

Factors influencing the compliance of enrolled nurses with procedural guidelines during patient care

DMV Msimanga

23905034

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Supervisor: Dr AC van Graan

Co-supervisor: Dr B Scrooby

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PREFACE AND DECLARATION

An article format was chosen for this study. The researcher, Mrs DMV Msimanga, conducted the research and compiled the manuscript. Dr AC van Graan (supervisor) and Dr B Scrooby (co-supervisor) acted as auditors. One manuscript has been compiled and submitted for publication in a South African Journal (Health SA Gesondheid) as follows:

MANUSCRIPT: Factors influencing the compliance of EN's with procedural guidelines during patient care.

Consent to submit the above-mentioned article (manuscript) for examination was obtained from Dr AC van Graan and Dr B Scrooby (co-authors).

I solemnly declare that this dissertation, entitled, *Factors influencing the compliance of EN's with procedural guidelines during patient care* presents the work carried out by myself and does not contain any material written by another person except where due reference is made. I declare that all the sources used or quoted in this study are acknowledged in the bibliography, that the study has been approved by the Health Research Ethics Committee of North-West University, Potchefstroom Campus (NWU HREC-00157-13-S1) (see Annexure 1) and that I have complied with the ethical standards set by the institution.

DMV Msimanga (Student number: 23905034)

Date 17th February 2016



DEDICATION

This dissertation is to the glory of God. I dedicate to the following people:

- My late father, for the way he influenced me to continue my education and urged me to understand patient care and needs. Dad, academically, I have achieved more than you, as I promised.
- My mother, for the unwavering support she gave me throughout this journey. I love you, you made impossibilities, possible.
- My family members and motivators. Abuti Danny le Nthabi, I could not have done this if you never persuaded me.
- My children. I left you alone and at times, not giving you the attention you needed, but you understood and supported me always, thank you, mummy loves you.
- My fellow friends and colleagues. If I could do it and make it through, so can you.



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Above all, praises and thanks giving to God, my Shelter and my Almighty, for being with me everywhere.



PERMISSION LETTER

Permission is hereby given that the following manuscript:

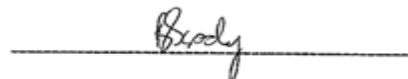
Factors influencing the compliance of EN's with procedural guidelines during patient care,

Intended for publication in "Health SA Gesondheid", may be submitted by Dimakatso Vivienne Msimanga for the purpose of obtaining a M. Cur degree (Health Science Education)



Supervisor: Dr AC van Graan

Date: 17 February 2016



Co-supervisor: Dr B Scrooby

Date: 17 February 2016



ABSTRACT

Background: The Free State Department of Health envisions a long and healthy life for all South Africans as one of its goals. To achieve this, the department prioritised the improvement of patient care as a means to effectively strengthen the health system, but the media still often reports unexpected poor clinical services or patient outcomes. Patient care at public institutions follows a multi-disciplinary approach rendered by trained personnel. Within this system, nurses offer their services round the clock, and as such nursing actions are the most identifiable causes of any unforeseen outcomes. The aim of this study was to explore and describe factors that influence compliance of enrolled nurses (EN's) to the procedural guidelines during patient care and to formulate recommendations towards promoting compliance to the procedural guidelines during patient care.

Method: An explorative, descriptive, contextual qualitative design was used. The sample included EN's in the Thabo Mofutsanyana district of the Eastern Free State from public clinics and hospitals who had recently qualified for enrolment (2008-2012). Data was collected by means of four (4) focus groups with n=34 participants. Data analysis was done by the researcher and an independent co-coder according to the principles of content analysis.

Results: Seven themes with subsequent sub-themes emerged to explain non-compliance to procedural guidