsters en die bestuur voldoende toe te rus vir die uitdagings wat hulle in die gesig staar deur middel van die verbetering van veerkragtigheidsbouvaardighede soos vasberadenheid, kommunikasie, verhoudingsgroei, probleemoplossing en organisatoriese vermoë.

Die kennis wat deur middel van hierdie studie verkry is, kan aangewend word om die veerkragtigheid, sterkte/stamina en algemene welsyn van die verpleegsters te verbeter. Dit kan ook hul werksomgewing verbeter, wat tot groter werksbevrediging sal lei.

Sleutelwoorde: verpleegsters, veerkragtigheid, wat van taaiheid/sterkte, welstand, ondersteuningstelsels

ABBREVIATIONS

OHC	Occupational health care
EAP's	Employee assistence programme
OHCP'S	Occupational health care practitioners
FGD'S	Focus group discussions
NWU	North West University
SANC	South African Nursing Council
HREC	Health Research Ethics Committee
ICAS	Independent Councelling and Advisory Services
SWOT	Strenght's Weaknesses Opportunities and Treats
FB	Female Black
FW	Female White
FA	Female Asian
MB	Male Black
FA1	Facilitator 1
PA1	Participant 1

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CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

Occupational health care (OHC) nurse practitioners experience numerous stressful situations on a daily basis in their different working environments. Resilience, hardiness and the well-being of OHC nurses are imperative aspects in this respect. The motivation behind this research is to explore and describe OHC nurses' perceptions about OHC support systems utilised within a private organisation towards promoting their resilience, hardiness and well-being.

Working in the health profession is challenging. In South Africa, there has been a recent transition in health care from hospital-based services to primary and community-based ones within the public and private sector. This exacerbates stress among nurses who are now held responsible for larger populations (Koen *et al*., 2011:1-11). This affects job satisfaction, invoking feelings of inadequacy, which can lead to burnout and compromised well-being. Such effects have implications for productivity and performance (Najimi *et al*., 2012:301). Studies done in the government sector in South Africa showed that increased nursing dissatisfaction and compromised well-being are due to staff shortages, high work-load and unsatisfactory, negative working environments (Bester & Engelbrecht, 2009:104-117). A similar study was done in the private sector and, according to Van der Westhuizen (2008:1-69) and Grove (2017:31), 60% of nurses in the private sector left their job due to poor salaries, patient overload, high work load and safety risks. It is therefore clear that factors related to staff shortage, high workloads and unsatisfactory, negative working environment contribute to high levels of stress and turnover in nursing.

Recent studies on the public health sector in South Africa have shown that the main determinants for increased job dissatisfaction and impaired well-being are high workloads, limited resources, negative working conditions, emotional climates in departments, an unsatisfactory work environment and shortage of nurses (Nyathi & Jooste, 2008:28-37; Mathibe-Neke, 2020:52). Staff shortages is ranked as the most stressful, indicating nursing demands first and excessive administrative duties next (Van der Colff & Rothman, 2009:1-10). Evidence shows that work stress contributes to higher burnout levels among nurses, and that it is associated with lower job satisfaction (Graham

et al., 2011:427-431). Prolonged work stress negatively affects physical and mental health outcomes among nurses (Idris, 2011:160).

Occupational health care is seen as part of the human resource function and compasses health care, health education or information, health surveillance and health protection (Occupational Health and Safety Act 85 of 1993). It is concerned with the effect of health on work as well as the effect of work on health. The Occupational Health and Safety Act (85 of 1993) stresses two premises. Firstly, occupational injuries and illnesses can be prevented by recognising and eliminating hazards and, secondly, employers have the primary responsibility for protecting employees' health by providing healthy working environments.

The nursing profession is stressful and widely known for its high rates of staff turnover, absenteeism and burnout. Occupational health care nurses are not excluded from this. Unrealistic workloads, poorly equipped facilities, unsafe working conditions, lack of commitment, poor leadership and unfair compensation feature among the many factors affecting the work life and performance of today's healthcare professionals and healthcare workers (Duffield, *et al*., 2011:24; Lambert, *et al*., 2004:641). These negative stress outcomes can impact not only on the well-being of health professionals, but also on their ability to care effectively for others (Barnett *et al,* 2007:603-612).

Professional nurses need to find meaning in their work to be successful caregivers; they are in need of a responsibility to model health care behaviours to assist patients to achieve healing (Van der Zyl, 2002:4; Mathibe-Neke, 2020:55). Instead, nurses experience insecure environments, limited career advancement and acknowledgement deficit in the working environment (Koen *et al.,* 2011:114; Van Der Westhuizen, 2008:8-22).

The shortage of professional nurses in South Africa adds to the shortages of staff in a health care facility at any given time, as confirmed by the statistics released by the South African Nursing–Council. Another factor that plays a role in the well-being of nurses is verbal abuse by other healthcare professionals such as physicians, which could result in more nurses leaving the institution (Roche & Daffield, 2010:197). These toxic practise environments can also result in burnout among the nursing personnel, which leads to stress that can manifest itself either physically, socially or psychologically (Aiken *et al*., 2011:358).

Understandably, then, given the adverse workplace conditions where nursing is associated with excessive workloads, lack of autonomy, bullying, violence and organisational issues such as restructuring with its associated problems, retaining nurses in the workforce are becoming a challenge and poses dangers for the nursing profession and health care services (Koen, 2010:11). Consider here that the professional nurse is a multi-dimensional being of physical, emotional, intellectual and spiritual dimensions that are integrated and dependent on one another, so that he or she cannot be expected simply to cope with the given stressors, and will suffer, affecting every area of his or her life on a professional and personal level (Cilliers, 2002:61; Pienaar & Bester, 2011:113-122). In the community, nurses are seen as leaders: health care providers, educators, counsellors, referral resources, role models and advocates, who further serve as initiators and primary influencers around creating a positive, safe and healthy work environment (Brown & Bar, 2013: E1; Clark, 2008:20). It is therefore imperative that a preventative approach is adopted to ensure the well-being, resilience and hardiness of nurses.

Nurses, who are predominantly women working in a highly bureaucratic and arguably masculinized workplace, experience the negative effects of hierarchy, top-down decision-making, inter- and intra-professional hostility, limited autonomy, public stereotyping and invalidation as additional psychological strain in that workplace (Jackson *et al*., 2007:9; Guidroz *et al*., 2012:69). The distressing situation in this regard is an adversity which puts the well-being of the nurses at risk. Such adversities may ultimately lead to lowered quality of health care (Koen & Du Plessis, 2011:3). Much is therefore needed to make positive practise environments the norm. The need to create a healthy work environment that will encourage nurses was identified as an essential component in nurse job satisfaction and turnover rates, and it was shown to play a positive role in patient outcomes (Ulrich *et al.,* 2006:46; Payne *et al.*, 2019:2). Creating a healthy work environment is a priority for maintaining an adequate nursing workforce (Shirley, 2006:256; Payne *et al.*, 2019:2). Until such a time as the realisation of a healthy work environment for OHC nurses is created, nurses need to be resilient and hardy and sustain their well-being in order to cope within their working environments.

It has been estimated that approximately 90% of companies provide at least one subset of a wellness program for their employees (Aldana *et al.*, 2005:31-137; Berry *et al*., 2010:104-112). Regarding organisational support, Liou and Cheng (2010:1635-1644)

found that a positive organisational climate may increase nurses work commitment, which will in turn prevent them from leaving the organisation. Other studies concur with the latter and it is widely accepted that organisational support correlates negatively with turnover intention as well as actual turnover (Hui *et al*., 2007:735-751; Berry *et al*., 2010:104-112).

Parks and Steelman (2008:58) found that providing an organisational wellness program will engender a positive attitude among their employees resulting in their employees being happier with the organisation and the end result, namely that employees show higher levels of job satisfaction. Organisational wellness programmes are thought to reduce stress by improving the health of employees and providing educational programmes to help them cope with stress at work (Aldana *et al.*, 2005:31; Berry *et al*., 2010:104-112). Others suggest that the mere presence of an organisational wellness program may help to demonstrate to employees that the organization cares about them and thus improve employee job satisfaction (Zoller, 2004:278-301; Berry *et al*., 2010:104-112). Wellness programmes, then, indicate to nurses that the company cares about their well-being and promote individual and organisational well-being.

1.2 PROBLEM STATEMENT

Health workers in general, and midwives and nurses in particular, experience high levels of stress or distress due to the nature of their work and workplaces (Cohen-Katz *et al*., 2004:302-308; Barr, 2017:214). Considering the current workplace challenges faced by the nursing workforce in South Africa, including OHC nurses, and the impact thereof on the country at large, facilitating occupational health care support systems among OHC nurse practitioners could enhance their resilience, hardiness and well-being in stressful working situations. Employee assistance programmes and stress management techniques in general claim to relieve the symptoms of stress, improve mental health, increase productivity and produce cost saving to organisations (Arthur, 2000:556; Hart *et al*., 2012:721). Not only does occupational stress affect the employees who make use of OHC services, but also the OHC nurses who render this service. Around this, the researcher has established a lacuna in extant literature related to this topic. Little information is available indicating that OHC nurses in South Africa are partaking in support systems which build their own resilience, well-being and hardiness. Therefore,

the present project offers further research and a critical exploration of support systems to enhance the resilience, hardiness and well-being of OHC nurses.

Research findings and literature do indicate that professional nurses feel emotionally overloaded, stressed, fatigued, helpless, hopeless, angry, shocked, grieved, irritated, fearful, unsettled and, frustrated, while experiencing job dissatisfaction, moral distress and lack of personal accomplishment; for these reasons they often leave the profession (Aiken *et al*., 2001:255-263). It is also evident that health care staff has a higher tendency to develop stress related illnesses (Dean, 2012:16). The nursing profession and the stress commonly associated with it has been the subject of considerable research for decades. This is not surprising, given that nursing is widely known for its high rates of staff turnover, absenteeism and burnout (Kirkcaldy & Martin, 2000:77-89; Kikuchi *et al*., 2014:426-427).

Occupational stress has several other negative effects, such as impaired performance and effectiveness, reduction in productivity, diminishing levels of customer service, health problems, industrial accidents, alcohol and drug usage and purposefully destructive behaviours such as spreading of rumours, stealing and even suicide (Happel *et al*., 2003:63-68). As a result, advocacy has increased, that is, organisations are regulated to provide greater flexibility to employees. In the western context, organisations are compelled to implement more organisational work-life balance policies and programmes as a way of improving workplace health and well-being (Pocock, 2011:198-209).

In response to a workforce increasingly concerned with maintaining a work-life balance, organisations now offer a range of initiatives designed to facilitate the integration of work and non-work domains. These initiatives usually take the form of flexible work options, family or personal leave, and organisational assistance with child care or elder care.
Implementing a healthy workplace programme that is sustainable and effective in meeting the needs of workers and the employer, however, requires more than knowing what kinds of issues to consider. To successfully create such a healthy workplace, an enterprise must follow a process that involves continual improvement, a management systems approach that incorporates knowledge transfer and action research components (Burton, 2010:89).

The healthcare industry is significantly concerned about the retention of professional nurses, as this has a direct impact on the quality of care and outcomes of patients. A stressful working environment is one of the major contributing factors to the high nursing staff turnover. South African professional nurses find themselves confronted by this high risk on a daily basis in the workplace, a stressful work environment affecting their physical health and emotional well-being (Levert *et al*., 2000:36; Hart *et al*., 2012:721).

Tugade and Fredrickson (2004:320-333) and Mealer *et al.* (2012:1445) suggest that everyone has resilience potential, but its level is determined by individual experiences, qualities, the environment and each person's balance of risk and protective factors. Researchers believe that individuals can develop and strengthen personal resilience by means of adopting strategies for reducing their own vulnerability and the personal impact of adversity in the workplace (Makikangas *et al*., 2004:556-575; Koen, *et al*., 2011:103).

A growing body of evidence suggests that the personality trait of hardiness helps to buffer or neutralize stressful events or extreme adversity (Judkins *et al*., 2005:314-321; Zander *et al.*, 2011:17). Hardiness has been described as having three dimensions: being committed to finding meaningful purpose in life; the belief that one can influence one's surroundings and the outcome of events; and the belief that one can learn and grow from positive and negative life experiences (Bonanno, 2004:25; Dehghani *et al*., 2019:1-10). Literature supports the notion that hardiness can be learned (Judkins *et al*., 2005:314-321; Dehghani *et al*., 2019:1-10).

Well-being can be described as a state of emotional, physical and psychological health in the presence of feeling fulfilled and satisfied with life (Centres for Disease Control and Prevention, 2016). It is imperative that nurses and other health professionals are equipped with and supported by the resources and knowledge to succeed in their profession. The development of resilience and the promotion of staff well-being can be enabled by several factors at an individual and organisational level (Brennan, 2017:43).

The aim of facilitating support systems is to make it possible for OHC nurse practitioners to cope with daily stressors and ensure quality of life by maintaining emotional, physical and social well-being. Enhancing well-being is also important to achieve physical vitality,

strong mental ability, good social interaction amongst nurses, a sense of accomplishment and personal fulfilment (Brennan, 2017:43).

A deeper understanding of the OHC nurses' perceptions of the current content of wellness programmes, EAP's and OHC support systems within an organisation, specifically pertaining to resilience, hardiness and general well-being, can assist and ultimately lead to more effective and sustainable OHC support interventions, programmes and strategies.

1.3 RESEARCH QUESTION

Given this contextualisation and the problem statement that stems from it, this study aims to answer the following **research questions**:

What are OHC nurses' perceptions about the adequacy of current OHC support systems as utilised within a private organisation with special reference to the well-being of OHC nurses?
How do these support systems effectively promote resilience, hardiness and well-being of OHC nurses?

1.4 RESEARCH AIMS AND OBJECTIVES

The aim of the study is to explore and describe OHC nurses' perceptions of the current content of OHC support systems utilised within a private organisation towards enhancing the resilience, hardiness and well-being of OHC nurses.

Based on the findings gleaned from the research project, new, revised and/ or alternative interventions and/ or programmes for supporting the current OHC support programmes and strategies can be introduced to promote the resilience, hardiness and well-being of OHC nurses.

Given this aim, the following objectives are employed towards guiding the answers to the research questions as posed above:

- To explore and describe the perceptions of OHC nurses of the adequacy of current OHC support systems, as utilised within a private organisation, with special reference to the well-being of occupational health nurses.
- To explore and describe OHC nurses' perceptions of how these support systems effectively enhance their resilience, hardiness and well-being.

1.5 Paradigmatic perspective

Polit and Beck (2012:622) state that a paradigm is defined as a world view and is compared to observing the world by means of lenses that will assist one's focus and broaden one's mind around a given phenomenon.

The paradigmatic perspective is therefore defined as assumptions or beliefs that form a framework for observations and reasoning necessary for interpreting and internalising the research process (Botma *et al.,* 2010:187). In this research study, the researcher discusses the paradigmatic perspective with a view to meta-theoretical, theoretical and methodological assumptions.

1.5.1 Meta-theoretical assumptions

Meta-theoretical assumptions are not scientifically proven, yet these beliefs are still considered to be true and factual by the person adhering to the assumptions (Polit & Beck, 2012:622).

Person

The researcher beliefs that a person is a holistic human being created in the image of God, who comprises a body (physically), soul (intellect, emotions and will) and spirit (beliefs and norms). In this research, a person is referred to as the participants who will

be is the actual occupational health care nurse working for a private organisation. The researcher believes that the person is unique, with characteristics of resilience enabling him or her to function and thrive in their working environment

Environment

The term environment is defined by the Macmillan Dictionary (2009-2015: online) as an external condition in which a person works, as well as the social and cultural forces that shape the life of a person or community. In this research, it will refer to the workplace where the occupational health care nurses are working. The environment has an impact on the health and well-being of a person.

Health

Health is defined by the World Health Organisation (2013: online) as a “state of complete physical, mental, social well-being and not merely the absence of disease or infirmity.” In this study, health is viewed as occupational, where care nurses provide and foster a caring presence and resilience to provide optimal care and well-being for their patients/ clients and for themselves. The researcher realizes the importance of complete health for occupational health care nurses to be happy and productive in their working environment.

Nursing

Henderson’s theory (as cited by Letsie, 2015:109) views nursing as a profession with the unique function of assisting individuals (sick or well) in the performance of attaining health or its recovery. In this study, nursing is viewed as a caring profession that requires occupational health care nurses to effectively portray nurse-patient interaction by means of being resilient, which will then provide optimal patient care and improve the well-being of nurses.

1.6 CENTRAL ARGUMENT

The exploration and description of OHC nurses' perceptions about the current content of OHC support systems utilised within a private organisation and whether these support systems effectively promote resilience, hardiness and well-being of the OHC nurses.

1.7 CONCEPTUAL DEFINITIONS

1.7.1 Nursing

The Nursing Act (33 of 2005) defines nursing as a caring profession and makes provision in Section 30(1) and 31(1) of the Act for the prescribing of a scope of practise for professional nurses who are qualified and competent to independently practise nursing and are registered at the South African Nursing Council (SANC). The present project views nursing as a specialised occupational health service rendered in a private organization.

1.7.2 A professional nurse

A professional nurse is a person who is registered at the SANC in terms of Part 31(1) (a) of the Nursing Act, 33 of 2005; who is qualified and competent to practise comprehensive nursing independently to the prescribed level; and who is capable of assuming an accountability for such practise (Government Gazette, 2013). According to Section 30 of the Nursing Act (33 of 2005), a professional nurse is qualified and skilled to autonomously practise comprehensive nursing in the manner and to the level prescribed, and who is able to assume responsibility and liability for such practise (South Africa, 2005). In practise, as well as in extant research literature, a professional nurse is also referred to as a registered nurse. In this study a professional nurse will be defined as a skilled and qualified person who renders occupational health care services in a private organisation.

1.7.3 Enrolled nurse

An enrolled nurse is a person educated to practise basic nursing in the manner and to the level prescribed in the Nursing Act (33 of 2005). In this study, the enrolled nurse

occupies the role of the audiometrist, who has received special training in conducting hearing tests only, while not performing any other nursing duties.

1.7.4 Occupational health practitioner/ occupational health care nurse

An occupational health practitioner is a health practitioner or a person who holds a qualification in occupational health recognised as such by the South African Medical and Dental Council as referred to in the Medical, Dental and Supplementary Health Service Professions Act (56 of 1974), or the South African Nursing Council as referred to in the Nursing Act (50 of 1978); Occupational Health and Safety Act (85 of 1993). An occupational health practitioner will be the qualified nurse who will be rendering occupational health services to employees employed by a specific private organisation in a petrochemical industry for the purpose of the present research.

1.7.5 Occupational health services

The ILO (International Labour Organisation) Occupational Health Services Convention (No. 161) defines "occupational health services" as services that entail essentially preventive functions. These services include advising the employer, the workers and their representatives in the undertaking of the requirements for establishing and maintaining a safe and healthy working environment, which will facilitate optimal physical and mental health in relation to work and the adaptation of work to the capabilities of workers in the light of their state of physical and mental health.

Provision of occupational health services means carrying out activities in the workplace with the aim of protecting and promoting workers' safety, health and well-being, as well as improving working conditions and the working environment. These services are provided by occupational health professionals functioning individually or as part of special service units of the enterprise or external service deliverers.

1.7.6 Workplace

A workplace is any premises or place where a person performs work in the course of his or her employment (Occupational Health and Safety Act, 85 of 1993). It is a place such as an office or factory, where people are employed. A workplace is viewed in this research

as a medical centre that provides health services to employees who are working in the mine or in an organisation.

1.7.7 Employer

An employer is any person who employs or provides work for any person and remunerates that person or expressly or tacitly undertakes to remunerate him or her, but this excludes a labour broker, as defined in Section I (1) of the Labour Relations Act (28 of 1956); Occupational Health and Safety Act (85 of 1993). The employer in this research will be a private organisation in a petrochemical industry.

1.7.8 Employee

This is any person who is employed by or works for an employer and who receives or is entitled to receive any remuneration or who works under the direction or supervision of an employer or any other person (Occupational Health and Safety Act No. 85 of 1993). In this study, the occupational health practitioners or occupational health care nurses will be referred to as the employees.

1.7.9 Resilience

The word resilience stems from the Latin word *resilience*, which means the “action of rebounding”. Atkinson *et al*. (2009:137-145) describe resilience as the “capacity to recover from extremes of trauma, deprivation, threat, or stress”. Grafton *et al*. (2010:698) describe it in similar terms, but also describe resilience as a continuing process of struggling with adversity and just not giving up. Resilience is a state of recovery after an adverse event or stressful situation (Atkinson *et al*., 2009:137-145).

Resilience furthermore refers to a set of attributes that enables a person to demonstrate flexibility, succeed and live in a positive manner, despite the stress and adversity of life (Howe *et al*., 2012:350). Resilience, or the phenomenon of “bouncing back” from adversity, is common to societies that grapple with threatened well-being. Resilience, which is currently defined as a process and an outcome characterised by positive adaptation to adversity, is a relatively novel and decidedly complex concept (Theron, 2010:1). Occupational health care practitioners who participated in this study need to be given the opportunity to develop resilient attributes so they can cope successfully with stress when faced with adversity and be retained in their area of speciality.

1.7.10 Hardiness

Hardiness is a combination of three attitudes: commitment, control and challenge that, together, provide the courage and motivation needed to turn stressful circumstances from potential calamities into opportunities for personal growth (Kobasa *et al.,* 1982:168-177; Dehghani *et al*., 2019:1-10). From the viewpoint of this study, hardy occupational health practitioners should be creative, resourceful and innovative, and emerge victorious under conditions of indecisiveness and stress.

The occupational health practitioners must show commitment in order to have the ability to believe in the truth, importance and value of who they are and what they are doing, which result in a tendency to involve themselves in many aspects of life, including work, family and interpersonal relationships (Kobasa *et al*., 1982:168).

They should have control: the inclination to believe and act as if they can influence the progression of their life events by means of their own efforts. They should possess coping mechanisms that enable them to act effectively on their own, interpret and incorporate various life experiences, making them manageable and beneficial (Kobasa *et al*., 1982:168).

Their challenges should be based on the belief that change, rather than monotony or stability, is the norm, thus forming motivation for personal growth rather than taking refuge. They are more likely to thrive under the circumstances of a new challenge or opportunity brought about by new endeavours (Kobasa *et al*., 1982:168).

1.7.11 Well-being

The World Health Organisation defines health as “a state of complete physical, mental and social well-being” (Flynn, 2010:318). Well-being is further defined by Seligman (2011:16) as comprising five key elements, including positive emotions, engagement, relations, meaning and accomplishment. When a person fails to maintain his or her mental health or well-being, he or she cannot cope with stressors and may need interventions from health professionals (Koen, 2010:19). In this study, the focus is on support programmes for occupational health nurses, with the expectation that it may motivate and inspire them to function positively and flourish, so that it may contribute to their well-being for them to be able to cope with stressors in their profession.

1.7.12 OHC Support systems

OHC support systems refer to a network of people who provide an individual with practical or emotional support (Merriam-Webster.com). In this study, the OHC support system refers to the network of people in the private organization that provide practical and emotional support by utilising wellness programmes, including employee assistance programmes (EAP).

1.7.13 Wellness programme

Wellness programmes are defined as long term organisational activities designed to promote the adoption of organisational practices and personal behaviour conducive to maintaining and improving employees' physiological and mental well-being (Janice, 1997:127; Berry *et al.*, 2010:104-112). Wellness programmes can incorporate a variety of components such as flu shots, gym memberships, coaching on weight loss or smoking cessation, company health fairs, wellness newsletters and employee assistance programmes (Linder & Hatcher, 2011:5-6).

1.7.13.1 Employee assistance programme (EAP)

An EAP may entail the provision of confidential assessment, counselling and therapeutic services for employees and dependants experiencing a wide range of personal, emotional and psychological problems, with a telephone helpline for advice and information on domestic, legal, medical and financial matters (Schoeman & Pelzer, 2005:119; Jacobson, 2013:12-19). The EAP in this study will be a benefit provided by the employer of the private organisation to reduce the effects of stress on individual occupational health care practitioners by providing tools to improve workplace performance and productivity.

1.8 RESEARCH DESIGN

The research study employed an interpretive and descriptive qualitative design as described by Botma *et al.* (2010:110) towards answering the research question as posed above. This design was chosen, as it gave the researcher opportunity to explore, describe and importantly understand OHC support programmes from the OHC practitioner's perspective. The researcher gained the perspective of the nurses on how the OHC

support programmes in the private petrochemical organisation enhanced the resilience, hardiness and general well-being of their nursing staff. The design is described in more detail in Chapter 3.

1.8.1 Research method

The research method refers to the population, setting, sampling, method of data gathering, analysis of gathered data and ensuring of rigour in the research (Botma *et al*., 2010:199). A more detailed description of the research method follows in Chapter 3.

1.8.2 Study population

The target population were OHC practitioners across the country, who worked in different settings such as mines, private organisations, hospitals and universities. The study population were staff from two medical centres and consisted of all OHP nurses who render occupational services and registered with SANC. from a private organisation in a petrochemical industry situated in the Free State and Mpumalanga provinces of South Africa.

There were only two centres in this group. The one in the Free State province, which consisted of 12 nursing staff members (OHP's), and the other in Mpumalanga, which consisted of 14 nursing staff members (OHP's), all of which functioned as OHPs and saw 10 -12 patients per nurse per day.

This population was purposefully chosen based on the research problem. The reason why this organisation was chosen was because it consisted of a much larger medical centre with more OHC nurses compared to the majority of other organisations, which mostly have only one or two OHC nurses.

Large private companies experience higher rates of negative attributes, as discussed in the study background. The researcher was therefore able to obtain more information from the OHC nurses at this specific organisation. The conflict of interest was managed by not allowing the researcher to conduct the focus group discussions (FGDs) at the medical centre where she was working at that stage, where a moderator (independent researcher) conducted the session. The researcher conducted the FGDs in Mpumalanga where she was not known to anyone. Results obtained by means of this research will

primarily benefit OHC nurses within the organisation and could ultimately lead to more effective and sustainable OHC support interventions, programmes and strategies.

1.8.3 Sampling

Sampling refers to the selection process of the sample from a population in order to obtain information regarding a phenomenon in such a way that the sample represents the population (Brink *et al*., 2012:1312).

A purposive sampling strategy was employed. This strategy was chosen as it allowed the researcher to select the most appropriate participants in achieving the overall purpose of the research. Purposive sampling in this research was used to ensure consistency and unbiased representation (Botma, 2010:124-127). The researcher aimed to involve all nursing staff from the two medical centres because it embodied such a small population. This included a total of 26 nurses. The selected method was used to ensure that only nursing staff from the specific private petrochemical organisation who complied with the inclusion and exclusion criteria would participate after voluntary signing of consent.

The nursing staff of the medical centres of a private organisation from a petrochemical industry were invited for this study, because they were able to provide answers and share their opinions about the research questions.

The planned sample size was 26 participants from the two medical centres. This number included all OHC nurses from both medical centres. Due to the small sample size, the researcher strived to reach data saturation by employing probing questions during the focus group discussions. Data saturation occurred when additional data collection provided no new information. This point was reached when the researcher heard themes repeated without hearing any new information from the participants.

Inclusion criteria of participants consisted of the following:

- Male and female nurses could take part in the research study.
- Occupational health care nurses, who had been in an occupational health practitioner's role for at least six months and registered with SANC (South African Nursing Council).
- Participants who were willing to participate freely, based on informed consent.
- Participants who were able to communicate in English.

Exclusion criteria consisted of the following:

- Nurses who had been working at the medical centres for less than six months at the time the study was conducted.
- Nurses who were not in an occupational health practitioner's role.
- Non-occupational nurse practitioners working at the medical centre (such as medical practitioners, administrators, pharmacists and radiographers).
- Participants who were not informed about the study prior to the FGD and who did not sign informed consent.
- Nurses who were on leave at the time the study was conducted.

Recruitment of participants

The recruitment of the participants in the sample was fair and they decided out of free will if they wanted to be part of the research. The recruitment of participants was mediated by a mediator identified and appointed by the researcher. The appointed mediator was a lecturer at the NWU, Vanderbijlpark campus. The researcher provided the mediator with the email addresses of all potential participants, and then the mediator contacted them via email a month before the actual FGDs. The mediation occurred during a short information session whereby the aims and objectives of the research were explained to the participants. The information session was held at the boardroom of the medical centres, as this venue was centrally located and convenient for all stakeholders, and therefore also accessible for the mediator. The information session gave prospective participants the necessary information on resilience, hardiness, well-being and the purpose of the research, as well as the aim and the methods to collect data for the research study.

The participants were given a week to reflect and ask questions concerning the research before they committing themselves by giving written consent. Recruitment material in the form of a pamphlet, as represented in Appendix J below, was available to participants a month in advance of the study, which included all relevant information pertaining to the study and the researcher. Participants were also prepared and expected to complete a biographical questionnaire and to be voice recorded during the focus group discussions.

1.8.4 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study (Grove *et al*., 2013:45). The data collection, for the objective within the qualitative approach chosen, utilised focus groups as technique, because the emphasis was on small group interaction and in-depth discussion among the participants about the issue studied. Focus groups were especially useful for exploring ideas and obtaining in-depth information about how people thought and interacted about the issue examined (see Christensen *et al*., 2011:56). The researcher used a combination of the US AID Centre of Developing Information and Evaluation (1996) practical guidelines and the theoretical underpinning of Krueger and Casey (2015) for the planning and facilitating of the focus group discussions. More detail is available in Chapter 3.

1.8.4.1 Role of the researcher

The researcher obtained ethical clearance, reference number NWU-00129-18-A1, from the Health Research Ethics Committee of the North-West University, Potchefstroom Campus. The researcher furthermore obtained permission to conduct the research from the vice-president, senior manager and immediate manager of the private organisation where the research was performed and, lastly, from the nursing participants who voluntary participated in the study. The purpose and importance of the research was explained to all relevant stakeholders in order to obtain written consent. The researcher identified one mediator to assist the researcher during the process of the group discussions. This person provided mediation between the OHC nurses and the researcher.

1.8.4.2 Physical environment

The participants were all occupying their own offices where they saw their clients or patients and were usually very busy with medical surveillances, injury on duties or primary health care duties. So, it was not suitable to use their offices. The researcher identified and arranged a convenient setting for the participants who had consented to participate in the focus group discussions. The planned venue for the discussions was a private room: in this case, the boardroom at the different medical centres. The room was suitable, safe and comfortable, while ensuring confidentiality, and was available at times set as

convenient for the researcher and the participants. The boardrooms identified were also chosen to be clean, quiet and spacious, with appropriate room temperature control.

1.8.4.3 Data collection method

Focus group discussions were conducted to explore OHC nurses' perceptions of support systems to enhance their resilience, hardiness and well-being. Focus group discussions were held in the boardrooms of the respective medical centres by means of a semi–structure interview guide. The first group of interviews were conducted in Mpumalanga on a Thursday. Two interviews were conducted, each involving five participants in a group for 75 minutes per discussion. On the next day (Friday), the last interview was conducted, which also involved five participants in the group, while it lasted 80 minutes. The participants in this centre were noticeably relaxed and co-operative. At times, one or two would deviate from the topic, at which point the researcher had to remind them of the study focus and bring them back to the questions that were asked. The researcher observed that the participants felt the need to vent their feelings, and they tried to use the group discussions as a platform to do so.

The interviews in the Free State province were conducted two weeks later on a Friday and consisted of two separate interviews on that particular day with a 90-minute break in between discussions. The focus group discussion again involved five participants in the first group discussion and the second group discussion engaged six participants. The participants in this centre were also freely participating and co-operative.

A short briefing was given at the onset of the discussion, and the purpose of the focus group discussion was shared with participants. Ground rules were set before the onset of the FGD, which included that any person could withdraw at any time without any penalties; that the participation of everyone was required; and that each person's opinion was valid and valued. The focus group discussions ensured the collection of rich and comprehensive data collection at saturation. The focus group discussions were audio recorded with the participants' consent, and field notes were taken after the focus group discussions and during the entire data collection process. The focus group discussions were conducted in English, as it was a language that all stakeholders understood.

The researcher conducted interviews at the medical centre in Mpumalanga, as indicated, where she was not known to anyone, while the independent moderator conducted the

interviews at the medical centre in the Free State where the researcher was working then, so as to prevent any conflict of interest and bias. The voice recorded data was transcribed and coded.

1.9 DATA ANALYSIS

Data analysis can be described as a process where the researcher tries to make sense of all the data that have been gathered (Botma *et al.,* 2010:220). The first step was to organise, anonymise and manage the data that had been gathered (Creswell, 2009:184). The data collected included focus group interviews and field notes, which were kept during the duration of the research study. Data were analysed and coded to ensure rich, descriptive and accurate information. All the transcribed interviews were reviewed to form a general impression of the responses. Themes were identified according to the research objectives and grouped into columns. During a subsequent round of revision, notes were made pertaining to the identified themes. Each theme was given a descriptive heading and divided into categories, and similar categories were grouped together. The data gathered from the audio-recorded interviews were transcribed with the assistance of an independent transcriber employed at the North-West University, while the field notes were reviewed after data analysis to verify and confirm the themes (see Botma, 2010:221-230).

Data was analysed by making use of the ATLAS.ti computer program with the service and assistance of an independent co-coder also employed at the North-West University. Attention was given to the subjectivity of the analytical process to ensure inter-analyst reliability. On discussion with the co-coder, the results were divided into appropriate main and subcategories.

1.10 BENEFIT – RISK RATIO ANALYSIS

No inflicted danger was foreseen during this research as no interventions or procedures were administered to the participants.

Indirect benefits:

Self-growth of some of the participants occurred through self-reflections and the voicing of their experience on the topic under discussion. The organisation where the researcher is working will also benefit by gaining new knowledge.

The research findings will contribute to the OHS body of knowledge and more specifically assist OHP involved in OHCS for a healthier and more conducive work environment in these type of organisations.

Rigour was ensured by applying trustworthiness strategies, such as truth value, applicability, consistency and neutrality. The applications of these principles are discussed in more detail in Chapter 3.

1.12 DATA MANAGEMENT

Data management are discussed in more detail in chapter 3

1.13 DISSEMINATION OF RESEARCH RESULTS

The application is discussed in more detail in chapter 3.

1.14 DISSERTATION OUTLINE

The dissertation outline is as follows:

Chapter 1: Overview of the research

Chapter 2: Literature review

Chapter 3: Research design and method

Chapter 4: Research findings and literature integration

Chapter 5: Conclusion, limitation and recommendations

1.11 SUMMARY

The introduction thoroughly explains the motive behind the research topic, namely “Exploring the perceptions of OHC nurses about support systems to enhance their own resilience, hardiness and well-being”. Furthermore, the problem statement and research questions substantiated the need for this research. The purpose of the study was therefore stated in correlation with the research questions. The research design and method were identified and will furthermore be elaborated on in Chapter 3. Lastly, an outline of the dissertation was compiled. Chapter 2 will engage a review of relevant extant literature.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The literature review, according to Grove *et al.* (2013:40), is an organised, written presentation of what has been published on a topic by scholars and includes a presentation of research conducted in the selected field of study.

OHC nurses experience numerous stressful situations daily in their working environments and, as a result, they may require support continuously. The aim of this literature review is to explore extant evidence and findings around support systems to enhance the resilience, hardiness and well-being of OHC nurses, and to elaborate on this discourse showing, among others, how it is relevant to the present project. Due to the qualitative design of the project, this literature study was limited to a general exploration of the evidence on current support systems, while a thorough literature integration to support the research findings can be found in Chapter 4.

2.2 LITERATURE REVIEW

For this review, the researcher employed a systematic approach to identify relevant evidence to explore and explain the phenomenon of support systems to enhance the resilience, hardiness and well-being of OHC nurses.

A computerised search was conducted using the following databases: EDS, Google Scholar, EBSCOHOST and BOLOKA. A search was done using the following keywords; nurses, support systems and resilience. Eight articles were found to be relevant to the process, and these will subsequently be discussed briefly.

2.3 Resilience, hardiness, well-being and support programmes

Resilience in nursing has been identified as a personal capacity that aids nurses to deal with workplace adversity and demands (McDonald *et al*., 2013:134).

The broader literature defines resilience as a trait, process or outcome depending on the context within which the concept is used (Fletcher & Sarkar, 2013:12). Masten (2015:187) asserts that resilience can be understood as the capacity to positively and successfully adapt to challenging circumstances or adversity, and can occur in individuals, families, or other dynamic systems. In nursing, resilience has been explored primarily in relation to

individuals and conceptualised variously as an ability or attribute, characteristics, or innate life force (Grafton *et al.,* 2010:698; Hart *et al*., 2014:720; Jackson *et al*., 2007:5) or on the one hand, as contextual and dynamic in individuals and their environment, involving internal and external protective factors (Aburn *et al*., 2016:980; Gillespie *et al*., 2007:124).

Hardiness, according to Semmer (2003:92), is perceived as comprising three components: commitment, challenge and control. Control refers to the tendency to believe and act as if one can influence the course of life. Commitment is the ability to believe in the truth, importance and interest value of who one is and what one is doing. Challenge is based on the belief that change, rather than stability, is the normative mode of life.

The World Health Organisation defines health as “a state of complete physical, mental and social well-being” (Flynn, 2010:318). Optimal well-being or flourishing consists of positive feelings and positive functioning in personal and social spheres of life. When a person fails to maintain his or her mental health or well-being, he or she cannot cope with stressors and may need interventions from health professionals (Koen, 2010:19). In this study, OHPs will be motivated and inspired to function by means of support programmes in a complete state of well-being, so as to be able to cope with stressors in their profession.

A support programme is a network of personal and professional contacts available to a person for practical and emotional support (American Heritage Dictionary of the English Language, 2013). The purpose of support programmes in this study is to make the OHC practitioners and their dependants aware of the provision of confidential assessment, counselling and therapeutic services when experiencing personal, emotional and psychological problems. Support programmes have a considerable number of positive benefits, such as higher levels of well-being, better coping skills and a longer and healthier life (Koen, 2010:19). They also encourage social support amongst occupational health practitioners to reduce depression and anxiety.

2.4 Occupational health care

OHC is seen as part of the human resource function and compasses health care, health education or information, health surveillance and health protection. It is concerned with the effect of health on work as well as the effect of work on health. The Occupational Health and Safety Act (85 of 1993) stresses two premises. Firstly, occupational injuries and illnesses can be prevented by recognising and eliminating hazards and, secondly, employers have the primary responsibility for protecting employees' health by providing healthy working environments. The emotional labour of nursing work involves managing the emotional demands of relating with patients, families and colleagues (Delgado, *et al*., 2017:71). Building nurses' resilience is an important strategy in mitigating the stress and burnout that may be caused by ongoing exposure to these demands.

2.5 Nursing challenges

Without adequate support, emotional labour can lead to stress and burnout of OHC nurses. This can negatively impact nurses' well-being, their job performance and the quality of their care delivery (Delgado *et al*., 2017:71).

There are many contributing factors to the high incidence of burnout among nurses, such as undesirable schedules and work hours; daily confrontations with pain, loss, death and traumatic illnesses; higher acuities and patients-to-nurses' ratios; the diverse roles required in nursing; verbal abuse from physicians; staff shortages and inadequate medical supplies (Cook, 2006:11; Engelbrecht *et al.,* 2008:16; Gustafson *et al*., 2010:24; Sherring & Knight, 2009:1234). It is clear that burnout does not affect only nurses, but also other health care workers. Nurses, their patients and organisations are negatively affected by burnout of staff, which ultimately leaves patients unsatisfied, while it might even lead to unsafe patient care (Cook, 2006:11).

In South Africa, nurses form the backbone of the health care system (Engelbrecht *et al*., 2008:15). Since the launch of a democratic political dispensation in South Africa, the health care system in particular has been under heavy pressure (Heyns *et al.,* 2003:81). According to Heyns *et al*. (2003:81), the perception exists that working conditions in some state hospitals are mostly unsatisfactory. A larger section of the population with no previous access to health care are now eligible for free health care due to the rapid pace of transformation of the South African health care sector into a unified health care system

(Pienaar & Bester, 2011:17). As a result, the workload of the existing nurse corps in the public sector has increased dramatically. Research done by Pienaar and Bester (2011:113) to determine the level and the potential impact of burnout among professional nurses and their intentions to quit in the Free State region, has found that nurses indeed experience high levels of burnout.

Pienaar and Bester (2011:113) furthermore state that thousands of qualified nurses are leaving the South African health sector on an annual basis for various reasons – including burnout. The South African public health services are "crippled by these severe staff shortages due to a flight of skills, "where nurses move from public service to the private service sector and countries abroad (Engelbrecht *et al*., 2008:15). Although nurses are leaving the health care system because of issues associated with workplace adversity, others remain (Jackson *et al*., 2007:7). Nurses who remain are more likely to make use of negative coping strategies, such as distancing or avoidance in relationships with patients and colleagues (Grafton *et al*., 2010:699). According to Koen *et al.* (2011a:1), some of these nurses do, however, survive, cope and even thrive, despite workplace adversities, and they continue to provide high quality care. According to Tugade and Fredickson (2004:320), the ability to move on despite these negative stressors does not demonstrate luck on the part of these nurses, but rather a concept known as resilience.

2.6 Resilient nurses

High levels of resilience in nurses have been associated with increased overall well-being (Ablett and Jones, 2007:733), psychological health (Mealer *et al.,* 2012a), improved work relationships (McDonald *et al*., 2013:134), professional quality of life (Hegney *et al*., 2015:5), and increased job-satisfaction (Matos *et al*., 2010:307). Building nurses' resilience by means of personal and professional development and education can increase their capacity to deal with workplace stress and burnout (Delgado *et al*., 2017:71). Research done in South Africa shows that resilience development among nursing staff leads to positive outcomes, enabling professional nurses to overcome difficulties, adjust, and become tougher and more committed to the profession (Koen *et al.,* 2011:643-652).

Resilience, as described by Kaplan (1999:1784) and Landon (1993:21), includes hope, optimism, coping and self-efficiency as well as a sense of coherence, mental health and

well-being. Other characteristics that play a role in building resilience are joyfulness, entertaining dreams for the future, hope, forgiving, self-respect, perseverance, overcoming obstacles, self-reflection, self-control, self-discipline, being passionate, being flexible and confidence (Koen *et al.*, 2011:104; Lowe 2013:53). Other traits related to resilience are empathy, positive self-image, self-reflection and adaptability (Pine *et al.*, 2011:1483-1484). All these traits and many others can equip nurses to be more resilient in the workplace and to cope better with stressful work situations (McAllister *et al.*, 2008:373). More such traits include adoptability, positivity and cognitive flexibility. Nurses who apply adaptability have better problem-solving skills in the workplace (Gillespie *et al.*, 2009:969). Those who possess these traits normally stay in the job and continue to enjoy a passion for what they are doing.

Positivity is another characteristic that, if applied, can make a positive contribution to the work experience of nurses and patients (Jackson *et al.*, 2007:6). A positive approach can be linked to an optimistic attitude, which can help in difficult situations. It can also improve the health and well-being of nurses. Cognitive flexibility engenders and/ or is related to or derived from optimism, self-care, emotional health, coping skills, optimism, finding resilient role models, social networking and developing a set of moral behaviours.

Self-reflection, which is also one of the traits of resilience, can at times teach nurses how to acquire other traits of resilience. Self-reflection allows nurses to reflect on why they behave in a specific manner under certain circumstances (Edwards *et al.*, 2010:241). Self-reflection also enables nurses to reflect on how they responded to changes, stress or a situation in the workplace. This enables them to reflect and find solutions and ways of coping better and reacting differently (Edwards *et al.*, 2010:241-242).

2.7 SUMMARY

Researchers suggest that a higher degree of resilience among nurses can lead to a decrease in burnout. The extant literature examined here further makes clear that it is possible for resilience to be developed, enhanced, or learned in the workplace. Although global evidence indicates that resilience in nurses have been studied, however, little information is available on South Africa when it comes to providing OHC nurses with support systems on how to enhance or learn resilience, hardiness and well-being.

Knowledge about current support systems to enhance resilient behaviour among South African nurses can lead to improvements in clinical outcomes. This chapter has provided an overview on the literature relevant to this concern. A more detailed discussion of the research design, method and a discussion of trustworthiness and ethical considerations follows in Chapter 3.

CHAPTER 3: RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter will present an overview of the methodology used in the present study. Attention will be paid to the research design and method, population, sampling, data collection and the analysis of data. The ethical considerations that were followed while conducting research as well as trustworthiness of the study will be unpacked.

The methodology in this research refers to how the study was done and the logical sequence of its progression and structure. The focus of this study was to explore and describe the OHC nurses' perceptions about the current content of OHC support systems utilised within a private organisation towards enhancing the resilience, hardiness and well-being of these nurses.

3.2 RESEARCH DESIGN

The design of the study is the end result of a series of decisions made by the researcher concerning how best to implement it (see Grove *et al.,* 2013:214). It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal.

An interpretive, descriptive qualitative design was followed, as described by Botma *et al* (2010:110), in order to answer the research questions posed. "Interpretive description" is an analytical, inductive approach designed to create ways of understanding human health and aspects related to the experience of a disease that have consequences for the clinical context and practice in health matters, and which are of interest for nursing researchers. It stands out as a qualitative research method capable of generating reliable and meaningful disciplinary knowledge, allowing the evolution of the qualitative methodological application in the scope of nursing. This referential method has been used as a basis to support several nursing studies in an international context (Nery, 2018:3). This design was chosen for the present project, as it gave the researcher the opportunity to explore, describe and, importantly, understand OHC support programmes from the OHC practitioner's perspective. The researcher examined the perspective of the nurses

on how the OHC support programmes in the private petrochemical organisation enhance the resilience, hardiness and general well-being of their nursing staff, or not.

This design enabled the researcher to explore and describe the experiences of participants such as their beliefs, feelings, decisions, judgements, memories or phenomena that relate to behaviour. The researcher set aside her own experiences in order to understand the experiences of participants in the research (see Botma, 2010:194). This was done by means of a process of continuously bracketing her own interests, experiences and assumptions about the topic by means of reflection during data collection and analysis of the data (Tufford & Newman, 2010:86). In this research the data sources consisted of focus group interviews.

3.3 RESEARCH METHOD

The research method included the population, setting, sampling method, data collection, analysis of gathered data and ensuring the rigour in the research (Botma *et al.,* 2010:199).

3.3.1 Study population

Population is the entire group of people that the researcher has an interest in (Brink et al., 2012:131). The target population was all OHC practitioners across the country, as differentiated in the sense that they were working in different settings, such as mines, private organisations, hospitals and universities. In the case of the present study, the population was the staff of the two medical centres, while comprising all categories of nurses (OHPs) from a private organisation in a petrochemical industry, as indicated, situated in the Free State and Mpumalanga provinces. This population was chosen based on the researchers' interest, where the problem was identified based on personal experience, and commitment arose as an OHC nurse to the well-being of the people working for this organisation, which included the health care nurses.

3.3.2 Sampling

A purposive sampling was employed. This strategy was chosen, because it allowed the researcher to select the most appropriate participants towards achieving the overall purpose of the research. Purposive sampling in this research was furthermore used to ensure consistency and unbiased representation (Botma, 2010:124-127). The researcher

aimed to involve all nursing staff from the two medical centres, because it was such a small population. This included a total of N = 26 nurses. The selected method was used to ensure that only nursing staff from the specific private petrochemical organisation who complied with the inclusion criteria participated, after voluntary signing of consent.

The planned sample size was 26 participants from the two medical centres. This number included all OHC nurses from both medical centres. Due to the small sample size, the researcher strived to reach data saturation by probing questions during the focus discussions. Data saturation occurred when additional data collection provided no new information. Saturation of data occurs when additional sampling provides no new information, only redundancy of previously collected data (Grove *et al*., 2013:371).

Inclusion criteria of participants consisted of the following:

- Male and female nurses could take part in the research study.
- All OHP nurses who render occupational services, registered and enrolled with SANC, who had been in an occupational health practitioner's role for at least six months and registered with SANC (South African Nursing Council).
- Participants who were willing to participate freely, based on informed consent.
- Participants who were able to communicate in English.

Exclusion criteria consisted of the following:

- Nurses who had been working at the medical centres for less than six months at the time the study was conducted.
- Nurses who were not in an occupational health practitioner's role.
- Non-occupational nurse practitioners working at the medical centre (such as medical practitioners, administrators, pharmacists and radiographers).
- Participants who were not informed about the study prior to the FGD and who did not sign informed consent.
- Nurses who were on leave at the time the study was conducted.

3.3.2.1 Institutional access

The researcher gained permission from the management of the private organisation, including the two medical centres identified, to conduct the research. This permission was

gained by means of the organisation's formal internal research permission procedures. Suitable dates and times were arranged to provide managers with relevant information on the study, including the objectives. During the ensuing meetings, information and aspects about the possible impact of the research on the health centres were discussed. This included, but was not limited to, the responsibility of the participants during data collection, and how this responsibility and the researcher's expectations would not influence the daily work performance of the participants during data collection. This process expected from the researcher to consult with her direct manager. Her direct manager with his input consulted with the senior manager. The senior manager consulted with the vice president in order to grant permission. Once permission was granted, final ethical approval from the North-West University, Faculty of Health Science, Health Research Ethics Committee (HREC) was obtained and the researcher then started the process of recruiting the participants. See Appendix A in this regard.

3.3.2.2 Recruitment and enrolment process

The recruitment of the participants was done fairly. They decided of their own free will that they wanted to be part of the research. Recruitment was mediated by a mediator, who was identified and appointed by the researcher. The appointed mediator was a lecturer at the NWU, Vanderbijlpark campus. The researcher provided the mediator with email addresses of all potential participants, and the mediator contacted them via email a month before the FGDs.

The mediation occurred during a short information session whereby the aims and objectives of the research were explained to participants. The information session was held at the boardroom of the medical centres, as the venue was centrally located and convenient for all stakeholders and, therefore, also accessible for the mediator. The information session gave prospective participants the necessary information on resilience, hardiness, well-being and the purpose of the research, the aim and data collecting methods for the research study. The participants were given a week to reflect on and ask questions concerning the research before they committed themselves by giving written consent. The principle of justice, namely the fair selection and treatment of participants, was applied to the sampling process. Recruitment material was available to participants in the form of a pamphlet that included all relevant information pertaining to the study and the researcher. See Appendix D. Participants were also prepared with

information on what they could expect during data collection. This included that they could expect to complete a biographical questionnaire and to be voice recorded during the FGDs. The research question, aims and objectives were taken into consideration and explained during the information session to ensure that participants met the criteria.

Written consent was obtained from all the role players and the participants as well as the mediator and the independent researcher. The researcher firstly made an appointment with the individual managers of the medical centres to establish their willingness to give permission and to allow the nursing staff to participate in the study, and produced letters to explain the research objectives, while also requesting for the research to be conducted at the facility. The researcher made use of the mediator, who facilitated mediation between the participants and the researcher. Written informed consent was obtained from participants by means of this mediator once details had been explained to participants at each of the facilities. By means of the guidance of the researcher, the mediator acted honestly and fairly during the sampling process, and trained in the overall research objective and, importantly, around ethical considerations as relevant to the research.

3.3.2.3 Informed consent

The individual managers of the medical centres were contacted by the researcher only once organisational permission and ethical approval had been obtained, with a view to permission to use the boardroom for the FGDs. The researcher provided all the relevant information and documentation of the study to the facility manager and made the necessary arrangements for data collection by means of a site visit and information session. The information session included relating the aim of the study, expectations from the researcher and the participants, how contact would be made for further arrangements about the venues and times available for support if needed. The researcher also gave assurance that they could withdraw at any time. Only once all the relevant permissions had been obtained from the relevant authorities, were the participants contacted by the mediator via emails, as indicated. Again, participants had one week to consider their participation after receiving the informed consent forms. The mediator followed up in person, face to face with each potential participant, after the week had elapsed, and at the two different medical centres, while allowing participants to sign consent in her presence, subsequently and immediately to collect the signed and sealed informed consent forms at the office of each person who were willing to participate in the study.

3.3.3 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose as unpacked in specific objectives, questions or hypotheses (see Grove *et al*., 2013:45). The purpose of this study was to explore and describe OHC nurses' perceptions about the current content of OHC support systems utilised within a private organisation towards enhancing the resilience, hardiness and well-being of these nurses.

Data collection was based on a qualitative approach that utilised focus group discussions as its technique, because the emphasis was on small group interaction and in-depth discussion among the participants about the issue studied. Focus groups are especially useful for exploring ideas and obtaining in-depth information about how people think and interact about an issue (Christensen *et al*., 2011:56).

The FGDs were held in the boardrooms of the respective medical centres by means of a semi structured interview guide. They were recorded with the participants' consent. The voice recorded data was subsequently transcribed and confidentiality agreements were signed by the researcher, mediator, moderator, transcriber as well as an independent coder to protect the privacy of the participants. Five FGDs were conducted: three in Mpumalanga and two in the Free State centre. For the purpose of this study, while taking into account the nature of the FGDs and the context of the project, the researcher made use of a moderator, that is, an independent person, who was trained and experienced in conducting FGDs, at the medical centre where the researcher was employed, so as to prevent conflict of interest and bias.

3.3.3.1 Planning and preparing for the FGDs

In planning and preparing for the focus group, the researcher considered the following:

- The focus of the group discussion;
- The composition of the group;
- Development of the question guide;
- Decision on the venue and time of the focus group and;
- Planning and preparing the recording of the FGD (see Christensen *et al*., 2011:56).

3.3.3.2 The FGD semi-structure interview schedule

The researcher developed and revised or adjusted the semi-structured interview schedule, which was first included in a trial run, before it was utilised with the actual FGDs. This was done to identify problems or obstacles and ensure the smooth running of the actual group discussions. This trial run did not include any of the participants within the planned sample, as this would have minimised the available participants. The researcher identified peers and colleagues with similar working conditions to participate in the pilot study. The target population for the trial run were OHC nurses from another private OHC facility, also based in the Free State, where similar working conditions prevailed. This facility consisted of one medical centre where only two OHC nurses were at work. Verbal consent was given, and they were informed that their data would not be used for any other purpose than that specified by this study.

3.3.3.3 The FGD settings

The planned venue for the FGDs was a private room, in this case a boardroom, at the different medical centres. The room was suitable and comfortable. The boardrooms identified were chosen because they were clean, quiet and spacious, with appropriate room temperature control.

3.3.3.4 Focus Group discussions

The method used during the research study was that of FGDs, as indicated. The first of these were held in Mpumalanga. Two interviews were conducted on a Thursday and Friday. On the day of the first interview, two groups were interviewed. The first group consisted of five participants. Group discussions started at 09h45 and ended at 11h15. The second group also consisted of five participants and group discussions began at 12h00 to end at 13h15. The following day, another discussion was held, which involved six participants. This group discussion commenced at 10h10 and ended at 11h30.

The group discussions in the Free State Province were conducted two weeks after the Mpumalanga interviews. Two interviews were completed on a Friday. The first interview involved five participants, starting at 09h00 and lasting until 10h15. The second interview also involved five participants. The group discussion started at 11h00 and ended at 12h10.

The interviews were conducted in the medical centres' respective boardrooms and the participants focused on their perceptions, as nurses, about support systems that would enhance their own resilience, hardiness and well-being. The interviews began with the following leading phrase: "Comment on the adequacy of the current occupational health care support systems with relevance to the well-being of occupational health nurses"; see the interview schedule in Appendix G. A short briefing was given at the onset of the discussions, and the purpose of the focus group discussion was shared with the participants. Ground rules were laid down, which included that any person could withdraw at any time without any penalties.

The FGDs were audio-recorded and transcribed. These ensured rich and comprehensive data towards understanding the experiences of participants, and the meaning they made of those experiences (Botma *et al*., 2010:207). Data was collected until saturation occurred, which was the point during the discussions where no new information was discovered, and they had become repetitive (see Terre Blanche *et al*., 2006:372).

3.4 DATA ANALYSIS

Data analysis can be described as a process where the researcher tries to make sense of the data been gathered (Botma *et al.,* 2010:220). A descriptive approach was followed in data analysis (Creswell, 2009:184). The first step was to organise, anonymise and manage the data (see Creswell. 2009:184).

All the transcribed interviews were reviewed by the researcher to form a general impression of the responses. Themes were identified and grouped into columns. Each team was given a heading and grouped into categories, and similar categories were, in turn, grouped together. An independent co-coder was appointed to co-analyse the data. The ATLAS.ti computer program was used for the analysis. Based on a discussion with the co-coder, the results were divided into appropriate main and sub-categories.

3.5 LITERATURE INTEGRATION

The purpose of literature control was to compare the findings of the study with extant literature (Botma *et al*., 2010:196). The available findings were compared to those of this

study. New findings that were found, but not supported by available literature, were identified. The synthesis of these two sets of findings is documented in Chapter 4.

3.6 TRUSTWORTHINESS

Trustworthiness, as described by Babbie and Mouton (2004:276) was implemented in this research. The framework entails four main criteria for trustworthiness, namely truthfulness, applicability, consistency and neutrality.

3.6.1 Truth value

Truth value, as described by Botma *et al*. (2010:233), "determines whether the researcher has established confidence in the truth of the findings with the participants and the context in which the research was undertaken". Prolonged engagement was allowed, entailing that adequate time was spent with the participants. This allowed time for the establishment of trust between the research team and participants so that they could feel comfortable and safe enough to share opinions, even on sensitive issues. Engagement with participants continued during the FGDs, which concluded the data collection. During these discussions, nurses reflected on their experiences about support systems towards enhancing their resilience, hardiness and well-being. Given the cross-sectional nature of this study, the researcher relied on triangulation of and between the different data sources (FGDs and field notes) generated by the study and literature. The interviews were voice recorded and transcribed to induce additional truth value. Responses were analysed and discussed with a co-coder to ensure that the participants' true opinions were identified, that is, by means of triangulation. Consulting with a study leader and supervisor to review the process and the findings induced further truth value. Truthfulness was also ensured by comparing the findings with other studies and extant literature, that is, further triangulation.

3.6.2 Applicability

"Applicability refers to the degree to which the findings can be applied to different contexts and groups" (Botma *et al.,* 2010:233). The transferability carried by the qualitative nature of this study was ensured by means of the sampling approach that was selected. In this study, an all-inclusive purposive sampling approach ensured the applicability of the study. A thick description, as dictated by the data analysis strategy chosen, and the data

saturation reached to the extent that it was possible within the all-inclusive sample, ensured applicability of the study findings. This research was contextual, and the intention was not to generalise the findings, but they could be applied in other groups and contexts. Therefore, within the domain of nursing, this research might be applied to other contexts if the need arises (Cameron *et al*., 2011:1372).

3.6.3 Consistency

Consistency has to do with whether the findings of the research will be logical, should it be repeated among similar participants in a similar context (Botma *et al*., 2010:233). Consistency is considered to be achieved when the replication of the study gives consistent results when applied among the same participants in a different context. Dependability strategies were employed throughout the entire research process in correlation with the other trustworthy strategies. These included, again, thick and dense description as the methodology used in the study, prolonged engagement with the study topic, design and literature as well as utilising the services of an experienced co-coder in data analysis.

3.6.4 Neutrality

Neutrality refers to the degree to which the researcher can ensure that the findings are based on the information gathered from among the participants, and not biases and motives stemming from different sources (Botma *et al*., 2010:233). Strategies of confirmability were applied to ensure neutrality in the present study. These strategies included triangulation of data collection methods, which included FGDs and field notes. To minimize bias, the researcher maintained a researcher role and referred participants to resource persons, who could be the moderator, mediator or a counsellor when necessary. Researcher-participant relationships did form during data collection. Data collected during interviews ensured that these were rich descriptive and saturated, while the report on the research further will ensure neutrality.

3.7 ETHICAL CONSIDERATIONS

Ethical considerations were considered throughout the research process. Special care was taken to ensure confidentiality, and cognisance taken of the private organisation and the stakeholders involved in the study, such as the management team of the private organisation. Permission for the study was obtained from the managers of the private

organisation where the study was conducted. Informed voluntary consent was obtained from the participants to take part and be recorded during the group discussions. Protection from discomfort and harm was also ensured. Before permission was sought from the private organisation, the researcher obtained written permission and approval from the Human Health Research Ethics Committee of the North-West University. The three fundamental ethical principles defined by Brink et al., (2006:31) are; respect for persons, beneficence and justice and human rights to be protected such as: the right to self-determination, right to privacy, the right to anonymity and confidentiality and the right to fair treatment and protection from discomfort and harm. These principles will subsequently be discussed as implemented in this study.

3.7.1 Principle of respect for persons

Individuals are autonomous: that is, they have the right to self-determination (Brink, 2006: 32). Within this study, taking cognisance of its qualitative nature, this principle was implemented in the following manner: An individual had the right to decide whether or not to participate in the study. Participation was voluntary and no participant had been coerced in participating. The researcher made use of a mediator during the recruitment and enrolment process in order to facilitate mediation between the participants and the researcher. Communication by means of the recruitment and enrolment process and, importantly, as found in the consent form, was clear. If the participants were to decide not to participate and/ or withdrew from the study, they could do so without any risk of penalty or prejudicial treatment. During the informed consent process and on the day of data collection, the participants were again made aware that they had the right to withdraw from the study at any time. They were informed that they did not have to give information if they did not want to and that they could at any stage ask for clarification about the purpose, process and outcome of the study.

3.7.2 Principle of beneficence

The researcher secured the well-being of the participants, who had the right to protection from discomfort and harm – be it physical, emotional, spiritual, economic, social or legal (see Brink *et al*., 2012:36). The researcher protected participants from harm by carefully structuring the questions and monitoring the participants for any sign of distress. An internal counsellor from the private organisation was available for needs that might arise.

The researcher was a qualified OHC Practitioner with experience in dealing correctly with human experiences of discomfort and harm.

The principle of beneficence was also applied by ensuring that the benefits of this study outweighed the risks by means of a benefit-risk ratio. Risk refers to the possibility that the participant may be harmed during the research (Brink, 2006:39). No infliction of danger was foreseen during this research, as no interventions or procedures were administered to the participants. There were no direct gains for the participants when they took part in this study. Participants were not remunerated, also because the FGDs never exceeded an hour of their time. The participants were not inconvenienced, because the discussions were held during working hours at the medical centres where they were employed. There was no need for special travelling or expenses carried by participants. The researcher provided light refreshments before and during the group discussions. The organisation where the study took place will benefit by gaining new knowledge, which could affect future policies and procedures. The research findings will contribute to the occupational health and safety body of knowledge and will assist the occupational health practitioner involved in OHC services for a healthier and more conducive work environment in these types of organisations. The benefits of this study outweighed the risks.

3.7.3 Principle of justice

This principle includes the participant's right to fair selection and treatment. The researcher selected the study population in general and the participants in particular with fairness (see Brink *et al*., 2012:36). It was taken into account that the researcher should select participants for reasons directly related to the study problem and not because they are readily available or can be easily manipulated (see Brink, 2008:33). Participants were selected fairly, and all participants were informed of the study findings and how they might indirectly benefit from this study. The researcher respected all agreements that she made with the participants. Participants were not paid to take part in the study. Refreshments were served before and during the FGDs.

The researcher also respected the participants' right to privacy and dignity by treating them as persons with their own values, preferences or commitments. Consider that the process of ensuring anonymity refers to the researcher's act of keeping the participants' identities confidential with regard to their participation in the research study (Brink, 2008:34). The process of ensuring confidentiality centres on the researcher's

responsibility to prevent all data gathered during the study from being divulged or made available to any other person, and this was implemented.

3.7.4 Data management, storage and archiving of data

The collection of data was done by the researcher herself, so as to ensure the confidentiality of all participants at all times. These data are kept safe under lock and key and is only accessed by members of the research team. All data and informed consent forms are stored in a locked cabinet (hard copies) and password protected computer (electronic copies) with the researcher. All informed consent forms will be taken to the NWU, Potchefstroom campus, to be stored separately in the research entity's office in a locked cabinet, while the research remains in progress. The same protocol will be sustained for the electronic copies generated, but these will be stored on the researcher's password protected computer. Audio recordings were removed from the recording devices by the moderator who recorded the sessions directly after interviews had been conducted and were placed on a password protected computer. Electronic copies were saved on a disc and stored by that research office, known as the NuMIQ. On completion of the study, all the data (both hard- and electronic copies) will be securely stored for seven years in the NuMIQ office as per HREC requirements and NWU policies. All records will be destroyed after seven years in accordance with NWU requirements and procedures.

3.7.5 Dissemination of research results

Once the study is completed, the findings will be disseminated to the participants, the management team of the organisation as well as the research community. To the participants, dissemination will be done in the form of a power point presentation. To the management team of the organisation, dissemination will be done in the form of a report, and findings will be communicated to the research community by means of publication in a peer–reviewed journal, namely *Health SA Gesondheid*.

3.8 SUMMARY

A detailed description of the research design, methods of trustworthiness and ethical considerations relevant to the study have been discussed and presented in this chapter. The next chapter integrates research and relevant extant literature related to participants'

perceptions of OHC nurses and support systems that enhance their resilience, hardiness and well-being.

CHAPTER 4: INTEGRATION OF RESEARCH FINDINGS AND LITERATURE

4.1 INTRODUCTION

In this chapter, the findings regarding the perceptions of OHC nurses about support systems to enhance their resilience, hardiness and well-being will be discussed. The findings were supported by the data from interviews conducted with OHC nurses working at a private organisation. Relevant literature was used to draw comparisons between the findings of this research and extant literature.

Group interviews were conducted with the staff of two medical centres, consisting of all nurses from a private organisation situated in the Free State and Mpumalanga provinces. A total of five groups of nurses were interviewed, each comprising five to six members. All group interviews were conducted in English. Field notes were taken by the researcher and the independent interviewer. Data saturation was reached during the group interviews at the respective medical centres. The focus group interviews were audio-recorded and transcribed with the assistance of an external transcriber. Data were coded by the researcher and independently co-coded. The researcher and co-coder were in agreement about the codes and emerging themes.

4.2 Results

Twenty-six (26) participants were recruited to take part in this study. In total, five group interviews were conducted. All interviews were conducted in English and all nurses took part in the discussions. The interview groups consisted of five participants per group with only one consisting of six participants. Data analysis and coding of the data collected from the FGDs resulted in distinct codes that were grouped into four themes, the latter which answered the research questions.

4.3 Demographic profile of OHC nurses

The following demographics of the participants are included in the table below: focus group interview, average age, gender and race, language, highest qualification, years in current position, years in organisation and position.

Table 4.1: Demographic profile of OHC nurses

The focus group discussions were conducted in English only, not available in other language.

Focus group interview	**Average age**	**Gender & race**	**Language of participants**	**Highest qualification**	**Years in current position**	**Years in organisation**	**Position**
Interview 1	35-60	F/B=3 F/W=1 F/A=1	Sotho Afrikaans English	Diploma's	10-20	10-20	OHCN
Interview 2	40-55	F/B=3 F/W=1 M/B=1	Sotho/Zulu Afrikaans Zulu	Diploma's	8-10	8-10	OHCN
Interview 3	35-55	F/B=2 F/W=2 M/B=2	Sotho/Zulu Afrikaans Sotho	Diploma's/ degree's	10-20	10-20	OHCN
Interview 4	40-50	F/B=5	Sotho	Diploma's/ degree's	02-15	02-15	OHCN
Interview 5	40-50	F/B=3 F/W=1 M/B=1	Sotho Afrikaans Khoxa	Diploma's/ degree's	10-15	10-15	OHCN

Total number of participants (N) = 26, F/B = Female black, M/B = Male black, F/W = Female white, F/A = Female

Table 4.2: Demographic profile of participants

Medical centre	Number of participants
Free State	F/B = 8 M/B = 1 F/W = 1
Mpumalanga	F/B = 9 M/B = 2 F/W = 4 F/A = 1

Table 4.3: OHC nurses' perceptions about the current content of OHC support systems in promoting the resilience, hardiness and well-being of OHC nurses

Themes	Sub-themes
1. Effective support systems promote personal and professional growth and well-being	- Personal growth and well-being - Professional growth and well-being - Family included in support systems
2. Salary package benefits are perceived as support system	- Expensive medical aid benefits as support system - Cash flow relief options as support system
3. Improving constructive internal communication	- Inclusive decision-making - OHC nurses' need for recognition
4. Acknowledging nurses' professional contributions	- Display of appreciation as part of support system - Managerial support - OHC nurses responsible for own well-being

4.4 OHC nurses' perceptions of current support systems

This study had two objectives. The first was to explore the perceptions of OHC nurses about the adequacy of current OHC support systems utilised within a private organisation with special focus on the well-being of occupational health nurses. The second objective of the study was to explore how, and if, existing support systems promoted resilience, hardiness and well-being of OHC nurses. In response to the first aim of the study, the data engendered the following themes: 1) effective support systems promote personal and professional growth and well-being; and 2) salary package benefits are perceived as

support systems (see Figure 1 below). Findings that speak to the second aim of the study are unpacked in the subsequent section.

Figure 1: Visual summary of nurses' perceptions of services

The majority of participants focused more extensively on salary package benefits rather than support system services that were accessible to them. The discussions focused on benefits such as medial aid, school fees bursaries and taxes. Participants who were familiar with other support system services spoke mostly about those provided by ICAS (the Independent Counselling and Advisory Services).

The participants entertained different perceptions of current support systems. Some were not satisfied with support services from human resources (HR) and their respective managers. They said that HR somehow were not very receptive, failing them, and never engaging them for any support. Participants also highlighted unhappiness with some line managers who did not provide any individual support to their subordinates, while they focused only on the work that had to be done.

Participants agreed that, because they see themselves as providers of wellness services, which include taking of blood pressure, blood glucose tests and cholesterol screening tests, they did not feel that accessing wellness services for themselves was relevant to them, and so they rather chose to go to one another for that support instead. They

mentioned that they formed a strong support system amongst themselves. They were frequently considerably busy with their daily routine at work and stated that it was always more convenient just to go to a colleague and share how one felt rather than contacting ICAS, where you would have to talk to a person over the phone that you did not know. Participants experienced it as very impersonal and they found it difficult to open up with “strangers”. That is why they preferred each other for support and assistance at work. Where relationships with colleagues were convivial and collegial, nurses agreed that patients also received good care, while nurses who helped one another made the workload more bearable, thus contributing to lower turnover rates. The first theme in this section speaks to support systems that were perceived as valuable, followed by a final theme that speaks to salary package benefits, which are perceived as an important part of the support system.

Literature that refers to the uniqueness of the nursing profession, for example Schaufeli *et al.* (2002), discusses the positive side of nursing. The benefit of caring for others or being altruistic and help-oriented, are explained by authors who indicated that, by helping others, personal stress is relieved (Cilliers, 2002; Milne, 2007). Literature therefore confirms that supporting each other not only promotes resilience, but also creates a caring bond between colleagues, which enables them to carry on and perform with greater efficiency at their workplaces.

Cameron and Brownie (2010:68), Lucy (2015:160), underscore the importance of support – especially from colleagues. Ramalisa (2014:75) furthermore mentions that support provided by colleagues can be seen as valuable, because it provides knowledge and guidance, and colleagues share similar situations and experiences. Collegial support also provides the opportunity to validate experiences (Cameron & Brownie, 2010:66). According to Hart et al. (2012:727), collegial support helps nurses to overcome stress in the workplace. Edward (2005:142) demonstrates that resilience in nurses was promoted by non-work-related support and by means of support at work, which dovetails with the nature of support mentioned by participants in this study.

Participants in this research identified that support amongst colleagues at work is imperative. Caring presence is to show collegial care by smiling, touch, sharing and

openness. Caring is the act of generously choosing to give more than expected amongst colleagues.

4.4.1 Effective support systems promote personal and professional growth and well-being

The participants identified support systems that were made available to them by means of an external service provider named ICAS that was contracted by the organisation for which they worked. The types of support offered by ICAS included psychological and psychiatric services, financial well-being, support for wellness campaigns and information on various topics related to health and finances.

4.4.1.1 Personal growth and well-being

Participants mentioned that these support systems promoted their personal growth, resilience, hardiness and well-being by means of information and counselling services that helped them overcome or manage personal and/ or professional difficulties, while these systems further provided information that guided good financial and health choices. The following citations found in the FGDs engendered this theme.

> *"I had previously consulted the psychologists here at work. Sometimes people feel like if you consult the psychologist you've got major problems maybe, but sometimes the systems under which you work force you to consult them. And I found them very helpful and could at the end resolve the problems that were there" (Participant 1, Transcript 2).*

> *"I think bringing it [information] to the nurses. We do get emails from wellness. I'm sure you've seen it. What do they call it? eCares? They are here. I think in that sense [it is helpful] because all of us here as nurses, we do have access to a computer. You are able to go and read the articles. They send health articles, advice on finances, wellness, and all that. In that sense, I think it's effective because then you can just read it… It's accessible in that way" (Participant 4, transcript 3).*

Various authors stress the importance of efficient and solid emotional support and social supportive networks for people to function with resilience (Cherniss, 2001:1).

The presence of a solid, working infrastructure rendering support and support services has been shown to be a vital component of causing and sustaining resilience (Sirgy & Cornwell, 2002). Such support is essential because, emotionally, nurses are challenged by periods of considerable emotional stress as they watch experience degrees of illness and death, sometimes feeling frustrated and inadequate as they battle with an increased work load while, simultaneously, trying to fulfil patients' needs (Vogt, *et al*., 1993). Jackson, *et al*., (2007:3) and Shojaei *et al*. (2019:242-247) emphasise professional relationships for nurses that become a professional support system. The support provided by nurses to one another facilitates teamwork in the workplace. Nurses who experienced resilience ascribed it to the caring environment of the team in which they worked (Warelow & Edward, 2007). Koen *et al*. (2011:103). Shojaei *et al*. (2019:242-247) and Gillespie *et al*. (2007:125) identify the role of the support system enabling nurses to cope in their workplace, as it facilitates resilience. The latter authors state that strengthening peer or collegial support requires collaboration. Their research demonstrates that resilience is characterised by providing support, social inclusion and valuing other nurses' contributions (Gillespie *et al*., 2007:124; Shojaei *et al*., 2019:242-247). Physical or psychological support, including opportunities to self-reflect, debrief or validate and provide relief by means of humour as well as camaraderie, foster resilience (Cameron & Brownie, 2010:66). Participants in this study felt that their colleagues provided physical and psychological support, and that they could talk to other team members, debrief and even validate feelings. According to Cameron and Brownie (2010:66), this can foster resilience.

4.4.1.2 Professional growth and well-being

In terms of professional growth, participants said that they were able to further their education by means of their organisations who paid tuition fees. This did allow nurses to pursue postgraduate degrees, increase their professional skills and advance in their field. However, the debilitating aspect was that this benefit focused on professional development that was not related to promotions within the organisation, which nurses found to be demotivating, because it made them feel "stuck".

"The study support system really is working. It's working... You are supported and you're getting whatever you planned to get. Like maybe when you're doing master's

degree, they will definitely allow you to do it and pay everything. But after that you are stuck" (Participant 3, transcript 2).

"*Study aid. I think the company has got good study benefits…Refresher courses that are done and any other courses, whether it's internal or given by outside agencies". Those are quite good benefits I would say" (Participant 1, transcript 2).*

Access to furthering education was seen as highly positive because, when employees were interested to further their education, the organisation allowed them to apply for funding, and even assisted employees with the full payment of fees for the entire duration of their studies, while providing study days to those who needed to attend classes. Many participants nonetheless reported that they felt demotivated due to the lack of opportunities for upward mobility within the organisation/s for which they work, as stated by this nurse, for instance: *"Educational wise, yes, we are benefiting a lot. But it is just to get the papers [certificates] and qualifications, whereby they are not going to utilise you anywhere [within the organisation] until such person moves away or dies". (Participant 3, transcript 2).*

"We realised that there isn't much growth within our career field… There was a proposal that, let's say now you'll have to wait for somebody to die to be promoted, so how about maybe after five years you get promoted, if you are still there. Yes, specialist or senior. And still there's no room for that also. So we're just sitting here, waking up, coming to work every day and then that's it, knowing that we're just an occupational health nurse and hoping someone die, no promotions". (Participant 2, transcript 2).

"… we are old women, but we are studying. And for one to study and at the end being told that; 'don't think that you are studying to get more money'. Because, really, when you study, you're studying towards getting something and we are not asking for much. They say if you are an occupational health nurse you need to have occupational health nursing, but it's not recognised and say we are not specialists. It's so demotivating". (Participant 2, transcript 1).

Muller (2005) has shown that nurses should receive the necessary training to ensure competent performance. In addition, the former Minister of Health, Dr Manto Tshabalala-

Msimang, promoted the notion of wellness centres for health care workers to promote their well-being (Khumalo, 2008). If peer cohesion is facilitated and promoted and educative support offered, nurses will manifest higher levels of hope (Gillespie *et al.,* 2007). The notion of professional support was also emphasised in Koen *et al.* (2011). Stapleton *et al.*, (2008:6) state in the same vein that organisations do not readily encourage new learning, as they thrive on routine and status quo. Nevertheless, nursing is classified as an academic and practical discipline, and is a dynamic profession that blends evidence-based practice with intuition, caring and compassionate traits, so as to provide the best quality care to patients (American Nurses Association, 2004: online). Therefore, constant training and education is needed within health care settings and among professional nurses in order for them to feel confident in the workplace and develop personally and professionally (Stapleton *et al.*, 2008:11).

In order to give quality care, nurses need development in order to be empowered. According to Butler (2000:5), the best places to work are those where nurses are provided with training and opportunities to develop. Improving professional practise and enhancing nurses' clinical competence by means of ongoing education may increase retention and job satisfaction and help ensure a stable workforce.

4.4.1.3 Family included in support systems

Participants also reported that the most valuable aspect of support systems available to them was that these extended to their families. Family members could access medical aid, which meant parents and their children below the age of 21 could be included in the medical aid scheme. Grandparents could also be added to the benefit scheme at additional cost. Nurses received bursaries for school fees, whereby the organisation paid a certain amount of school fees to all children of employees. Family members were able to access psychological and psychiatric services, whereby they had direct access to the organisations' ICAS. Participants expressed that this promoted their wellness by means of the feeling of knowing that their families had access to support systems they might need.

> *"I just want to add something of the support system. You know, as we are sitting here, we are mothers. The nice thing about ICAS is even your children can phone in to ICAS. Because you know, if you're not well, if your kids, your family member is*

not okay, you are also not going to be okay at work. So, knowing that they are getting help also, they can just phone in. That is very nice. I think they phone in with your control number. I gave it to my kids to say, I gave them the cards, I say please phone if you don't want to talk to me about certain things. You know somehow that at least your kids are covered at least your family members. Its immediate family members. So, I think that's a really excellent benefit" (Participant 4, transcript 3).

Most of the participants were excited and satisfied to be able to include family members in support services at no additional cost. Nurses perceived support services as effective when they knew that their entire family was covered, and this promoted personal well-being amongst them.

4.4.2 Salary package benefits were perceived as a support system

Perceptions of OHC nurses varied around this: some identified specific services offered by ICAS as well as internal services offered by the companies they worked for. Other support systems included mental health programmes and weight loss services, but nurses were of the opinion that they would promote these services but not make use of them. The reason for this intriguing finding was a medical account that they would see subtracted from their payslips at month end.

Most of the participants paid attention to salary package benefits, such as medical aid, bursaries for school fees, travel allowances, and discounted gym fees at a specific gym owned by the organisation. All the nurses highlighted that a good salary would be the best and most important benefit as compared to all others. Participants viewed salary as the primary source of job dissatisfaction amongst nurses and did not think that messages of encouragement and congratulatory notes recognising good performance would make any difference to motivate nurses. They felt that they would be very satisfied if a good salary would be granted to them. Participants were of the view that they should receive an increment in their salary. The two main reasons why participants suggested this salary increase were to support their families in a country where the cost of living is high, and the fact that they were constantly working hard to provide optimal care for clients. An increment is believed by some participants to motivate staff members to perform better, as it would illustrate recognition and appraisal of their work at their organisation.

The researcher found this and its intensity to be unexpected, as salary package benefits are not usually counted as support, nor grouped among OHC support systems. However, the researcher realised that this theme should have been expected if one considers Maslow's much-discussed hierarchy of basic human needs (Maslow, 2013). To be sure, it remains important to establish the necessity of employers helping employees to be content at their place of work. Research has shown that a contented worker will be a more productive worker. Taken together, it is generally accepted that contentment, or "happiness", refers to a subjective and global judgement that one is experiencing a good deal of positive emotion and relatively little negative emotion (Cropanzano & Wright, 2001:183). Cropanzano and Wright (2001:184-185) draw on many different studies on worker happiness, but do not offer a definitive answer as to its exact nature. Their work also emphasizes that people who feel they do enjoy happiness in their lives are better able to solve problems, help co-workers and believe in their own abilities. Furthermore, there are four ways in which happiness has been measured in previous research: job satisfaction, positive and negative affectivity of the worker, lack of emotional exhaustion, and psychological well-being. Happiness could be broken down into two basic parts: economic state and overall emotional state. Emotional state refers to how workers feel about their environment and themselves as well as their stress levels. The reason happiness is important for employees is that it enables them to perform their job at a higher level, regardless of what it is. Also, there are less conflicts with co-workers, since contented people tend to overlook small slights or frustrations (Cropanzano & Wright, 2001:186-192).

From a work perspective, the theory of Maslow (2013:2-8) brings together wages, perks, company culture and how management is performed into one unified whole. Physiological needs are satisfied by the wage given to the employee. Safety needs involve job security and defined responsibilities, that is, structure. Love needs can be satisfied by a positive work culture that allows employees to establish rapport among themselves. Esteem needs can be satisfied by a positive management relation with employees that makes them feel trusted and capable. Self-actualization needs are harder to satisfy and involve management actively engaging motivated employees with work that meets their potential. An example might be the promotion of a motivated employee into a more challenging position. There are further nuances to Maslow's theory, but it is easy to see how the

undermining of one need can lead to the detriment of others, hence leading to a defensive response from employees.

4.4.2.1 Expensive medical aid benefit as support

Participants expressed unhappiness about the benefits in terms of medical aid, as paid by the organisation. They were dissatisfied, because they regarded the medical cover as expensive and not comprehensive, resulting in paying additional fees towards doctors and for medication. Participants then tried not to use the medical aid, because they were uncertain of what additional costs there might be.

> *"The reason for not using it is not that you don't have to use it or there's no reason for you to use it, but we're scared of that medical account that you see on your payslip, having to think that you pay R8 000 every month, but once you go to the doctor, at the end of the month you get the medical account. So sometimes we get sick and then we go to our clinics, we nurse ourselves. And sometimes you don't feel like you want to use something that you learnt from your grandmother, but sometimes we do that because we're scared to use the medical aid" (Participant 2, transcript 1).*

Additionally, the medical aid plan only accommodated immediate family members, and not the extended family that many participants supported financially, which placed additional financial strain on them.

> *"And besides, The organisation's medical aid is a closed system. So, if you've got other people besides your immediate family, people who are financially dependent on, you can't put them on" (Participant 3, transcript 1).*

> *"I don't know, just… Because for me, I can speak for myself, I don't use my medical aid at all. Literally unless It's an emergency, which I've had one in like my entire... And it's a lot of money to contribute towards that medical aid. It truly is" (Participant 1, transcript 1).*

4.4.2.2 Cash flow relief options as support

The organisation provided cash flow assistance to employees in the form of study bursaries, paying school fees as well as a deposit for first time home buyers, because employees were complaining of receiving poor salaries and the organisation tried to assist them around these short-term financial burdens.

Regarding the school fees or study bursaries provided, participants explained that these were taxed, and they did not receive the full amount they expected. They found this financially challenging, and proposed paying the tuition fees, after which they could be refunded, as a better option.

> *"It should have been better if they give me that 10 000 and I go and pay in the institution, I bring the receipt to them. Like we are doing with my studies. With my studies they would give me cheque, I pay into the institution, I bring back the slip to them. Very clear. If I get R10 000, everybody got R10 000. Now somebody will get R10 000, someone R9 000 according to the structured tax. Somebody will get R1000, but originally this was meant to be R10 000. Then do away with this tax. Like I'm applying for a study leave, they give me R20 000 cheque, I go and pay into institution, I bring back the receipt. It will be equal and fair to all" (Participant 5, transcript 2.)*

> *"If you have a child at school, you take the R1 000 to school. So now they tell you they're going to pay R10 000 for you or R5 000 for you, you don't expect that to be taxed. You expect it to be taken to school as it is. That's the perception we had" (Participant 2, transcript 2.)*

Participants were aware of benefits; however, they were not aware of how taxes impacted all the benefits offered to them. They expressed that this should be explained to them, because they expected certain amounts, and then experienced financial challenges when the amount they received did not match the amount they were told they would receive.

Literature confirms that employees may feel demoralised about their salaries if the remuneration they receive is not sufficient to cover the cost of living (Larrabee *et al*., 2003:272; Emanuel & Pryce Miller, 2013:17). A poor remuneration also contributes to job

dissatisfaction (Larrabee *et al*., 2003:272). The government needs to address the remuneration of professional nurses and communication between human resources and the employees should also be improved by regular induction meetings, feedback concerning remuneration and reasons for increment delays (Larrabee *et al*., 2003:272). Professional nurses should be counselled and advised on financial aid and budgeting to empower them to take control of their finances. Petersen (2006) and Emanuel & Pryce Miller (2013:17) underscore the importance of a sufficient salary, physical security, opportunities for ongoing development and support from management. According to literature, employees value working surroundings that do not pose discomfort or physical harm. Emanuel & Pryce Miller (2013:17) emphasise organisational issues that need to be attended to: flexibility, responsibility, standards, rewards, clarity and team commitment.

4.5 Promoting nurses' well-being

The second objective of the study has been to explore and describe OHC nurses' perceptions of how these support systems effectively enhance resilience, hardiness and well-being of OHC nurses. The majority of the participants in this study did not make use of support systems available to them; instead, they emphasised that they relied on one another, as well as their families for psychological and financial support. As mentioned, the participants did not perceive the wellness services as meaningful to them, because they considered themselves to be wellness professionals, preferring to rely on one another for encouragement, emotional support, and checking of basic health markers such as blood pressure and blood sugar.

When asked as to what should be in place to promote resilience, hardiness and well-being, two main themes emerged: 1) improving constructive internal communication and 2) acknowledging nurses' professional contributions (see Figure 2 below). These themes are discussed in more detail below.

Resilience is described as the ability to encounter and overcome significant hardship while still being effective in your daily life (Rice & Lui, 2016:326-328). Earvolina-Ramirez (2007:241), Hart *et al*. (2012:727) and Stephens (2013:128) mention that resilience can be fostered by means of personal characteristics such as adaptability or flexibility, courageousness, being hardworking, having a sense of humour, loyalty, being

motivated, patience, perseverance, being able to handle challenges and being purpose driven.

Figure 2: Visual summary of themes

4.5.1 Improving constructive internal communication

Nurses expressed a need to be included in internal communication within their organisation so that, when decisions were made, they could contribute towards the actions taken to ensure applicability to OHC. They mentioned that, when internal surveys were done within the organisation, the focus was on overall statistics, and their immediate needs were not represented. Participants felt that there was poor teamwork and communication at the workplace among staff members and also between staff members and management. At some clinics, there were no regular staff meetings and staff members treated one another as strangers, and for these reasons, the workplace seemed unpleasant. In addition, participants stated that the poor teamwork among staff members caused an overload of work, which led to burnout and stress.

4.5.1.1 Inclusive decision-making

OHC nurses voiced the need to be involved in strategic planning meetings with management, and improve communication across various departments, for example the administrative department. They emphasised that being involved in strategic planning and improving communication would allow them to plan their schedules more effectively.

> *"…Maybe if there was more engagement, particularly when it comes to the employees. What happened is that we felt as if maybe it is something that was decided upon and the employees were not given the chance to voice their views in as far as the way in which maybe it can be beneficial to them…" (Participant 4, transcript 2).*

> *"…At least the beginning of the year. When everybody comes back from leave, you must have a plan for the year. So, the team has to come together at least for one day and have our teambuilding. I think for me that's also crucial. Where we sit and have like a SWOT analysis and we plan this and that, and just that encouragement for us. It brings us together and we say this year we're going to work together irrespective, we're going to tackle everything together, nothing is going to come, you know, things like that. Informal sessions to say this year we will [accomplish various things] you know, so I don't know, but I think I will suggest even that. The beginning of the year to have things like that" (Participant 2, transcript 3).*

> *"If managers can just involve us in their decision-making. I think we can really be the best. Not to say when we are decision makers, not to say when we sit with them our word will be final. Because they can just let us sit with them, listen to our views, and then pick up what they think will be best, not for us, for the department actually" (Participant 3, transcript 2).*

Raso (2014:5) has demonstrated in this vein that nurses sometimes feel left out in their workplace and that recognising their efforts can lead to a feeling of being valued, which can ultimately lead to an increased commitment and dedication to the work they do. Leadership and teamwork were perceived by participants as important aspects of resilience. This is confirmed in literature that states that, in the workplaces or institutions where there are strong supervisory or leadership support, staff tend to be more positive

and people with leadership skills tend to embrace and encourage teamwork (Koen *et al*., 2016:6-7, Lowe, 2013:53, Rice *et al*., 2016:326-327). Resilience can be developed if the following is applied: support, supervision, reflective practise and professional development (Edward & Hercellinskyj, 2007:242). Lowe (2013:52-59) highlights the importance of leadership to create a healthy working environment. The participants mentioned that they needed leadership and team support to be resilient in their work area. In general, consider that communication skills are often disregarded and undervalued as effective tools associated with job satisfaction and contentment (Stapleton, *et al.*, 2008:9; Koen & Koen, 2016:6). Kalisch and Begeny (2005:550) as well as Lowe (2013:52-59) have in fact established that poor teamwork and one-way communication in the workplace negatively affect health care delivery, which can lead to negative consequences.

4.5.1.2 OHC nurses' need for recognition

Nurses wanted their voices to be heard within their organisations even when it came to apparently smaller decisions such as the colour of uniforms. Indeed, improved communication and being involved in decisions and strategic planning appeared to make nurses feel as though they were valued members of the organisation, rather than separate service givers just appointed to do a job.

Additionally, nurses seemed to want to be recognised as part of the organisation by means of small gestures, such as being invited to braais and being included in outings to get to know their colleagues and feel a sense of belonging.

> *"Outings, even if we go just on a night out, they will invite. And that makes you want to work there, it makes you feel you are also wanted there and that is quite good" (Participant 1, transcript 2).*
>
> *"But you know, teambuilding, even these braais we have on the patio that is also part of it. We don't really go like externally and have a teambuilding. He tries to get us together a few times a year" (Participant 2, transcript 3).*
>
> *"Just to say thank you. Sometimes you just need to hear that, to see your senior manager coming here and saying, hey guys, well done, this month we've done this and this and this" (Participant 3, transcript 1).*

"So, what I'm thinking is maybe people who are there, really, they are overlooking the health department, the nurses. That is why at this organization it seems as if we are just, you know, yes. Maybe they think that anybody can be taken to come and render health care services" (Participant 3, transcript 2).

"We as the clinic nurses, we do ask our boss, can we go to a restaurant on a Friday, just to sit and talk nonsense and have something nice to eat and then go home? You understand? Or we go to the park, we make a braai in the park, and it's part of that keeps us going. We make it for ourselves" (Participant 1, transcript 2).

"Celebrating nurse's days every year. Yes, women's day, Mother's Day. I mean we are mothers, but nobody sees that" (Participant 2, transcript 1).

Stapleton *et al.* (2008:6) aver that, as human beings, we believe and are motivated either towards pleasurable outcomes, for example receiving an appraisal or complement after helping patients or receiving additional money and gifts for a job well done. In addition, people are also motivated by the aversion of painful or unpleasant outcomes (Stapleton *et al.*, 2008:6) such as managers reprimanding professional nurses to perform better, otherwise they would face negative consequences such as receiving warnings (Stapleton *et al.*, 2008:6). Stapleton *et al.* (2008:6) suggest further that, while it is preferable to motivate staff towards something pleasurable, the reality is that employees are motivated in the opposite way, since they feel demotivated.

4.5.2 Acknowledging nurses' professional contributions

Most of the participants' view resilience, hardiness, and well-being as their responsibility, and referred to indicators of resilience as coming to work every day despite challenges. They also mentioned that resilience was something a person was born with. However, when asked about that which could promote their resilience, they indicated that being appreciated and recognised for their services would facilitate a sense of accomplishment and recognition.

4.5.2.1 Display of appreciation as support

Nurses bring a different set of skills and expertise to their organisations. They are primarily appointed to provide medical surveillance screenings, primary health care services, treatment for injury on duty and medical emergencies. The primary role of

the organisations examined here was the production of oil and gas linked to coal mines, and nurses emphasised their need for acknowledgment and recognition for their services by being thanked, including small gestures of appreciation.

"Just to add something in terms of support. We recently got bags for women. There was an email that came out to recognise women, as Women's month. I felt special as a woman. I mean, we know the history of women in this country. I felt recognised and special and this morning we got bags. We got very nice bags. As a thought to say as a woman we recognise you" (Participant 4, transcript 3).

"Just to say thank you. Sometimes you just need to hear that, to see your senior manager coming here and saying, hey guys, well done, this month we've done this and this and this. Just like it's happening at the mines" (Participant 2, transcript 1).

It has been established in fact on a broader scale that nurses want to be appreciated by management and doctors. They want their expertise to be recognised and to participate in decision-making processes (Upenieks, 2003:573).

4.5.2.2 Managerial support

Nurses also emphasised the need for managers with good leaderships skills who showed empathy and managers who managed disciplinary problems with colleagues effectively. When a colleague was continuously absent from work, the workload increased, and participants emphasised that the management team should implement disciplinary policies so that they can function well at work.

"*Well, I can think of if there's an issue with someone, they can be a little bit stricter in handling that issues at hand. Because of one person, for example, that is the rotten apple and is not being dealt with, the whole team is influenced negatively and that's when we get to a point where you just get to work... Yes, you don't care. Do your work, go home. Come late, who cares? Nothing happens to the rotten apples, so why should we do what's right to the company. I believe, I think that the big issues that people complain need to be listened to and attended to, that the whole team is complaining about… It's a team. You are always sick on Mondays and the whole team complains, but you're sick. It's as if the complaints of the group are not being*

listened to, it's not being attended to. And the guilty party is just having a breeze, doing what he or she is doing everyday" (Participant 3, transcript 4).

"*I think our managers, we should be able to go to them without fear. You should be able to go your manager and say, 'I'm going by means of this and this and this'. And not feel that whatever you are saying will be said somewhere else, you know what I mean? I think, you know as much as we are professionals, we also have leaders that we must feel free to go to, say whatever. It must be really a safe haven" (Participant 4, transcript 3).*

4.5.2.3 OHC nurses responsible for own well-being

The nurses verbalized that working in an environment where they were caring for people in need can in and of itself benefit them given the reward and satisfaction they feel when providing quality care. It was also important for them to focus on their own needs or well-being. They should treasure their own journey of happiness and resilience in the nursing profession, not passively react to negative circumstances, but actively engaging with people who are positive and supportive, thereby achieving psychological growth, well-being and building resilience.

"*As I said earlier, the reality with us nurses, you counsel yourself. Even if you've got colleagues, at times you just feel that, you know what, I'm me, and I'll deal with this thing until you reach that problem person or something" (Participant 2, transcript 2).*

In summary, nurses mentioned that the elements that could help promote their resilience and well-being were small, ordinary phenomena that would help them feel a sense of belonging at work, feeling safe with managers that showed empathy, and feeling valued by small gestures of appreciation and being thanked for the work they performed. They also needed constructive communication among themselves and with their managers as well as administrative staff who made bookings for employees at nurses' clinics. Their need for this was to feel valued, heard and appreciated.

Harrington (2012:27) has emphasised the need for being part of a unit "that is safe, supportive, loving and provides all the resources needed for all members to live in a healthy and secure environment".

The nurses further mentioned that operational factors led to stress at work. Research has identified that these factors in the environment can lead to burnout and workers have to find ways to deal with it (Lowe, 2013:52-59). Lowe (2013:52-59) emphasises the importance of leadership to create a healthy working environment. Boswell (2004:59) confirms that, in general, a lack of trust exists between nurses and management, because of nurses' perception that their well-being does not receive enough attention. Rice and Lui (2016:326-327) confirm that peer support as well as that from team members and management support lead to employee resilience. Furthermore, Stapleton *et al.* (2008:4) have found that "coaching" of staff should be utilised as a leadership tool to promote collaboration, innovation, development and employee motivation. This would allow staff members to plan and achieve short- and long-term goals within the workplace (Stapleton *et al.*, 2008:4). In addition, studies have shown that managers who show warmth and affection towards staff members are perceived as mentors who guide staff to develop their strengths and capabilities, improve and rectify faults and achieve a high level of positive performance (Stapleton *et al.*, 2008:4).

These actions, if applied as part of a support system by means of which resilience characteristics were to be developed, would create a more productive, pleasant and harmonious workplace.

4.6 SUMMARY

This chapter has truthfully described actual data collection and data analysis. A total of 26 participants participated in the FGDs, and five interviews were conducted. Data analysis revealed the following two main themes. Theme 1: OHC nurses' perceptions of current support systems. Theme 2: Promoting nurses' well-being, of which the sub-themes are as follows: Effective support systems promote personal and professional growth and well-being; salary package benefits are perceived as a support system; improving constructive internal communication; acknowledging nurses' professional contributions. These have been discussed within this chapter. Research findings and results gathered from the data collection and analysis were discussed separately and integrated with materials found in literature so as to ensure that the research study was authentic. Chapter 5 will centre on concluding reports, limitations and recommendations of the present research project.

Chapter 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The research findings, centred on perceptions of OHC nurses about support systems that would enhance their resilience, hardiness and well-being have been discussed in Chapter 4. In this chapter, conclusions based on the findings are discussed. Limitations of this study are addressed, and the researcher presents recommendations based on conclusions drawn from the research findings and supporting literature.

5.2 CONCLUSIONS

Initially, the researcher argued that occupational health nurses might require support over time, as they experienced numerous stressful situations in their different working environments. The motivation behind the research was thus to explore and describe the OHC nurses' perceptions about the OHC support systems utilised within a private organisation in promoting their resilience, hardiness and well-being. An interpretive and descriptive qualitative design was followed. This design was chosen, as it gave the researcher the opportunity to explore, describe and, importantly, understand OHC support systems from the OHC practitioner's perspective.

The target population was the staff of the two medical centres, who consisted of OHPs from a private organisation in a petrochemical industry, as indicated. The researcher involved all nursing staff from the two medical centres so as to counter the fact of a relatively small population. This included a total of 26 nurses. The researcher gained permission from the management of the private organisation, including the two medical centres identified, to conduct the research. This permission was gained by means of the organisation's formal internal research permission procedures. The recruitment of the participants was done fairly, and the participants decided out of their own free will that they wanted to be part of the research. The recruitment of participants was mediated by a mediator, who was identified and appointed by the researcher. There were five FGDs conducted; three in Mpumalanga and two in the Free State province. The interviews were done in the medical centre's respective boardrooms, and the participants focused on their perceptions as nurses about support systems to enhance their own resilience, hardiness

and well-being. The FGDs were audio-recorded and transcribed. All the transcribed interviews were reviewed by the researcher to form a general impression of the responses.

Themes were identified and grouped into columns. Each theme was given a heading and divided into categories, where similar categories were grouped together. An independent co-coder was appointed to co-analyse the data. The ATLAS.ti computer program was used to assist with data analysis. After discussion with the co-coder, the results were divided into appropriate main and sub-categories.

Trustworthiness was ensured by means of prolonged engagement, that is, adequate time was spent with the participants. This allowed time for the establishment of trust between the research team and participants, so that they could feel comfortable and safe enough to share opinions, even on sensitive issues. Engagement with participants continued during the FGDs, which concluded the data collection.

Main and sub-themes were identified as follows:

1) OHC nurses' perception of current support systems.

   The participants had different perceptions of their support systems. Some of the participants perceived the support systems made available to them by the organisation as effective, and others perceived it to be ineffective in promoting the resilience, hardiness and well-being of OHC nurses. The participants were delighted that they enjoyed good support amongst one other. They could encourage and be there for each other.

- Effective support systems promote personal and professional growth and well-being.

  The participants identified support systems that were made available to them by means of an external service provider named ICAS that had been contracted by the organisation for which they worked. The types of support services offered to them by means of ICAS included psychological and psychiatric services, financial well-being, support for wellness campaigns and information on various topics related to health and finances. Substantial emotional support and social supportive networks are imperative for people to be resilient: it is advocated here

that nurses should make use of the available support systems when the need arises.

Participants also verbalised that the best places to work for were those where nurses were provided with training and opportunities to develop. Improving professional practise and enhancing nurses' clinical competence by means of ongoing education might therefore increase retention and job satisfaction and help ensure a stable workforce.

- Salary package benefits are perceived as support system.

  Most of the participants spoke about salary package benefits, such as medical aid, bursaries for school fees, travel allowances and discounted gym fees at a specific gym owned by the organisation. All the nurses highlighted that a sufficient salary would be the best benefit when compared to all other benefits that the organisation offered. Participants viewed salary as the primary source of job dissatisfaction amongst nurses, and they did not perceive messages of encouragement and congratulatory notes recognising good performance to make any difference to their motivation.

2) Promoting nurse's well-being.

   Most of the participants in this study did not make use of formal support systems available to them. Instead, they emphasised that they relied on one another as well as their families for support. Nurses' well-being were therefore achieved by means of collegial and family support.

   - Improving constructive internal communication.

     Nurses expressed a need to be included in internal communication within their organisation so that, when decisions were made, they could contribute towards the actions taken to ensure applicability to OHC nurses. Participants in general felt left out when it came to decision-making. Participants felt that poor teamwork and communication existed at the workplace among staff members and management. In order to promote the resilience, hardiness and well-being of OHC nurses, improving poor teamwork and poor communication between staff members and management as well as involvement of staff members in decision-making clearly are essential.

- Acknowledging nurses' professional contributions.
  Nurses emphasised their need for acknowledgment and recognition for their services by being thanked, and with small gestures of appreciation. Nurses also emphasised the need for managers with good leadership skills, who had empathy, and were able to manage disciplinary problems with colleagues effectively. Acknowledgement could help promote their resilience and well-being, while small ordinary actions would help them feel a sense of belonging at work, such as small gestures of appreciation and being thanked for the work they do.

The researcher concluded from that participants, that is, these nurses, expressed different views on the effectiveness of current support systems in promoting the resilience, hardiness and well-being around OHC. Some participants were satisfied with current support systems. They also felt that the organisation took good care of their employees. The nurses felt they are making a positive contribution and received satisfaction from the fact that their primary role was to ensure that employees were healthy and injury free.

In contrast, some participants experienced frustration or perceived current support systems to be less positive, thus ineffective in promoting the resilience, hardiness and well-being of OHC nurses. Participants perceived the expensive medical aid contribution from the employees' side, as well as the lack of support from management, as negative elements of the organisations' support systems.

Nurses expressed a need to be included in internal communication and decision-making. Additionally, they voiced the need to be involved in strategic planning and meetings with management and improve communication across various departments.

Extant literature examined and integrated here dovetailed with this finding: it can be concluded that a meaningful framework to identify OHC nurses' needs is Maslow's Hierarchy of Needs. It is also important to understand the balance of power between employees and employers. Job satisfaction could include material compensation involving immaterial and economic human factors. From a work perspective, the theory of Maslow (2013:1) brings together wages, perks, company culture and how management is performed, into one unified whole, as indicated. Maslow's Hierarchy of Needs

advocates employee happiness. The basis of the theory is that there is a series of needs that escalate from basic physiological needs at the bottom level of the pyramid to the highest level, the need for self-actualization (Maslow, 2013:1). Each level of needs must be satisfied from the bottom upwards in order for a person to rise to the next tier (Maslow, 2013:1).

It can be concluded that nurses working for this organisation perceived support systems as positive or negative. Both perceptions can be used to make this organisation a working environment in which nurses can thrive. By means of support, recognition and motivation from management, nurses could enhance their resilience, hardiness and well-being.

5.3 LIMITATION OF THE RESEARCH

There were some limitations of this study that need to be noted. Only one private organisation was included, due to the fact that other organisations feasible for this study only employed one OHC nurse. This organisation had two larger medical centres, as indicated, each employing more than eight OHC nurses. As a result, a relatively small sample (N=26) of participants contributed. This was a limitation, but to ensure feasibility of the study, only one specific organisation was included. All of the purposefully selected participants experienced OHC support systems as implemented by the same organisation and were therefore able to partake in a group discussion on their perceptions of similar support systems.

5.4 RECOMMENDATIONS

The research was undertaken to explore and describe OHC nurses' perceptions about current support systems utilised within the private organisation towards enhancing their resilience, hardiness and well-being. Recommendations for nursing practice, nursing education and futher research were drawn from the findings of this study and conclusions made by the researcher.

Recommendations for nursing practice

The following are recommendations for support systems to improve the well-being, resilience and hardiness of OHC nurses: positive work environments should be created where nurses feel appreciated and be productive.

That promotional support for employees who had furthered/ completed their studies did not occur was experienced as demotivating, and it made nurses feel “stuck”. They felt demotivated due to lack of opportunities for upward mobility within the organisation for which they work. Therefore, promotions should be considered after, say, three to five years, to a senior or specialist position. Consider that there were no promotions at the time of the present research project.

A sufficient salary should be granted to the nurses. Participants viewed poor salaries as the primary source of job dissatisfaction amongst nurses. It is therefore strongly recommended that significant annual increments should be allotted to nurses to motivate them to do better along with a solid salary increase, which would demonstrate cognition and appraisal.

Demonstrate positive management relationships with employees that make them feel trusted and capable. Include nurses in internal communication within the organisation when decisions are made, since they could well contribute towards actions taken to ensure relevance for OHC nurses. Improve teamwork and communication at the workplace among staff members and management.

Appreciation and recognition for services would facilitate a sense of accomplishment, such as small gestures of appreciation, that is, in everyday parlance, just to say thank you. Appointment of managers with good leadership skills and who show empathy is critical.

Active engagement with people that are positive and supportive in order to achieve psychological growth, well-being and building their resilience, is further advocated on the basis of the research findings.

If implemented as part of the support system by means of which resilience characteristics are developed, the working environment would become more productive, pleasant and harmonious.

Recommendations for nursing education

Provide constant in service / on the spot training and education for nurses in order to feel confident in the workplace and develop personally and professionally. Good educational

training should also be implemented by management aiming at strengthening skills mentors, for example courses on how to effectively manage stress, in addition to training nurses in effective communication. Building these skills can help them develop resilience, and they will be able to manage workplace adversities.

In the field of nursing education, resilience development for students should also be incorporated in the curriculum, so as to prepare them properly for the matters raised before they enter the work force.

Participants suggested in-service training weekly or 2 weekly, on topics as a strategy to promote their resilience, hardiness and well-being. It may be valuable to include recommendations for promoting the emotional well-being, resilience and hardiness in formal and informal training.

Recommendations for nursing research

Further research on this topic could include an evaluation of different instruments used to measure the adequacy of OHC systems for supporting and enhancing the resilience, hardiness and well-being of the nursing staff.

Future research should be conducted about trust levels among different health care workers in private health facilities as well as between management and nursing staff.

Factors identified in this study, such as strengths, benefits and how to strengthen resilience should be incorporated in future research.

The effectiveness of the proposed recommendations on enhancing resilience, hardiness and well-being should be evaluated.

5.5 SUMMARY

In conclusion, it can be stated that the purpose of exploring and describing the perceptions of OHC nurses about the support systems that enhance their resilience, hardiness and well-being has been met. Limitations of the study were presented and recommendations made for nursing practice, nursing education and nursing research. These recommendations have the potential to adequately equip nurses and

management for the challenges they face around the factors examined here, by improving resilience building skills such as determination, communication, building work relationships, problem solving and organisational skills. Further changes as recommended above will improve and strengthen existing support systems with a view to enhancing resilience, hardiness and well-being of nursing professionals.

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APPENDIX A: ETHICS CLEARANCE FROM NWU ETHICS COMMITTEE

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21 May 2019

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North West University Health Research Ethics Committee (NWU-HREC) on 21/05/2019, the NWU Health Research Ethics Committee hereby approves your study as indicated below. This implies that the North-West University Research Ethics Regulatory Committee (NWU-RERC) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Exploring occupational health care nurses' perceptions of systems to enhance their own resilience, hardiness and well-being.
Study Leader/Supervisor (Principal Investigator)/Researcher: Dr S Scholtz
Student: Y Fox

Ethics number:

N	W	U	-	0	0	1	2	9	-	1	8	-	A	1
Institution				Study Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single Study
Commencement date: 21/05/2019 **Risk:** **Minimal**
Expiry date: 31/05/2020
Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of an annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.

Special in process conditions of the research for approval (if applicable):

- Please provide the HREC with a goodwill permission letter from Sasolburg and Secunda sites to be included.
- Please provide the HREC with a copy of the finalised interview schedule for approval, before implementation in the study.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

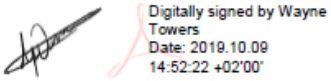
- *The study leader/supervisor (principle investigator)/researcher must report in the prescribed format to the NWU-HREC:*
  - *annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for an external audit.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility the NWU-RERC and NWU-HREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*

- *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 study are revealed or suspected;*
  - *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
  - *submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and / or*
  - *new institutional rules, national legislation or international conventions deem it necessary.*

- *NWU-HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.*

The NWU-HREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the NWU-HREC or the NWU-RERC for any further enquiries or requests for assistance.

Yours sincerely



Prof Wayne Towers
Chairperson NWU Health Research Ethics Committee

Original details: (22351930) C:\Users\22351930\Desktop\ETHICS APPROVAL LETTER OF STUDY.docm
8 November 2018

Current details: (22351930) M:\DSS1\8533\Monitoring and Reporting Cluster\Ethics\Certificates\Templates\Research Ethics Approval Letters\9.1.5.4.1 HREC Ethical Approval Letter.docm
3 December 2018

File reference: 9.1.5.4.2

APPENDIX B: PERMISSION LETTERS FROM MANAGEMENT

29 April 2019

Dr Suegnet Scholtz
Deputy Director
School of Nursing
North-West University, Vaal Campus

Permission for Yvonne Fox (24710547) to conduct research studies at Sasol's medical centres in order to explore occupational health care nurses' perceptions of systems to enhance their own resilience, hardiness and well-being.

Sr Yvonne Fox is granted permission to do research interviews at both Sasol Medical Centres situated in Sasolburg (Free State) and Secunda (Mpumalanga), as part of her studies for the degree Magister of Nursing Science in NuMIQ, Faculty of Health Sciences of the North-West University.

The aim of the research is to gain a better understanding of the current content of Employee Assistance-, Wellness- and OHC support- programmes from an Occupational Health Care (OHC) practitioners' perception working in Sasol's medical centres.

From the findings new, revised and/or alternative interventions and/or programmes in supporting current OHC support programmes and strategies can be introduced to promote the resilience, hardiness and general wellbeing of OHC nursing staff.

All information obtained through research must remain confidential at all times.

Regards,

Rightwell Laxa
SVP Sasolburg Operations

Sasol South Africa Limited 1968/013914/06
Sasol Place 50 Katherine Street Sandton 2146 South Africa Private Bag X10014 Sandton 2146 South Africa
Telephone +27 (0)10 344 5000 Facsimile +27 (0)11 788 5092 www.sasol.com

Directors: VD Kahla (Chairman) B Baijnath T Booley RM Laxa NP Magagqa Z Monnakgotla CK Mokoena M Solomon ET Stouder (American) LB Zondo

Company Secretary: M du Toit

Sasol Sasolburg Operations
1 Klasie Havenga Road Sasolburg 1947
+27 (0) 16 960 9111 www.sasol.com

08 January 2019

Dr Suegnèt Scholtz
Deputy Director
School of Nursing
North-West University, Vaal Campus

Goodwill permission for Yvonne Fox (24710547) to conduct research studies at Sasol's medical centres

Sr Yvonne Fox is granted permission to do research interviews at both Sasol Medical Centres situated in Sasolburg (Free State) and Secunda (Mpumalanga), as part of her studies for the degree Magister of Nursing Science in NuMIQ, Faculty of Health Sciences of the North-West University.

The aim of the research is to gain a better understanding of the current content of Employee Assistance-, Wellness- and OHC support- programmes from an Occupational Health Care (OHC) practitioners' perception working in Sasol's medical centres.

From the findings new, revised and/or alternative interventions and/or programmes in supporting current OHC support programmes and strategies can be introduced to promote the resilience, hardiness and general wellbeing of OHC nursing staff.

Peens

Corlia Peens
Senior Manager Occupational Health
Tel +27 16 920 4732
Mobile +27 82 210 8220

cc: Percy Seotlela
Manager Occupational Medicine
Sasolburg Operations

Lekgotla Gaseemeloe
Manager Occupational Medicine
Sasol Chemical Operations

31 May 2019

Deputy Director
School of Nursing
North-West University, Vaal Campus

Provisional permission for Yvonne Fox (247105470 to conduct research studies at Sasol Secunda medical centre.

Sr. Yvonne Fox is granted provisional permission to do research interviews at the Secunda Medical centre as part of her studies towards her Magister of Nursing Science in NuMIC, Faculty of Health Sciences of the North-West University.

I understand the aim of the research is to gain better understanding of the current content of Employee Assistance, Wellness and OHC support programmes from an Occupation Health Care practitioners' point of view working in the occupational health setting.

From the findings new programmes and strategies might be introduced to promote the general wellbeing of the OHC nursing staff.

Estelle van Niekerk
Manager: Medical Surveillance
017-61048209
0832787143
estelle.vanniekerk@sasol.com

SASOL HEALTH SECUNDA
E Van Niekerk - 100603
31-05-2019
SECUNDA CHEMICAL OPERATIONS

Secunda Chemicals Operations
PduP Kruger Street, Private Bag X1000, Secunda, 2302
Tel.: +27 17 610 1111 www.sasol.com

APPENDIX C: INFORMED CONSENT FOR PARTICIPANTS

NORTH-WEST UNIVERSITY
NOORDWES-UNIVERSITEIT
YUNIBESITI YA BOKONE-BOPHIRIMA

Private Bag X1290, Potchefstroom
South Africa 2520
Tel: +2718 299-1111/2222
Fax: +2718 299-4910
Web: http://www.nwu.ac.za

HREC Stamp

INFORMED CONSENT DOCUMENTATION FOR NURSING STAFF: FOCUS GROUP

TITLE OF THE RESEARCH STUDY: Exploring the perceptions of OHC nurses about support systems to enhance their own resilience, hardiness and well-being.

ETHICS REFERENCE NUMBERS: NWU (number outstanding)

PRINCIPAL INVESTIGATOR: Dr Suegnet Scholtz

POST GRADUATE STUDENT: Yvonne Fox

ADDRESS: PRIVATE BAG X6001, Potchefstroom, South Africa 2520

CONTACT NUMBER: TEL: 018 299 1876
FAX: 018 299 1827

You are being invited to take part in a **research study** that forms part of a Masters study in nursing, entitled: Exploring support systems to enhance resilience, hardiness and well-being of occupational health care nurses. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you

do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU.....)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- *We plan to get a better understanding of what support systems are being used by the private organisation where you are currently employed to enhance d resilience, hardiness and general wellbeing of the OHC nursing staff. Saturation of data will occur when additional data collection provides no new information.*
- *This study will be conducted at the medical centres in Sasolburg and Secunda, in the boardroom. The research will involve a focus group discussion and will be done by experienced health researchers trained in doing focus group discussions. We plan to include 26 participants in this study from the two different medical centres.*

Why have you been invited to participate?

- *You have been invited to be part of this research because you are a nurse registered with SANC, working at a private organisation in the capacity of an occupational health practitioner for at least six months, willing to participate freely, are either male or female and able to communicate in English. These aspects therefore qualify you to take part in this research.*
- *You will unfortunately not be able to take part in this research if you are not a nurse working for less than six months in an occupational health practitioner role or a non-nurse (e.g. medical practitioners, administrators, pharmacists and radiographers).*

What will be expected of you?

- *You will be expected to participate in a focus group discussion during which you will be asked two main questions relating to your experience of OHC support systems. Participants will also be expected to complete a biographical questionnaire and to be voice recorded. These questions will specifically focus around your experience in how OHC support systems enhance the resilience, hardiness and wellbeing of nursing staff working at your organisation. You will also be expected to communicate in English. The focus group discussion will take place at the boardroom of the medical centre, which will be a private, comfortable, conducive and well-ventilated venue. The focus group discussion will take place during office hours and will be approximately two hours long.*

Will you gain anything from taking part in this research?

- *There is no direct gains for you if you take part in this study. There will however be light refreshments before and during the group discussions.*
- *The organisation where the researcher is working will benefit by gaining new knowledge.*

The other gains of the study is that the research findings will contribute to the OHS body of knowledge and more specifically will assist the OHP involved in

- *OHCS for a healthier and more conducive work environment in these type of organisations.*

Are there risks involved in you taking part in this research and what will be done to prevent them?

- *The risks to you in this study are possible discomfort, fatigue and boredom but will be limited by providing body breaks during the focus group discussion if the need arises. Refreshments will also be served during this time to make you feel comfortable.*
- *You may feel uncomfortable to withdraw or to decline during the actual focus group discussion. In such a case you are more than welcome to withdraw your participation (information shared) after the focus group discussion, without any penalties.*
- *Possible loss of privacy and confidentiality. Due to the nature of focus group discussion, the researcher cannot completely protect the confidentiality of the participants. The researcher can only guarantee partial confidentiality. Ground rules will be established before the focus group discussion to reemphasise the importance of confidentiality and how the participants must also realise that the information shared during the focus group discussion should be viewed confidential.*
- *Possible emotional risk could result from revealing their true experiences, in such cases provision of councelling services by a qualified professional will be made available. An internal councellor from the private organization will be on standby may the need arise*
- *There are more gains for you in joining this study than there are risks.*

How will we protect your confidentiality and who will see your findings?

- *Anonymity of your findings will be protected by not disclosing any of the information. Your privacy will be respected by also not disclosing any information. Your results will be kept confidential by keeping it at a safe place. Only the researchers, focus group moderator, mediator, primary investigator, transcriber and the co-coder will be able to look at your findings. Both the focus group moderator, transcriber and the co-coder will sign a confidentiality agreement. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. (As soon as data has been transcribed it will be deleted from the recorders.) After the study has been completed all data will be stored in the Directors office for seven years at the NuMIQ research focus area, School of Nursing Science,*

NWU. Audio recordings will be removed from the recording devices directly after interviews and will be placed on a password protected computer. On completion of the study all the data (both hard- and electronic copies) will be securely stored for seven year in the NuMIQ office as per HREC requirements and NWU policies. All records will be destroyed after seven years as by NWU procedures

What will happen with the findings or samples?

- *The findings of this study will only be used for this study and results will be reported to the management of the organisation. A pamphlet will be distributed to participants in this study containing the results. An article will be published to inform the larger research community.*

How will you know about the results of this research?

- The researcher will give you the results of this research inside the content of a pamphlet after the study has been completed.

Will you be paid to take part in this study and are there any costs for you?

- This is a non-funded study and is part of my master's degree.
- No, you will not be paid to take part in the study.
- Refreshments will be served before and during the focus group discussion.

Is there anything else that you should know or do?

- You can contact me Yvonne Fox at 082 591 7408 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes/recordkeeping.
- You will be asked to complete a biographical questionnaire and hand it back to the mediator with this signed consent form.

Declaration by participant

By signing below, I …… agree to take part in the research study titled: Exploring support systems to enhance resilience, hardiness and well-being of occupational health care nurses.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- It was explained that the focus group discussions will be voice recorded.

- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.
- Informed that I'm going to be voice recorded.

Signed at (*place*) .....…….…… on (*date*) ……...…….. 20....

.....
Signature of participant

Declaration by person obtaining consent

I *(name)* …… declare that:

- I clearly and in detail explained the information in this document to participants.
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) .....…….……...on (*date*) ……...…… 20....

.....
Signature of person obtaining consent

Declaration by researcher

I *(name)* ……..…… declare that:

- I explained the information in this document to the mediator (name)……. who I trained for this purpose of the study
- I did not use an interpreter
- I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.

- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) .....….....……..on (*date*) ……...…… 20....

.....
Signature of researcher

APPENDIX D: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Private Bag X6001, Bus 520, Potchefstroom,
South Africa, 2520

INSINQ Focus Area - Quality in Nursing and Midwifery

Tel: (018) 299 1836
Fax: (018) 299 1827
Email: Karin.Minnie@nwu.ac.za
Website: http://www.nwu.ac.za

Mr FG Watson

Lecturer

Tel: 018 299 1874

Fax: 018 299 1827

Email: francois.watson@nwu.ac.za

Vise President SHE

1 Klasie Havenga Road

Block F, 9 Floor.

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am currently registered for a Master's degree in Nursing Science Management, at the North West University, Potchefstroom campus.

I hereby request permission to conduct the research: **Occupational health care support systems for enhancing resilience and general wellbeing of nursing staff.**

The purpose and objectives of the research are:

- To explore and describe Occupational health care nurses' perceptions of the current formal and informal OHC support systems utilised by a private organisation to enhance the resilience and general wellbeing of the nurses.

The exploration and description of the current formal and informal OHC support systems utilised by the private organisation to enhance the resilience and wellbeing of nurses will contribute to the formulation of recommendations to guide the development of nurses' resilience and general wellbeing.

The research will be conducted under the supervision of experts from the School of Nursing Science, North West University, Potchefstroom Campus. The period which I plan to do data collection is from 01 May 2018 to 31 July 2018.

Attached please find the research proposal as approved by the research committee of the School of Nursing Science, North West University, (as well as the Health Research Ethics Committee of the Faculty of Health Sciences, North West University under the umbrella research project.

Accompanying documents are:

- A supporting letter from my supervisor to indicate the approval of the research proposal, and
- An Ethical clearance certificate by the Health Research Ethics Committee from the Faculty of Health Sciences, North West University, Potchefstroom Campus.

Your favourable consideration will be appreciated.

Yours sincerely,

Yvonne Fox
M.Cur Student

Mr Francois G. Watson
Supervisor

Original details: (12010669) G:\INSINQ - Administration\INSINQ Letter head_Student Use.docm
26 October 2017

APPENDIX E: BIOGRAPHICAL QUESTIONNAIRE

Biographical information prior to focus group discussion

Answer the following questions by choosing the applicable answer:

1. **Age**
   Mark only one oval.

   - 24-34
   - 35-45
   - 45-55
   - 55-65
   - 65 and older

2. **Gender**
   Mark only one oval.

   - Male
   - Female

3. **Race**
   Mark only one oval.

   - Causation
   - Non-caucation

4. **Home language**
   Mark only one oval.

   - Afrikaans
   - English
   - Sesotho
   - Zulu
   - Xhosa
   - Tswana
   - Venda
   - Other

5. **Highest qualification**

Mark only one oval.

- Diploma in Nursing
- Bachelor degree in Nursing
- Advanced diploma in Occupational Health Care
- Advanced diploma in nursing speciality e.g. primary health care
-
-

Master's degree
Doctoral degree

6. Years in current position *Mark only one oval.*

- 6 months - 3 years
- 3 - 6 years
- 6 - 9 years
- 9 - 12 years
- More than 12 years

7. Years in the organization *Mark only one oval.*

- 0 - 3 years
- 3 - 6 years
- 7 - 9 years
- 9 - 12 years
- More than 12 years

8. Position

Mark only one oval.

- Principle occupational health practitioner
- Manager in occupational health care
- Manager in administration

APPENDIX F: CONFIDENTIALITY AGREEMENT BETWEEN MEDIATOR, INDEPENDENT INTERVIEWER AND CO-CODER

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING

entered into between:

I, the undersigned

Prof / Dr / Mr. / Ms. _____

Identity Number: _____

Address: _____

hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borcherd Street, Potchefstroom, 2520

(hereinafter the “NWU”)

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 “Confidential Information” shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 “Commencement Date” means the date of signature of this undertaking by myself.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1 .....

2 ....

(*Signatures of witnesses*) (*Signature*)

APPENDIX G: SEMI-STRUCTURED FOCUS GROUP SCHEDULE

Researcher's role during focus group interviews

A suitable venue will be selected at each medical centre to let all participants feel comfortable. This will be a quiet, well ventilated room with comfortable chairs. All other required equipment, voice recorder, note book and pen, as well as refreshments will be provided by the researcher. The researcher will take notes of the group sessions and record both majority and minority views on note sheets and with the voice recorder.

Researcher/Moderator's role during focus group interviews

The moderator will lead the semi-structured focus group and facilitate discussions. The moderator will seek to reach a group viewpoint and try to get everyone involved in the discussion. The moderator will commence the interview in the following manner:

Thank you for your interest and willingness to participate in the following study, "Exploring the perceptions of occupational health care nurses about support systems to enhance their own resilience, hardiness and well-being".

The aim of the study is to explore and describe OHC nurses' perceptions about the current content of OHC support systems utilised in a private organisation in promoting the resilience, hardiness and well-being of OHC nurses.

As part of the research, we are carrying out focus group discussions with the nurses at the medical centres at Sasolburg in Free State and Secunda in Mpumalanga.

The interview will be recorded as part of a qualitative research for a master's dissertation work. Your interview answers will be transcribed word for word in preparation for data analysis. You will not be personally identified in the research. The institution you work for will not be identified either.

Please acknowledge that you are aware of the digital interview recording. This information will only be shared with the research team who has signed confidentiality agreements. You are free to withdraw from this study at any time.

Do you have any questions or concerns?

The current Occupational Health Care support system in use by the organization will be shared with the participants, and they will then be asked to:

"Comment on the adequacy of the current Occupational Health Care support systems with relevance to the well-being of occupational health nurses."

The following prompts will be used:

1. How do you think the support systems could be improved?
    - Do you think there is a need for improvement?

2. What are the benefits of the training programmes/support systems?
    - Can you mention some of the benefits these support systems may offer for the nurses?

3. What are some of the challenges that the nurses may experience during preparing for training programmes/support systems?

Participants will then be asked to:

"Discuss whether Occupational Health care support systems include programs which effectively promote resilience, hardiness and well-being of OHC nurses".

The following prompts will be used:

1. What is your perception about resilience, hardiness and general well-being?
    - How would you describe resilience in nurses?
    - How would you describe hardiness in nurses?
    - What is your understanding about well-being in nurses?
2. What in your view can be done to sustain resilience, hardiness and well-being amongst nurses?
3. What training/support systems have the nurses received to enhance their resilience, hardiness and general wellbeing?
4. What programmes in your opinion can be offered to enhance the resilience, hardiness and well-being of nurses?

5. How often do you think the training programmes should take place or be offered to be effective?

Schedule

- The researcher will introduce herself and the moderator present.
- The researcher will ensure that everyone present has signed the informed consent forms and handed it in to the mediator before starting with the interviews.
- The focus group discussion will commence only after all participants and researchers are ready.
- Field notes will be taken during the focus group by the researcher, to note anything that was not verbalised, and it will be documented.
- After all the questions have been asked, discussed and no new information is given the interviews will the terminated.
- Participants are again reassured of confidentiality.
- If the participants have any questions it will be answered.
- The process of the analysis and sharing of findings are discussed.
- Contact numbers will be left should the participants wants to contact the researcher regarding the research.
- Participants are thanked for the time and the interview done.

APPENDIX H: EXAMPLE OF FIELD NOTES FOR SEMI-STRUCTURED INTERVIEWS

Methodological notes

The interviews took place at the private organization sites in Mpumalanga and Free State provinces. It took place in the respective private boardrooms of the medical centres. The boardrooms were well ventilated and had adequate light. The staff that were not part of the interview were informed not to disturb the interview process. Recorders were placed on the table to record clear and a clear note book were used to record notes. Recorder was switched of at the end of the interview but carried on with the conversation to get additional information.

Observational notes

Participants were scheduled according to availability. Participants from the mine shafts were interviewed first in order to finish first and to resume duties as soon as possible. Confidentiality was ensured and participants were asked to be relaxed and to feel free to actively participate during the interview. Participants were sitting opposite each other to have eye contact and to have a relaxed environment. Researcher introduced herself, the independent moderator as well as the purpose of the research to the participants.

Theoretical notes

After the introductions and consent was obtained the first question was posed whereby the participants responded well. Participants also freely enjoyed the free tea/coffee, snacks that was made available for them during the interview. All participants actively took part in the interviews.

APPENDIX I TRANSCRIPTION OF A FOCUS GROUP INTERVIEW

FA1: **Facilitator 1**

FA2: **Facilitator 2**

PA1: **Participant 1**

PA2: **Participant 2**

PA3: **Participant 3**

PA4: **Participant 4**

PA5: **Participant 5**

FA1	All right, ladies, I was thinking of currently at our workplaces, what current occupational support care systems can you think of? What we currently have here at our workplace. Can I mention one that I was thinking of? I was thinking what we get here, there's ICAS. It's a support system for us, isn't it? ICAS is broad. The boss, financial, stresses, whatever, then we get referred. I've mentioned some, but I don't know, can you think of other things? Current support systems for us.
PA1	Other than our line managers, I can't think of anything else.
PA2	We're supposed to be having HR as one of the support systems. But, to be honest, as I'm saying, they're supposed to be one of the support systems, but they are somehow failing us. But, as I'm saying, they are one of the support systems.
FA1	Something else?
PA3	For me, I'm not sure if this will be relevant in terms of a support system. But, remember, we are working under this umbrella, occupational medicine, but we are rendering a service to the mines at the satellite clinics. For me the mine that I'm working at, the support system is very good there in terms of if there's anything that I need or if you are not feeling well, you report, you go home, then you get the support. Or if something bad happens they will

	call you or even come and visit at home. But it's actually not specifically HR related, but it's the group of people that you are working with and the management as well. So on top of what we mentioned here, the ICAS. As far as our HR, I don't know.
FA1	No problems?
PA3	I've never engaged. Let me be specific, I've never engaged my HR for support.
PA4	I did engage them.
PA3	Why? Because...
FA1	What [inaudible 00:03:31] needs.
PA3	They chop and change, I never know who's there now and you just decide, okay, if I spoke to Carmen it's fine, then I will do my own thing, take it somewhere else.
PA4	I experienced it a bit different from Betty, sorry, a bit different, but the mines differs. It's big and it doesn't all the mines work the same. So from my side I think there must be also commitment from my mine mangers to also help me to get stuff done. And HR is non-existent for me. I ask them and there's nothing, sorry.
PA2	And from my view, again, we as the occupational health nurses, we form a very strong support system amongst ourselves. Because should any of us encounter any problems, you just take a call and you say, hey, what about this and this? So I would really say that we are a very strong support system amongst ourselves.
FA1	Amongst yourselves.

PA2	Yes.
PA5	I support that fully, that we're really supporting each other, but I will not go far and explain. Also, our line manager is very supportive. There is no but. ICAS is also there for us, it does help with us as individuals and also with us if we want to communicate something for the employees at the mines where we are working, based. And also, at the shafts where we are working HR is not supportive, totally not supportive. The unions, they're also very supportive at the shafts. But managers, they do support here and there. They are not hundred percent.
FA1	Depending.
PA5	Yes, it depends. Today they're going to say yes, tomorrow it's another answer and that is what we are getting.
PA2	To add on what my colleague has just said, I've noticed something when it comes to mine managers being supportive to the occupational health nurses. We are regarded as two persons because we work under the Mine Health and Safety Act and the Occupational Health and Safety Act. So, they just look at what favours them at the moment. If they feel that this is mine related, it's a mine-related issue, then you are part of them. But the moment they feel that you are an occupational health nurse under the Occupational Health and Safety Act, then you are not part of the mines. But all in all it's just for us to say, okay, now I'm an occupational health nurse, I'm functioning now, at the here and now I'm functioning under the Mine Health and Safety Act. So that's all that we do and it works for us.
FA1	So you guys actually put mostly emphasis on HR? You know, majority.
PA2	Yes.

FA1	But I was thinking of, remember I said ICAS. The support systems currently that I was thinking, what we get from our company, ICAS. Although I picked up that HR is not that very receptive or supportive. But the second thing that I noted here was that Sasol Cares.
PA2	Ooh.
PA3	Ah no, trouble.
FA1	Troubling.
PA2	Sasol Cares, I think... Sorry to just chip in. That's why the reaction once you say Sasol Cares. I'm expecting Sasol to really care for us as employees, but to me Sasol Cares is just a face. So sometimes when I drive in then I see Sasol Cares or Winning With People, I start questioning myself, which people are you guys wining with?
FA1	Talking about.
PA2	Because you're not winning with me. I don't know if I'll be right when I specifically look at the Sasol Cares as in now, that project.
FA1	Yes, I'm talking about their project.
PA2	That project, for one, I'm not convinced that Sasol cares. I don't know what is it that they're trying to do with that thing, because it is not...

FA1	Benefiting you.
PA2	Benefiting me. Actually it is chopping on my head. I'll cite an example. They say they're going to pay this amount towards the schools, but at the end of the day I find that my tax has gone up and this and this and this. So why is there? Why can't they give me the cash so that I see what I do with the cash? If it really belongs to me, why should somebody from somewhere want to do something on my behalf? I can do that. That is why as it is now, after they paid the first amount, I went to the school, I say how much do I owe you? They said you owe us this much, I paid that. Because I know that anything that goes with this, one day somehow somewhere it will hit the rock and then I'll be expected to pay interest. So with the Sasol Care, huh-uh.
PA1	I think for me, if you take into consideration the reason why this came out, was the system was brought about so that Sasol bypasses the taxman. And you can convince a layperson, but unfortunately as you move up the ranks, you can't convince the rest of us. So they actually moved the tax burden from Sasol onto us. So it's technically not a saving, because I did my own calculations, I actually ran a loss of R400. Which I could have taken the same amount of money and put into a tax-free investment with a lower risk and potentially having the same amount of money back, if not a little more, or I could have taken the same amount of money and invested it into a medium-risk portfolio and got an excess of R500, however less it is, but it's better than losing R400 or R600.
PA5	[Inaudible 00:10:52].
PA3	To add on that, the idea is a good and well idea, but when you look behind the scenes in terms of their service delivery as well, for instance, for me, I chose the education part and there's this e-mail that you must e-mail your stuff to, your forms and everything. Up until

	now, actually the money for my kids for school ended up not being paid and it was paid into my pension fund. They have all these nice things on face wall there, you know, the dashboard, you are doing well. They outsource the services to people who care cahoots about Sasol services, who are just there to milk the money. When you phone you get told the SMS or the e-mail is the only means of correspondence and you end up not getting help at the end of the day. So It's a good idea to say they care, but also they care to rob us.
PA1	They're going about it the wrong way.
FA1	They're thinking to rob us.
PA3	I'm going to just be honest. Yes, to rob us in terms of tax and also in terms of service delivery. I have got a certain expectation of Sasol in terms of service delivery, especially when it comes to this HR issues and things like that. But I never had pleasure with this part, the first part of the Sasol Cares thing because my money ended up being deposited into my pension without me being informed, hey, Mrs so and so, we didn't receive your forms or your forms got lost into the system so we are going to pay your money back into the pension. It was just you see your payslip, you send the e-mail, what is happening now? We don't have your forms. But they have corresponding, we received your forms, the money will be paid, it's with someone. You know? So they must just, well, for me is get your ducks in order first before you actually start to...
PA2	Implement something.
PA3	To implement. Don't announce and implement and expect everything to go smoothly. Some people received these small bags. You look at the bag, I mean, I ordered a bag for

	a child who's high school now, what am I going to do with this? The bag gets torn, they say it's because you patched it, you can't give it back to you. So if they do it they must really, really go give the heart to it and also make sure whoever has been recruited as a service provider, they make sure that they are aligned with Sasol values. Because those people don't care. Shame, you talk to them, you must call these ones, they are somewhere in Rosebank, or you must call these ones, they're somewhere, wherever. And when you call they don't have the patience to deal with whatever you're going through.
FA2	[Inaudible 00:14:10]. Thank you so much.
PA3	Yes, it's fine.
FA2	It's not.
PA2	You know what, my hand is on the block, you know.
PA5	You know what, what I think what Sasol should do, they're sitting in their offices, they do their planning, they finish and do everything, then they come to the people later, after they've done everything. They don't consult with us, people on the ground. They come and tell us, listen, we're going to do this, and then it becomes a failure at the end of the day. For instance, with this Sasol Cares, as they have mentioned already, the bags, I don't have a child, they're all grownups, I did not choose anything, but my daughter has a child at Curro. Then they get these bags, what contents are there in that bag? Firstly, the bag is not quality and the books or whatever that are in there, they are not used at Curro, they

	have got their own things that they do use. Secondly, I'm going to put it all under Sasol Cares, we are given gifts that are not hundred percent quality, which is really not on. If they can come to us, communicate it repeatedly that we want to do this, how about you tell us what you want or need, either you want the vouchers so that we can buy ourselves what is quality. Maybe they give us R200, you go to town and see what you want and then you add on that voucher that they have given you, not give you that something that is going to be put in the water and the next morning it's like a *skropping* brush or whatever.
PA3	It has shrunk.
PA5	Yebo, it has shrunk. It's not really. Communication by Sasol, they must come to the people. Our HRs must come and talk to us and then when we question them, they must be able to give us the correct answers. Because at times we're not getting the valid answers that we want or we expect from them.
FA1	She went to my next question now I wanted to ask actually. But you guys will agree that the current support systems that we currently have, whether we're happy or unhappy, we do have ICAS services that they offers, Sasol Cares. Although all of us, even my boys, I can take you to my house now, it's just standing there, they refuse use it. And then other support systems, wellness. Do you have it in Secunda?
PA1	We've got the wellness sisters for the employees that are coming in, but I don't think us as sisters has per se used them. Because the primary functions of the wellness sisters are to conduct wellness, so that entails like your blood pressure reviews, your sugars, your HIV testing, counselling.
FA1	So we test each other amongst, we don't go to the wellness sister.

PA1	We test ourselves.
FA1	No, that's what we also do. If I'm not feeling well I go to Sandile and say, my friend, take my BP quickly. I also don't consult the sister there. So that's what you're also doing this side, you don't make use of those services. But it's there, wellness, you do have wellness at Sasolburg. I was also writing down occupational, I was thinking, I don't know, here you guys must help me, current support systems. I was saying team building. Do you guys go on team buildings out?
PA1	No.
FA1	No?
PA2	No.
PA1	It was initiated, I can speak for myself, multiple times, but...
FA1	Not?
PA4	The problem I think is we sit for a very long time without a senior manager and our line managers was trying to fulfil the function, but they didn't have support. So at the end for more than a year, maybe two years we were just floating.
FA1	Without a senior manager.

PA4	Yes.
FA1	And occupational, I don't know if is this one relevant here, occupational services inhouse. We are not outsourced. Remember, like IC Health and those are outsourced. But don't you think that's also occupational support system from the company? For the fact that we are not outsourced. We're part of, they've got all the benefits and everything from the company. Is it part of the support systems? Remember, when you're not part of the company or of the organisation, I mean, I used to work at ArcelorMittal and then we got, you know, Mittal is not doing well and then we got outsourced and I was given over to Monyetla and that's how I ended up seven years ago here at Sasol. So I don't know, do you think that could also be a support system from?
PA1	I think long term it could be regarded as a support system. Because I think it will be a worry if you're an outsource company, like IC Health, with regards to taking out you own pension fund and saving schemes. Although not the best saving scheme, but it's there. And our medical aid, although, don't shoot me in the foot, although it is ridiculous, but at the end of the day it's still a medical aid, it's still comprehensive, don't shoot me [Mma Sisi? 00:20:10], there are co-payments and it comes straight out your salary [inaudible 00:20:14]. But I think if we were given the option to outsource a medical aid, like, I don't know, just... Because for me, I can speak for myself, I don't use Sasol Med at all. Literally, unless it's an emergency, which I've had one in like my entire. And it's a lot of money to contribute towards that medical aid. It truly is. But just a sense of belonging, like you said, to a company. And we must agree, through the tax, Sasol Pension is still one of the best pension funds you'll ever find.
FA1	And apparently the medical aid as well. I don't know that side.

PA1	In terms of structure and the added benefits, like the mental health programme, the weight loss programmes, services that some of us don't even use. There's all those benefits and I agree and I'll promote it, but I myself don't use it.
PA2	And the reason for not using it is not that you don't have to use it or there's no reason for you to use it, but we're scared of that medical account that you see on your payslip, having to think that you pay R8 000 every month, but once you go to the doctor, at the end of the month you get the medical account. So sometimes we get sick and then we go to our clinics, we nurse ourselves. And sometimes you don't feel like you want to use something that you learnt from your grandmother, but sometimes we do that because we're scared to use the medical aid. Like my colleague is saying, Sasol Med is one of the best, but it's also one of the most expensive. So whether you use it or you don't use it, you're still going to pay the R8 000. But once you use it for a consultation...
PA1	A GP.
PA2	A GP, then...
PA1	R150 is coming out your salary.
PA2	It's coming out from your salary.
PA1	Then you go to the pharmacy, if you don't want to go to the doctor, it's capped at R200 per day. If I take a Demazin, it's already R180, what will I buy for R20?
FA1	Nothing.

PA1	Chances are I'm going to have to pay a co-payment on that. So why am I paying this big, large amount?
PA2	So maybe if we would be given an option. I wouldn't say an option would be to say it's compulsory, as it is. But, hey, this thing of compulsory, it's killing us. It's really, really killing us. Yes, I'm ageing and maybe as I'm ageing I'll be having some other conditions. But as for now, for the previous five years I've never been in the hospital, I've never used that medical aid, but...
FA1	Every month.
PA2	Every month. It is one of the support system.
FA1	So we're discussing the support systems now. By listening to you guys there's definitely a need for improvement. Definitely. Can we talk about how we can suggest for? The lady over here already suggested earlier on. She also mentioned now something, if they can give us an option, not to make it compulsory. What do you think, ladies? What suggestions?
PA1	I also like that option of being given, do you want to take Sasol Med or do you want to go onto another medical aid? But I think where Sasol's concern is coming in is that they don't want an employee getting injured out of the work setting and then having to stay at home or go to an improper medical facility, which I understand. But say to the employee, look, go and get your medical aid, submit proof to us. That is what every other employer does outside Sasol. Go and give us proof that you're on a comprehensive or hospital where we know that should an emergency arise you are well taken care of, that you are going to come back to work. Not say this is your condition, because I got told by HR, this is your condition of employment, you signed it, you take it, you stick with it, end of story. I don't want to be

	obligated to a medical aid that's costing me an arm and a leg for something that I'm not using. Or give me an option, a hospital plan, an intermediate plan where you've got X, Y and Z benefits, or do I want that comprehensive medical aid with unlimited GP benefits. I haven't even visited the GP in I don't know how long.
FA1	Like in the government sector with GEMS with the different options, then you choose what. But like in my case, I'm working for Sasol, but I'm not on Sasol Med, I'm on Bonitas with my husband. And I must say, it's much cheaper, because my colleagues at work are complaining.
PA2	I am complaining.
PA1	I am complaining.
FA1	They Sasol, it is killing them.
PA3	And besides, Sasol Med is a closed system. So if you've got other people besides your immediate family, people who are financially dependent on, you can't put them on.
PA1	You can't add them on.
PA3	You pay that monthly premium and if your mother or somebody gets sick, you must still go and pay fees at the private hospitals and, and. I mean, we are at an age where we are taking care of our parents and stuff and you know the care in the public sector, how it is.
FA2	Let's just move on. I know I'm only supposed to sit here, but can I give a suggestion? Maybe something like, because I mean, if you're going to pay R8 000 a month, let's say if

	they say if you haven't used it for three years we're at least give you something back and then encourage them to just stay with it.
PA2	That's another thing.
PA3	That's another, that would be a good incentive.
PA1	There was something put in place where, remember a couple of years ago our medical aid, our GP visits were capped at a certain amount, at something, and then after that... Well, now they started off to say that your first, because initially they said that your GP visits are unlimited but they don't tell you that there's a 10% co-payment. Then this year, in 2019 they said that your first three GP consultations are co-payment free, anything other than three you'll be capped at 10%. But, yes, I don't know, even those types of benefits will... I was going to say something but it's lost now.
PA2	But I like the idea of saying if you haven't used this for a certain period, then you'll be...
PA1	Remunerated.
PA2	Remunerated to say, hey, you've behaved. But no we are trying to behave, but the more you try to behave, the more *hulle kap jou uit*.
PA1	What I was going to say is there are...
PA2	Okay, now I [inaudible 00:27:24].

PA1	There are talks between, because you know Dr Muriel is part, one of the board members for Sasol Med. So it is on the tables, it is on the cards. We don't know how long it's going to take or if it's going to happen at all. Because like Sister Betty said, it is a closed system. It's run by Medscheme, the administrators, so we have to wait and see. But I think what we need to do, and I don't know how we're going to go about doing this, is keep on pushing, keep on pressing on them to let them know that, guys, listen here, this is a crap load of money.
PA2	Can I please add on something? I don't know whether I was ignorant on the previous years because I was just fed up with whatever what was going on, but this year I saw something. We are getting a lot of SMSes to say so and so was saying please vote for me and such things. They gave me something to say we are moving towards somewhere. Because initially you just get an email, a board of trustees vote wah wah wah, you didn't even understand what is going on. But this year I saw something that's saying at least maybe we'll get somewhere in some years to come if we'll still be here.
FA1	Can we go to the next question? Can you mention some of the benefits these support systems may offer the nurses? Some of the benefits.
PA1	Hey, shame, incentive bonus at September. If it was not taxed, I promise you, I'd be the happiest employee. But it is one of the best incentives or bonusses or 13th cheque that you will ever find. There is no other company that comes close to that.
PA2	The only thing, like you say, tax. The tax is a half of what they gave you.
FA2	So they don't have an option where you can opt to be taxed for 12 months and then when you get your incentive it's not [taxable? 00:29:51]?
PA2	No.

PA3	It all gets. Which, hey, if they can add.
PA1	If I just see that amount and it not be taxed, I'll never complain.
PA3	It will be good.
PA1	I'll never complain.
PA3	But we are grateful though, because you will never get hat anywhere else.
PA1	Yes.
FA1	And remember, this year top management is not getting, so we are still...
PA2	That's what I heard.
FA1	Yes, they need to give an e-mail, so we're still on the safe side.
PA3	We're still safe.
PA1	No, no, guys.
PA3	Next year they'll come, we're not safe.

PA1	No, we are safe, but it doesn't mean that top management doesn't get a bonus. Their bonusses are coming. It's called a long-term incentive. So hypothetically speaking, if they are scheduled to get 10 000, they probably will get 100 000 when Lake Charles is up and running.
FA1	When that time comes [inaudible 00:30:39].
PA1	So I want to be there, but unfortunately I can't be there.
PA3	Yes, plus they get other benefits *mos*, the top management, the shares and their...
PA1	As well, yes. December they get their budgeted allowance to them.
PA2	And, I mean, for the previous years they've been getting the 15% as it is. And how much were we getting? If you are now lucky then you'll get five.
PA1	Five, yes.
PA2	But they knew that their 15% was a done deal. So even now, like they're saying they're not going to get something now, they know already...
PA1	It's coming.
PA2	That it is somewhere there.

FA1	That's why they're not fighting.
PA2	That's why they're not fighting.
PA3	No, they know they're covered. No stress.
PA2	Yes. And the other benefit that I would love to see from our company is, you know, we nurses' we usually get burnout, but we think we are strong and then we just go on. And going on, how many people do we counsel in a day? So we take all that burden and it stays there and then at the end of the day they say nurses are crazy. We're not crazy. They are pushing us to being crazy. But if they can have something to say the nurses... I mean, we've got the nurses' day and on our nurses' days I was happy in the previous two years where our doctors were coming up with something, then they gave something to us and it was from their own will. What does the company do for us during our nurses' days? Nothing. If they could take us, just take us somewhere, then...
PA1	Every year it's a budget, because I myself, I'm the one that initiates nurses' day every single year since I started with the company. And its, always budget, budget, budget, it falls on the wrong person's ears, then I must speak to this person. And I start from January. I look up the date and I start in January. These jackets, the idea came about in January, the design for the jackets were out end of January. I actually didn't want jackets, I wanted us to have sweaters, like how the wellness guys have, for us to wear on a Friday. And then they said, no, it's colour print, blah blah blah blah blah and we must be happy that we're getting jackets. We'll start earlier next year. How much earlier must I start?

	The previous year it was one chocolate, one pen, one highlighter whereas I started in January for us to have golf t-shirts and to be taken out for lunch at the company's cost, not at our own cost. Eventually I got told, no, your packages are in the offices, come and collect it. I go there, there's one slab of chocolate, one pen and one highlighter and I'm like.
FA1	But at least you guys got something. We don't even celebrate nurses' day, so I need to connect with you.
PA2	Just to add on what she just said, there's a word that I heard, it's a favour.
PA1	We are lucky to have a job.
PA2	For everything you should be happy you've got a job.
PA1	We've got a jacket.
PA2	You should be... I mean, I'm not here as a favour. I'm adding value to this company, but why is it every time when I need to get something, then I'm reminded. For instance, for the uniform we are told one day that it's a favour for you to have a uniform. Then I just said there and there there's no favour for me to get a uniform. If you think it's a favour for me to get a uniform, then you must think it is a favour for the other people to get PPE. Then I said the uniform for me, it's my PPE, it's not a favour.
PA1	Yes, it's a substitute.
PA2	But there is that word that usually comes from management to say it is a favour, be happy that. So something should be done there.

PA1	And also the fact that nurses are not recognised, because we considered admin workers. You'll find that we've had these arguments for years on end with HR and everything. If you find an admin lady in the plant, she earns the same as us whereas it took us to go and get our degree in nursing, then we went and did occ health, that's a further two years of our lives, then there's other training and then you keep on adding two years, two years, two years, and then we don't get remunerated. I'm not saying that we must go and study midwifery, come and do occupational health and then ask for a salary increase because it's two worlds apart, but if it's work related and if it can add value, then why not? Because at the end of the day if I'm educated I'm looking at things from a different perspective which is adding value to the company. So after a while I'll just stop speaking because it's getting me nowhere. You want to use me for my valuable skills that I have, but you don't want to remunerate, so I just don't say anything anymore. If you want my information, you're going to have to treat me right. I'm not asking specifically for a monetary value, but just a pat on the back, well done, we really appreciate that idea, maybe we'll consider that or whatever the case is. So it also in turn creates negativity amongst some of us to say that, you know what, what am I doing this for? So I'll just take my skills and I'll go elsewhere where I'm recognised for it.
PA2	Ooh, and they like saying that. They like saying, you know what...
PA1	Yes, if you're not happy...
PA2	If you're not happy, if you're not happy of the piece of cheese that we have here...
PA1	There's the door, there's the door.

PA2	You can go look for the piece of cheese somewhere else. Who said I wanted that piece of cheese? Because I came here for this one. So in other words, they are aware that somewhere somehow they are not bringing their part and they know that they should do that. That is why they're trying to get rid of anybody who voices out. Because once you say something, then they say, if you're not happy, there's the door. I mean, what kind of management is supposed to say that? I should get a positive response from my management to say we'll look into that. Even if they say, they can say we'll look into that, we know that sometimes they won't even do that, but if I can just say...
PA1	It's the response back, just to not agitate the employee.
PA2	Yes.
PA1	It's simple management and leadership skills that's seriously lacking.
PA4	I heard a lot of times where they said we are just an *uitgawe*.
FA2	Expense.
PA4	Expense, we are not...
PA1	Yes, we're not production, we don't bring money in.

PA4	We don't bring in money and that's also always upsetting me because we are looking that the people that does the production are within legal requirements, that they are healthy, that they are fit for work.
FA1	Yes, we play a vital role.
PA3	Very vital.
PA1	Let alone that, the company will shut down.
PA4	We do and we just hear, we ask something, we are just an expense for the company. So it upsets me, yes.
PA1	But yet if we are not here, the company is forced to close down.
PA4	Yes.
FA1	Exactly.
PA3	Just wait one person get injured, they are all over you, you are now all of a sudden important.
PA2	Are we still on the...?
PA1	On track?

FA1	Benefits.
PA2	On the benefits.
FA1	Yes.
PA2	To say what benefits would we like to see?
FA1	For the nurses.
PA2	For the nurses. Most of us here, I can assure you, we are old women but we are studying. And for one to study and at the end being told that don't think that you are studying to get more money.
PA1	Because you won't.
FA1	Demotivating.
PA2	Because you won't. It's so demotivating.
PA5	Demoralising.

PA2	Because, really, when you study you're studying towards getting something and we are not asking for much. They say if you are an occupational health nurse you need to have occupational health nursing, but it's not recognised. And we are not specialists.
FA1	Exactly. [Inaudible 00:39:34] about the same thing.
PA1	We've had that argument.
PA2	And if you put that on the table, to say as an occupational health nurse already I'm a specialist, then they will tell you, I don't understand why you want to be specialists. Then I ask myself, why are there, I'm sorry to say it, why are there are pharmacist specialists? Why are there X-ray people, specialists? What is the difference between myself and them?
PA1	And, Mma Sisi, can I add that the guys at radiography who are radiographers, who are specialists, they only studied four years. The guys at pharmacy, they only studied four years for pharmacy. Whereas we studied four years plus an additional good couple of years after that. So who qualifies for that specialist title?
PA2	Everybody else except for the nurses.
PA3	And you also look at the scope of our work, we are really at a specialist level, but we don't get recognised for that.
PA1	And I've personally had this argument with HR, we took up to the unions, we took it up to the VP. The VP said, my darling, if you're not happy.
FA1	Huh?

PA2	Yes.
PA1	Not in a nice way, you know what sweetie, darling, lovey, honey. You don't like it.
PA2	There's the door, leave our badge. So those are the conditions that the occupational health nurses are living under. And as nice as we are, as our pledge says, we are just there and then we just say, okay, it's fine.
PA1	We're here for our people.
PA2	We're here for our people.
FA1	So when we pledged. Have we exhausted the point? Any other benefits?
PA5	Another benefit. We are the nurses at the clinics we are given laptops to use. We're only using the laptops with the Wi-Fi at work. If you are not at work, you are sick or whatever or there's any information that you want to send to your manager, whatever, you can't, you must use your own Wi-Fi. We're not saying we want that benefit to exploit it, we are adults, we can use it in a professional way, not for our outside things but for work. We must be able to use the laptop at home.
FA1	Like the other people or those [inaudible 00:42:25] and work from home.
PA2	Yes.

PA1	Yes.
PA3	And also, if there's anything happening at your plant or whatever, you can't even get the information on your phone and see what is happening. Who are we? We are nothing.
FA1	We've covered it all. The third one, what are some of the challenges that the nurses may experience during preparing for the support systems?
PA1	Lack of support.
FA1	Lack of support, yes. I think sometimes we're also so busy you don't even get time to leave your station and go. And you guys are not here, you guys are at our...
PA2	Satellite clinic.
PA5	The challenge, you are there on your own at the satellite clinics, you get an emergency, those people, they don't know your area of work, you are on your own. There's no second person to help you, please get me this, what. And then an ambulance is far away. The only thing that you get, it's the mining people coming in into the room, then...
FA1	So it's one person per clinic?
PA5	Yes.

PA3	And it's a dangerous situation. It's safe, but dangerous. Safe for them in terms of budgeting and making sure when things are still running smooth. But in the long run we might just have a situation where the [people? 00:44:15] this the fan. I'm going to just say it as it is. I think we are compromising on health in terms of staffing. Because from my personal experience where I am, I had two incidences where I had two emergencies at the same time, two people were sick at the same time and I'm alone and the ambulance takes about 20 to 35 minutes to arrive. And now you've got your room full of this, everybody who's claiming to be a first-aider and now you need to control the crowd and still look after your employees. You can't be at both places at the same time, you need to prioritise. But if they're both critically ill, what do you do? If something happens there, who's going to take the knock?
FA1	At least two-two per clinic, [to account? 00:45:14].
PA3	Especially the big shafts. I don't know, that is for me based on those experiences.
PA4	For instance, I sit at my mine the whole day, from 07:00 till 16:00. I don't take lunch because there is no time for lunch because the people that comes to the clinic is during their lunch times. Then you see it's already 15:00, then you didn't eat. You can't quickly just say, okay, today I'm just taking my lunch, I need a break, I need to go out, because there's nobody to stand in your place. You can't leave the site because it's a dangerous environment, there needs to be a nurse.
FA1	Don't want to relieve you even for tea or lunch or anything?
PA4	Nothing, nobody.

PA3	You eat on the go and it's unhealthy, you all know that. Pravitha has already experienced that with me at my clinic.
PA1	I just recently started at the clinics. I used to work here for three years.
PA3	There's no time when you can say, okay, now I'm closing, it's lunchtime and let me relax, get my lunch and rewind a bit. No. You eat on the go. Whatever you do is on the go. And the phone will be ringing and this manager wants that and this one is knocking and this one wants to know who's in hospital, who's doing what, now we must plan campaigns. Everything is happening within that space, you don't have a time when you can say, okay, now let me do some, it's lunchtime, let me look at my personal stuff. You don't have time like that. And it's not healthy.
FA1	Not at all.
PA2	And the issue of assistants for big and far-away mines has been an ongoing request and every time we are told that, no, there's no money. I remember one mine managers even said I'm aware that the medical fraternity is only looking at the finances, so if you guys think that your budget is more important than my people, let me pay for myself. And then that was crushed, to say he cannot say that. But, I mean, he was saying that out of frustration, to say my mine is far away, I only have got one nurse, if you are not able to pay for the second nurse, let me do that. Then that was a no-no. So as my colleagues are talking about not having lunch and the staff, I once raised that and my management said if you feel you want to take lunch and there are people that are still flooding in your clinic, just take your car keys and go out. Then I was like, you're saying it so nice because you're not in that situation. And then if I may cite an example, I'm a diabetic, but the diabetic that eats a lot of sweets, by the way. So it happened this day that I could not even have my tea or something. At around past one or so, then I started shaking and I just thought, ooh, my blood sugar

	levels are high. That's the only thing that came to my mind that time because I'm on medication and I haven't taken my medication. And every time I want to take my pills, somebody comes in.
PA1	Please help me.
PA2	And then eventually I said, you know what, let me just eat something and take my medications, but I could not do that. I could not eat something, I could not take my medications. Later on I said, let me check, let me see how high it is. You know how high it was? Two point three. So can you imagine if I took my pills?
PA1	Without eating.
PA2	Without eating. So those are the things that we're faced with and if there was an assistant, I remember I had to call a security guy to say, hey, come here, give me any nonsense so that I can eat. So he was the only person that could help me at that time. So we really need assistants at the clinics. And the other thing, our doctors are not entirely supportive. You will ask for something three years back and you haven't, it's still on the table. Whose table is it and who should take it out of that table so that it comes to us? So we're just talking, talking, talking, but nobody listens. Because they think that we are capable when it suits them, but actually we are not even recognised. Especially the clinic nurses, we don't do anything. If you don't know, we don't do anything.
PA4	You sit down.
PA3	You're just sitting there and drinking tea.

PA2	We just sit down there and we don't do anything.
PA3	Writing mails and...
PA2	But do they even get a complaint from the mine managers? No, and they're happy with that. But should there be one complaint, then the clinic nurses are useless.
PA4	Last month there was a college at my mine and I took students underground and they asked me, now, after how many employees does I look after? I said around 2 200. And they said, and your help, how many? I said I'm the only one. They were like, what? I said, yes, I'm one sister that looks after 2 200 employees. If there's projects on that mine, like the construction people building, there's even more. And with the contractors that doesn't have medical aid and the government hospitals that doesn't help them or doesn't have resources, this clinic focus more on primary healthcare than...
PA2	Any other thing.
PA4	Any other thing. You can't get occupational health things done because you focus more on primary healthcare. And they can't believe, then when I had to explain to them the role and responsibilities of me in that area, they were like, are you doing this alone? The lecturer was like, *sjoe*, that is not fair.
PA2	Can you imagine somebody from outside notices that, but somebody from inside, they don't.
PA3	And also in terms of, to add to what Lizelle is saying, if you look at the set-up of the complexes where you are working, at the shafts, you've got workshops there, this workshop there, that building over there, away from the clinic. And if somebody collapses

	you have to run out with the wheelchair, with your emergency bag and go there to go and assist the person. And sometimes you need to wheel that person into the clinic because now you've got this only amount of equipment, you need to do further tests in the clinic. You need to push that person or wheel them in. Sometimes you'll get help, people who'll be willing to assist you to push the person up until the clinic, sometimes you do it on your own. And it's a dangerous issue because at my shaft there's an incline like this that comes from the admin block. I had once had a person there and I refused to push the wheelchair. I said you guys are going to help me to push this up because I'm not going to hurt my back now. I'm trying to help this person, now I must also go up this incline with this person. I'm not going to do that. So actually it will be better. It's still to support the fact that staffing, yes, staffing, it's an issue. We will get hurt sometime and we are oldies right now, arthritis and things tripping in. Our health and safety is important as well.
FA1	I know guys, it's true, these are real issues that you are facing every day. It's actually nice to sit in and listen, because I was thinking I'm the only one. I'm actually the talkative one on the other side, so it's so nice to see the colleagues this side also. And then like she was saying, that when you talk it's like they look at you, that one, you know, with the big glass, to say that one is the one investigating whatever. But sometimes we just want better lives for ourselves, because really it's like in nurses are not recognised everywhere, all over. You know, I thought I'm going to leave the government, then I heard Sasol, I was like, wow wow wow. But let's see after all of this what can we achieve. Can we go to the next one? It says here discuss whether occupational healthcare support systems include programmes which effectively promote resilience, hardiness and wellbeing of the nurses, the occupational health nurses? And then I'm just going to ask some questions. What in your perception about resilience, hardiness in general can you

	describe resilience? How would you describe resilience in nurses or the meaning of resilience? When they say a person is a resilient person?
PA1	That person is motivated to work. There's something at the end of the rainbow that keeps that person up and going, waking up every single morning to come to work. Those types of people are usually appreciated, they're accounted for and things like that. Just in my opinion.
FA1	A person that irrespective of the circumstances would bounce back. Resilience, a resilient person. Through difficult. And I think we nurses can really, like I mean for you guys to be alone, at least there by us all of us is near the medical centre. We've got only one mine, Sigma, and there's also... But it's very small there by us. I was so shocked to hear. It was actually my first time a month ago when I came to introduce myself to see that it's actually bigger here, it looks nice to work this side. There it's only Sandile that's working at the mine, also one sister, but seriously, it's not busy there. When Sandile is off sick I normally go to the mine and then I was sitting for three days there, nobody came to visit.
PA3	That's nice.
PA2	*Lekker*.
PA3	That's a *lekker* place to be then.
FA1	And the other thing is, they prefer to come to the medical centre because if they go to the clinic there then they must go back to work. So if they come to us at the medical centre, then they take the day off. So you'll see the clinic is empty there and they come.
PA5	Okay, it's nice, hey. It's nice. Because if they come here you're supposed to go back to the mine.

FA1	But remember, they said they're going to align, everything must be... We normally hear, no, at Secunda you guys are having everything. So we normally fight and say but we want company. Like we've changed now our uniform, it's now grey and...
PA5	Red.
FA1	No, not red. I heard, is this new?
PA5	Yes. From Monday to Friday it's red.
FA1	They change it from grey and green and we were fighting for the green. They said, no, the people in Secunda are wearing this. Oh, we said we are tired to hear of Secunda. Everything is Secunda, Secunda, Secunda. But anyway, they forced us to wear that uniform, so we're wearing grey and... No, currently there's no budget for uniform. I remember when I started I used to get five suits, one suit per day. And a suit like in a three piece.
PA1	You can have one suit per year with the budget we have.
FA1	It doesn't work. So resilient, can you think about that? How would you describe that, resilience in nursing? Or resilient nurse.
PA5	For me is, to be resilient, to me it means having a strong character and able to withstand any difficulties and challenges. If I just put it in a simple way, being able to smile through challenges and you still push on.

PA2	I would say I am made to be resilient. Sometimes I feel it's not by choice, but it's by circumstances, to say I need to get through this for my survival. Because if I don't do that or if I'm not resilient then I won't get to where I want to be. Remember, we are parents as we are here. So if you're not resilient you'll end up breaking down and that would mean two, three mouths having to suffer. So you need to be strong for the people that you are living for. So I usually say if I was just the only one in this planet earth, I didn't have mouths to feed, immediately somebody says there's the door, I'll just pack and go. But you start thinking...
PA3	Yes, it's true.
PA2	Can I really do that to my family? So we are by force having to be resilient and to say, okay, I'll have the shock absorber and I will take everything as is. But like I said, it happens that at times you feel you've reached there and once you start to explode then it's too late. But we are, against all odds, against all what is said and done. They know exactly that when you go to medical centre, you request for something then it will be done, it will be given to you. So even if we are not entirely recognised as an important species here at medical centre, but they know exactly that, you know what, if you want something done, go to medical centre, they will help you.
PA3	Yes, and that also what Mma Sisi is saying, it tapers onto the fact that it seems like you'll have an open job description, to be specific. Because now you know this is your roles. If there's additional things, it can just keep on being added and added and added and added and you just take, take, take. Because you know, like she's saying, you've got other responsibilities outside your work and... Yes.
FA1	Exactly, and that pushes us.
PA3	Yes, it's just this open description thing. If there's anything that needs to be done, then it gets shifted clinic nurses this, clinic nurses that, you take on.

PA5	From my side, being resilient is every day you wake up, even if you don't want to go to work, because there are people waiting for you there at the door. And also, with the projects that you are doing at the shafts, like the wellness, you also get negative responses from the management, but you keep on pushing until it is done. So then you want to see the results and even go out of your way, take your car and go and collect this and that and this and that and do whatever so that things can happen. So that is being resilient.
FA1	Exactly.
PA5	And it is done.
FA1	We've covered that. How would you describe hardiness within nurses in the difficult things that we experience, hardiness? I think everything is so integrated I think you've mentioned it also. I think I can move to the next one, your understanding about wellbeing in nurses. When we say we as nurses are, what does it entail when a person is fine?
FA2	You know, I'm sitting here and I'm thinking, and I made a note here and I wrote, who's consulting the nurses? Seeing that you're consulting everybody else, who consults you, who consoles you?
PA1	Each other.
PA2	This is why I mentioned earlier that we take all the problems of other people, but there's no way where we take out...
PA3	There's no debriefing or area where you can say...

PA1	That's the area of wellbeing.
PA3	There's no debriefing.
FA1	Who makes sure that we are fine?
PA2	I know in the government sectors they've got one of us, I'll cite an example, here is the medical centre and then there is one of us who is also an occupational health nurse. She's got an office there, if I'm sick, if I've got problems, I go to her. But there's nothing like that within the Sasol.
FA1	To ensure the wellbeing of the nurses.
PA2	Yes, there's nothing like that. So they will defend themselves by saying but there is ICAS, but I feel comfortable talking to her rather than talking to somebody who doesn't know me. She knows me. She knows that when I'm happy I'm happy and she knows that when I come in and my nose is looking the other way, then she will say, hey, what is wrong with you? Because she knows me. So maybe if we can have something like that. To say, okay, there is an occupational health setting for the other employees, what about...
FA1	Here at work?
PA2	Yes, here at work. If I've got challenges here at work, where do I go to? Who do I confide with? Yes, the wellness nurses are there, but where are they? Here.
FA1	You have to drive all the way from there to...

PA2	Yes. So I can actually go to...
PA3	You're looking at 28 km or even more to come. And if you...
PA2	And if you come here sometimes, sorry, you come here sometimes and then somebody's looking at you, ooh, she went to talk to this one, then she went to that one, she is now disturbing my department. And sometimes we just go to those people to say, hey, you know what, I'm so angry, just to share with them. But then somebody will be taking notes to say she's been here for two hours now. So when it comes to the wellness of us it is zero unless somebody will talk about ICAS, unless somebody will talk about the wellness which I do not need. I need to confide with somebody that I know, somebody that is here.
FA1	And it's so impersonal because you call them over the phone whereby when you sit with the person I think that makes a difference.
PA3	And even if you can say you take time maybe to come here, the shaft will start complaining the sister is never there. Even if you report you are going somewhere then you are torn between your time and doing stuff, taking care of yourself. There'll be repots flying, she's never there.
PA2	Just to add on that, now that you're talking about the wellness of the occupational health nurses. I was so annoyed one time. I had a terrible headache and I know we've got our pharmacy. And then I just went there, I say, hey guys, just give me two Panados. Then they said, but where is the prescription?
FA1	Are you serious?

PA1	Go get your file.
PA2	So go get your file. I mean, what if I fall, I collapse there whilst on the way to get the file when they could have just given me the two Panados?
FA1	You guys don't have a primary setting, like there by us we've got a primary sister, Sister Anna, if I've got a headache, whatever problem she gives TTO immediately.
PA2	That's why I was citing an example to say...
FA1	[Inaudible 01:09:11].
PA2	She must have the office somewhere just to look after the staff. There's nothing like that.
FA1	Sister Anna makes sure from the pharmacy side there by primary healthcare everything is loaded and packed. So we go to Sister Anna for whatever.
PA2	No, bring your Sister Anna here.
PA3	Tell her to come this side.
FA1	You know, I think it's important. Because like you said, you actually started with that point and it really caught my mind then, we see so many people per day but we don't have a place whereby we can vent. And I think it's Richard Branson who says look after your employee and then they will look after your clients. Make sure they are happy. So I think it's really something that they need to look.

PA4	I'd also like just to see if something [inaudible 01:10:09] happens, and I was very traumatised a year back about a very serious mine accident and the way it was my responsibility to help. And, yes, in that moment you just go, the adrenalin is going, but afterwards when you break down there was no support. I would like to see just then that there is also debriefing for that sisters.
FA1	Yes, we're human beings.
PA4	Seeing then, also then to ICAS, make sure that they go and get help. Being there and, yes, sometimes it's not nice seeing the people that comes out and you are traumatised, but you must just go on. At that time, the accident happened 09:00 the morning, 13:00 I needed to be in a meeting.
FA1	Get back and everything.
PA3	And carry on.
PA4	And, yes, it was not nice for me.
FA1	At least to give the person off, to say this has happened, take the day off and relax and whatever.
PA4	Yes.
PA1	And follow up with that person to see are you okay, are you coping, are you good?

PA4	No, nobody ever asked me really afterwards, are you okay? Do you need to see somebody? Do you...? Maybe I'm just *pieperig*.
PA1	I think it's also management.
FA1	No, it's not, we're human beings.
PA2	It' really.
PA1	It's also management
FA1	I mean, you see terrible, we've seen a guy that from the mine as well, he was pulled in, he's at the conveyor belt. That guy was... So we nurses' but really, we've got feelings then to see a person like that. So it's...
PA4	We also got posttraumatic stress. We do have it. And, yes, we maybe know how to deal, but sometimes it gets to a point where we also don't cope anymore.
PA5	And then you become...
PA3	I think we are resilient, we are strong, we can take it.
PA5	You become another person at home. You change the personality, it just changes because, yes.

PA2	And you'll find most of us are on antidepressants not because we want, but because...
PA3	The circumstances.
PA2	Of the circumstances. For you to keep your calm then you need to take those things, but nobody sees that. They will only notice that something is wrong with you when you start...
FA1	Withdrawing.
PA2	And then they say, *haai, mevrou, is jy oraait?* And then you say, no, I'm not all right, but I cannot talk here. Unfortunately, I know the situation. So some of the things we cannot just talk about them, but they are a reality, to say I've seen this person breaking down and none of the management was there to say let me hold your hand. Instead they were saying, everybody is going through this, why does she want to be treated specially? But not taking into consideration that I can handle something but she can't.
FA1	But the next person not.
PA2	Yes.
PA4	Or maybe that person had handled so many times situations, isn't it time...
PA3	To break up.
PA4	To assist now, to see, okay, you could see something is wrong, but nobody did something.

PA3	And also the labelling part now. You'll be labelled, given a certain label or this one is, you know. You are like the weak link, yes, the weakest link or something. So some things you end up handling on your own and just sucking it up with a smile.
FA1	And we've learnt to pretend nicely. We come to work in the morning but nobody knows what's going on. And not even work-related stuff, think about we've got our problems at home as well. So you want to when you come to work and you're not feeling okay to at least, to a trustable.
PA1	If I can give a personal experience. Las year November my three-year-old fell from a two-storey building onto concrete onto her head, so it was disaster. And then I came back to work after three weeks just for a week because my mum and I were alternating to take leave because she had to be at home for two months. And the one afternoon I went to my boss and I said, you know what, I'm not coping, I need to be off work. She says, okay, so what's your plan? I said I'm going to see the doctor tomorrow morning. She asked what time? I said 09:00. And I explained the whole story to her I told her I'm not coping, I'm not sleeping. She says, but couldn't you make your appointment for 14:00? And I'm like, you know what, stuff you. This is where now I draw the line because clearly you're not listening to me. Henceforth I'll do as I please. So that's the type of attitude we are forced to develop. That was so insensitive, if I could, and your recorders are on, if I could *klap* her then I would *klap* her. That's my child. Couldn't you do it at 14:00 in the afternoon? No, darling, you can be glad I'm here at work now.
FA1	Yes, sometimes just an empathy. Think if it was your child, how would you have reacted?
PA2	Can I say something? That's why I start by laughing. You know, if I may be very straightforward, our manager when we started here, she didn't have kids. So for her to

	say, no man, you see that, it was very easy. And then she got pregnant and I went to her, I say welcome to the club. Then I say welcome to the club, from now onwards you'll know...
FA1	And understand.
PA2	Or you'll understand when I call you at 06:00 and say my child started getting sick from 02:00. And you know what, she's now a lovely person. She understands. Once you say my kid, I need to go and get him from school, he's been left by the bus, she'll just say, okay, it's fine. She's now the sweetest person. That I must say. Why? Because now she's in that situation.
FA1	Experiencing the same.
PA2	She's now experiencing that. So sometimes it takes a manager to be in your shoes for her to understand. If the manager is not married, you come here and you tell her the stories about your husband, this and this and this, she doesn't hear you.
FA1	Understand.
PA2	She can't see you, just like John Cena. But once she's there, then she start understanding. That is the story of our lives. It is like that, straightforward.
FA1	I think we've covered wellness, wellbeing. I'm just left with three questions. What in your view can be done to sustain resilience, hardiness and wellbeing amongst us nurses? To sustain it. I think we've mentioned all these things previously.
PA1	Just encouragement.

FA1	It is.
PA3	And support, recognition.
FA1	Recognition was on my top [inaudible 01:18:44]. I appreciate this, but.
PA2	Because when you talk about recognition, they will quickly bring you to say when I say thank you then that's part of recognition. Because to them when you say we want to be recognised, yes, moola is also one important thing, but not according to the management. Because we were saying, you know what, when this thing of recognition stated it was such a marvellous thing. Although we used to weigh it against what Sasol Mining was doing and what the rest of the Sasol were doing, it wasn't the same. When you went to Sasol Mining they were giving R5 000, this and this. When it comes to us, when they say they've recognised you, it's R200, maximum R230. And where does it go? In your pay. What happens to your tax? It goes up.
FA1	Yes, well, it's true.
PA2	And what happens to your net that month?
FA1	Less.
PA2	It goes down. So they should get another form of recognition. If and if possible, let us go back to the points where we used to get the cards.

FA1	Yes, that card. Bidvest.
PA2	The Bidvest. Because that was the most, nice thing that ever happened.
PA1	Even if it was R200, it stayed there.
PA2	It stayed there.
PA1	And it accumulated and was not taxed or anything.
PA2	Yes, so that would be one thing. Recognition, but a very good form of recognition. If needs be, let's go back to the basics.
FA1	What else? Recognition, yes.
PA2	Thanksgiving, just to say thank you.
FA1	Exactly.
PA2	Just to say thank you. Sometimes you just need to hear that, to see your senior manager coming here and saying, hey guys, well done, this month we've done this and this and this. Just like it's happening at the mines. At the mines every month somebody will say we managed to...

FA1	No injuries.
PA2	No injuries and this much of tons of coal, congratulations guys. And what do they get? We know it's not...
FA1	A thank you.
PA2	A thank you. And...
PA4	A braai.
PA2	A braai or a...
PA3	Chicken, Cokes, drinks.
PA2	Chicken or Coke. What do we get here? Nothing.
PA5	We only go out with our monies.
PA2	Yes.
PA5	To go and celebrate whatever.
PA3	We pay for ourselves.

PA5	We pay for ourselves.
PA1	Also for me to enhance management's leadership skills. I'm not talking about management skills, but to enhance leadership skills in the sense that if I've got a problem I need to feel comfortable enough if we haven't got these services to go to my manager. I don't even have respect for my manager anymore, it's lost, gone. It's one thing to be a manager, but it's a total ball game when you're a leader.
FA1	Exactly.
PA2	To add on that, our managers should be our role models. I should see them doing something good so that I can also follow. But if I see them getting to work at 07:45, are they going to tell me not to get to work at 07:45 in the near future? Never. So our managers must learn to be leaders.
PA5	By example.
PA2	And they should lead by example. So that when they reprimand me on something, then I say I'm sorry. But from what I've been seeing here, I'll be honest, with us at the mines, when they say we get to work at 07:00 we are there at 07:00.
FA1	Do you have to report here first and then go directly?
PA3	No, straight to the shafts.
PA2	No, but let it happen that you have to come here at the medical centre in the morning, you'll wait for your manager until 07:30, until 07:45 and then they come in. Then you start

	asking yourself, why do I have to be there at 07:00? And once you're not there at 07:00 you're going to get a call, hey, I went through your clocking system, you... But they are not doing that. So the request is the managers should lead by example. Especially when it comes to the clinic nurses, I can bet on my head, we are there. You can call at 07:00, you'll find us there. You can call at 15:40, you'll find us there. I came here one day, 15:30, the lights were off.
FA1	Dark city.
PA2	The lights were off. Then I called the person, I say I'm here, I brought your parcel. They said, ah, we went early today. Then I say don't say today, always. So what is happening at the clinics is not what we see happening here. But we never had the father figure, maybe that will change. But these other years it wasn't.
FA1	But the senior manager has started now *mos* recently?
PA2	Yes, he just started. So maybe we'll see something different. But you know what they usually say, their mind works faster than any other thing. If their minds are set up to say I'll be at work at 07:30, even with the new manager it can still continue. And it demoralises us, to say...
PA4	And what...
PA2	Oh, sorry.
PA4	No, what demoralises me is if I'm asking them for to go and look at the hockey match.

PA2	From 15:00.
PA4	Okay, just remember to put in the hour.
PA2	Yes.
PA4	But, yes. That's things that breaks me, really. Because then you will hear, ooh, I saw that and that in town in the morning.
FA1	Before coming to work.
PA4	Yes. But you must remember to put in your hour, please. That is tough.
FA1	No, at least my boss is not that strict.
PA3	Is it?
FA1	We can negotiate with him. I can't remember when last I opened ESS to put something, your hours or, no. Okay, guys, second last question. What support systems have the nurses received to enhance? Can you think of anything? If there is, we can name, if there is nothing, then... To enhance resilience, hardiness and wellbeing.
PA1	Other than ourselves and our colleagues helping us through, I can't think of any.

PA3	I can't recall.
FA1	There's no team building, nothing where they send you off for the day?
PA2	Oh, the only important thing from the clinic side is that we have the monthly meetings. So that usually, it has groomed us from where we used to be, the monthly meetings. Because that is where sometimes we just sit and just fire shots and then we get everything according to how we want it to be. Otherwise...
FA1	These will be once a month?
PA2	Yes, at least. Because we cannot have frequent meetings because of our obligations at the mine.
FA1	And then Fridays at the mines, is it also closed? Like here Fridays they say they don't do medical surveillance, they do admin.
PA1	No.
FA1	So you see Monday to Friday?
PA2	Monday to Friday. For us it's Monday to Friday.
PA3	Yes, Friday 07:00 till 13:00. [Makhulu? 01:27:40] offs you are at work.

PA2	So that is the only thing.
PA3	Makhulu offs, it's when the mines are having their long weekend.
FA1	Yes, we also have. Yes.
PA3	But as nurses we work.
FA1	Are you serious? Because the sister at the mine there by us, when it's makhulu off then the person doesn't even go to the mine, then he's there with us the whole day.
PA2	Are you going?
PA4	Hm?
PA2	Are you going off during your makhulu off?
PA4	I'm at work.
PA2	Okay.
FA1	I just wanted to make sure.
PA4	I mean, we've got work. *Stoksielalleen*, but *ek is daar*.

FA1	So there's nothing that you can say that, support systems?
PA1	No.
PA2	No.
FA1	So in your opinion, what do you think they can offer? Team buildings, [inaudible 01:28:27], at last the beginning of the year. Team buildings, I think it's very, very important, at least twice a year. January when we open, then we say the groups for... Other companies are doing it a weekend or sometimes one day the whole day.
PA3	Yes, I know the mines have team building sections every Mondays. They go away from work, they go to Sasol Club, sit there the whole day and fire whatever needs to be fired and bandage each other, come back to work and work, implement the changes.
FA1	What else can we ask from them? I was thinking of team buildings. It's crucial. To break away at least.
PA2	Celebrating the nurses' day.
FA1	Nurses' day celebration.
PA2	Yes. Women's day. Mother's day. I mean, we are mothers, but nobody sees that.

PA1	They celebrate that in the plant because in the plant they give, for every mother's day or women's day they give the ladies things who are mothers and things like that. But here amongst the nurses, nothing.
FA1	The nurses there's nothing.
PA2	So what I can say in short is these things that we are suggesting here, like the team buildings, the celebrations, we see them at the mines. So as we're working at the mines, when it's mother's day I would get a package, but nothing from the medical centre. When it's women's day you'll get a package, when...
FA1	But from the mine's side.
PA2	From the mines, not from the medical centre itself.
FA1	Management.
PA2	From management from medical centre. So maybe if they can adopt that style it will lift, boost our morale energy a bit. But now the thing is you'll be told about cost containment.
PA1	Budget, it's not on the budget.
PA2	It's not on the budget. But then as it is now we're making suggestions, we're putting the budget aside and then we just say we would be glad to see one, two, three.

FA1	And this support systems, like the one that I've mentioned now, team building and the other things, how often do you think we can ask them to? I was thinking twice a year, the beginning and then midyear, July.
PA4	And they must budget for it that we don't pay it out of our own pockets.
PA2	Twice a year.
FA1	Twice a year at least. And you guys are happy with the monthly meeting, not like at least every second?
PA2	No, we're happy with the monthly meeting.
FA1	With the monthly meeting to come.
PA3	Yes, the reason for me, it's because we are so far away from each other, we hardly see each other and it also forms part of socialising.
FA1	I was also thinking of that, yes.
PA2	But the monthly meeting...
FA1	It's all right?
PA3	With the monthly meeting it's fine.

PA2	Yes, it's fine, it's working. It's really working. And they were mentioning the support from ourselves. Because we've noticed that there's nothing that we get from management. If it's somebody's birthday then we give something. And then we used to have a party with some cakes and that was also something.
FA1	Interesting.
PA2	It was really something. And...
FA1	So you...
PA2	Oh, sorry. The other thing that they've done away with, and I questioned it and nobody could give me an answer, if it was her birthday we would get an e-mail saying happy birthday Portia, happy birthday whoever it is. That has stopped and nobody told us where it has vanished into. Then when I tried to find out, then they said, no, but so and so was supposed to send out the messages and she's no more doing the messages. Then the other thing is she gets a new-born baby, because she's a friend of somebody then all of a sudden everybody needs to know. If it's her, you won't even know.
FA1	But if it's a birthday...
PA3	It's quiet.
FA1	No consistency.
PA2	So, yes, there should be consistency. If they do something, let it be done for everybody. Because at the end of the day we regarded ourselves as the mining clinic nurses. We

	didn't regard ourselves as part of the medical centre and they started moaning. But we made it clear that we are not part. And we would just sabotage anything. They say meeting, we don't come. They say this and this, we don't come. Up until somebody came to us and said, guys, you are part of us. We said, but you didn't make us feel part of you. So, yes, communication, very important.
FA1	Very crucial. Is it everything, ladies?
PA3	Yes.
PA2	Yes.
FA1	I think we've covered everything. Before I switch off the recorders, really from my side, thank you so, so, so much. I know we've been sitting here for more than an hour and I know it's hard to sit for a full hour without any breaks. So ladies, really, from your side, thank you so, so much. You know, it's my first time. I was saying to the group on the other side, is it possible, please, organise a trip to Secunda so that all of us one Friday come and meet our colleagues this side or let's organise for them to come and visit. So it's really nice to... So when I go back on Monday I'm going to tell them that I actually had a good time with my colleagues on the other side. So once again, I really appreciate it. I'm going to give you feedback by the end of the year and just explain everything what happened and then I'll even give you the records and everything. So thank you, thank you, thank you so much. I don't know whether Nella want to say something?

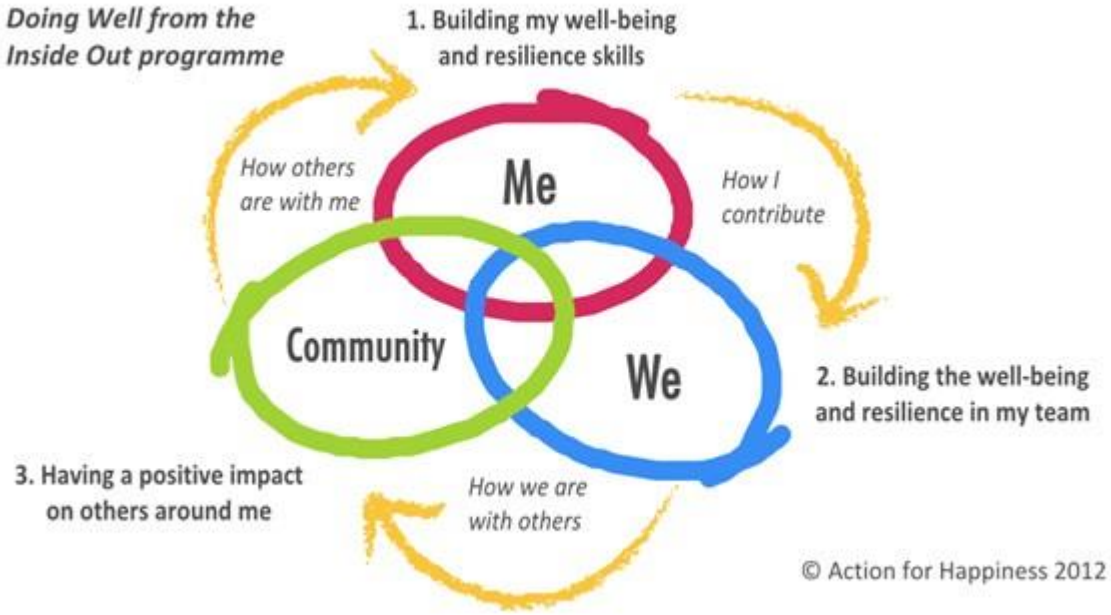
FA2	I just made a few notes, but just of part, but just if you can, just for some clarity or if there's something that I missed. I just wrote here, first one was HR. Then it was the Sasol Cares gifts are not good quality. School bags are not school specific. There's a lack of communication with Sasol Med. It's one of the best but yet one of the most expensive and there's no option. Incentive bonusses are taxed. You're not given an option to divide it over a few months so that when you do get it you pay less tax. The nurses, as I said, who do they consult? Appreciation. It's not a favour, they've earned their way. Recognition for their qualifications. Because, I mean, everybody gets recognised for their qualifications, why can't you get recognised? Wi-Fi, enabling nurses to work outside of their offices. The challenges. Lack of support. There's not assistants. They need a second pair of hands. Could become detrimental in the long run. It's set up for one person to be assisted per time. What happens if there's more than one? Who actually takes responsibility for that? Let's say where you are five comes in and according to you help the first one, but yet the fourth one is in a worse condition. Who then takes responsibility? Do they say that you didn't check or how does that work?
PA1	If the five come in at the same time we'll prioritise.
PA3	We can triage.
FA2	Let's say it's just Novak. Let's say she's busy because she's the only one. She's busy with the first person. So while she's busy with the first person, the fourth person's condition is actually worse. What happens in a case like that? Do they...?
PA3	Triage.

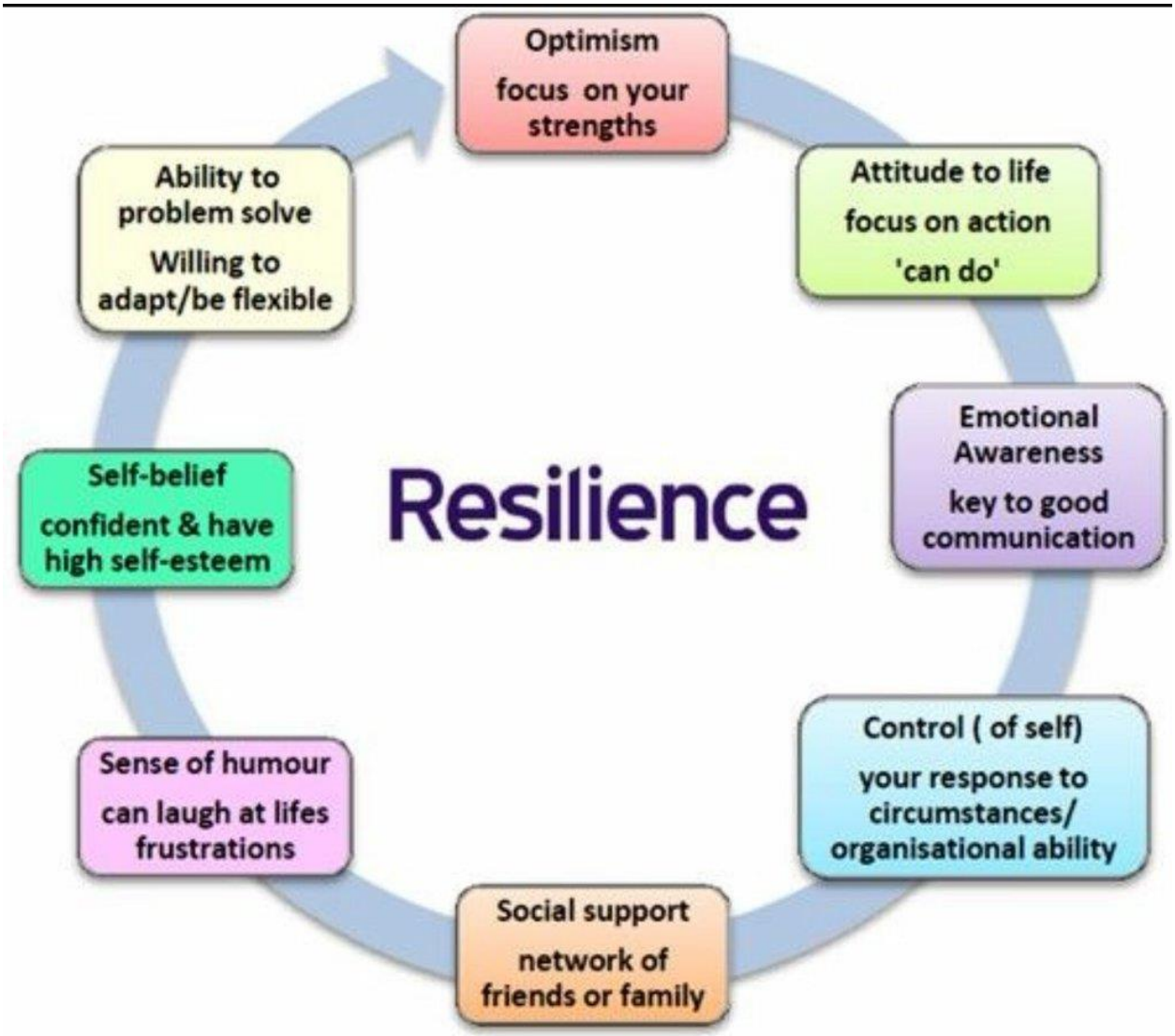
PA1	You prioritise.
FA2	Is it? So then she leaves the first person...
PA1	Yes.
PA3	Yes.
FA2	And then you go to the fourth person?
PA1	Yes.
FA2	And then while you leave the first person, you go to the fourth person, the first person becomes worse. Then you just hope and pray nothing happens.
PA1	Yes. You just pray very hard.
PA3	Yes, you just walk on thin ice then.
FA2	[Yes, they're keeping you prayerful.
FA1	I think at least two per shaft.

FA2	And it says set up for one person to be assisted per time. Okay, what happens if there's more? There's no relief, no assistants. For big and far-away mines [inaudible 01:37:56] is needed.
FA1	Guys, thank you once again so, so, so much. We're just going to take a tea break now, then we're going to get the second group. But please, please, humbly [inaudible 01:38:12]. So we're going to collect, yes, Nella's going to take these, the biographical data and then the informed. It's signed, ladies? Remember, on the biographical data list no names, it's anonymous. Remember, I said these things are not going to management. These are going to the university and they're just going to do the coding and everything. So once again, thank you, thank you, thank you.
PA1	Have you got one?
PA2	Yes, I've got.
FA1	There's the participation declaration [inaudible 01:38:45]. Yes, this is right. Only this form has to be signed, ladies. Is this one signed? Did you sign this bit? Okay, Nella will, I'm not supposed to take it. Let me just switch it off. Maybe non-Caucasian. Caucasian is white. So we're non-Caucasian.

APPENDIX J: INFORMATION LEAFLET ISSUED AT INFORMATION SESSION


10 Tips
to Boost Resilience
Communicate regularly and effectively.
Maintain positive and personal connections.
Avoid seeing a crisis as unconquerable.
Be accepting of change.
Move toward your goals.
Take positive, decisive actions.
Look for opportunities for self-discovery.
Keep things in perspective.
Nurture a positive view of yourself.
Look to a hopeful future.


Doing Well from the Inside Out programme
1. Building my well-being and resilience skills
How others are with me
Me
How I contribute
Community
We
2. Building the well-being and resilience in my team
3. Having a positive impact on others around me
How we are with others
© Action for Happiness 2012


Optimism
focus on your strengths
Attitude to life
focus on action
'can do'
Emotional Awareness
key to good communication
Control (of self)
your response to circumstances/ organisational ability
Social support
network of friends or family
Sense of humour
can laugh at lifes frustrations
Self-belief
confident & have high self-esteem
Ability to problem solve
Willing to adapt/be flexible
Resilience

What is mental wellbeing?

- Mental wellbeing is about how feeling positive about ourselves as individuals, our work and our relationships, all interact (see Glossary)
- For most people, finding a good balance in our lives helps to sustain our wellbeing
- And is part of our identity

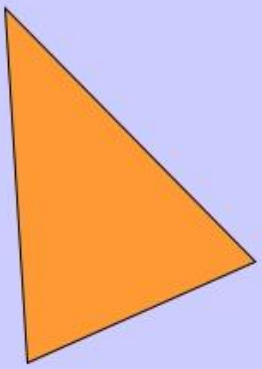
Building resilience:

- Involves identifying strengths and capacity
- Using these to deal with setbacks in life
- Adapting to change and facing adversity

12

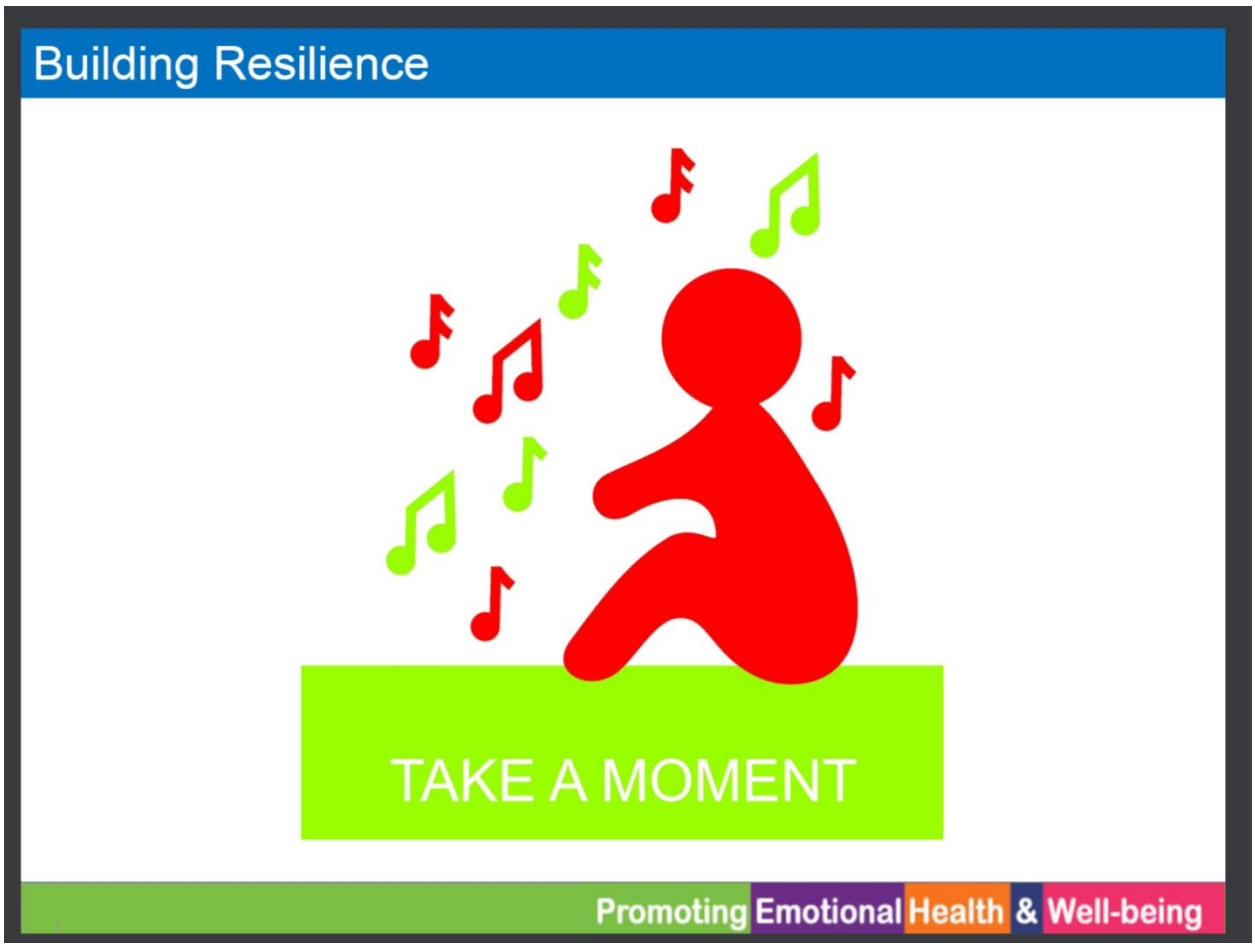
Terms such as 'mental wellbeing', 'resilience' and 'wellbeing' are used interchangeably

Emotional Health



Emotional health is expressing your emotions in a positive, nondestructive way.


BETTER BRAND IMAGE
HIGHER PRODUCTIVITY
BETTER ENGAGEMENT
BETTER ATTENDANCE
BETTER RETENTION & RECRUITMENT
KEEP LEARNING
CONNECT WITH OTHERS
GIVE/VOLUNTEER
TAKE NOTICE
BE ACTIVE
BETTER PHYSICAL & PSYCHOLOGICAL HEALTH
Create an environment that promotes healthy behaviours
BETTER WORK**
Create a happy & engaging work environment
WORKING WELL
BETTER SPECIALIST SUPPORT
Provide interventions to manage health and wellbeing
BETTER RELATIONSHIPS
Promote communications and social connections


Building Resilience
TAKE A MOMENT
Promoting Emotional Health & Well-being

Building Resilience

The way we are feeling affects our wellbeing

When Skipper is safe, healthy, achieving, nurtured, active, respected, responsible and included he feels emotionally, socially and physically well.

However when one of these areas is not going well, he can feel down

Promoting Emotional Health & Well-being

Why is mental health and wellbeing important?

- Healthier lifestyles
- Better physical health
- Improved recovery from illness
- Fewer limitations in daily living
- Higher educational attainment
- Greater productivity
- Greater employment and earnings
- Better relationships
- Increased social cohesion
- **Improved quality of life.**

cumlaude
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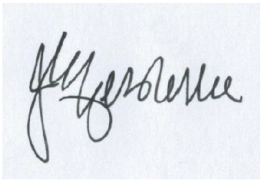
DECLARATION OF LANGUAGE EDITING

I, Juan Etienne Terblanche, hereby declare that I edited the MSc dissertation entitled

Exploring the perceptions of occupational health care nurses about support systems to enhance their own resilience, hardiness and well-being

for Y. Fox for the purpose of submission as a postgraduate research degree. Changes were indicated in track changes and implementation was left to the author.

Regards,



Prof. J. E. Terblanche

Cum Laude Language Practitioners (CC)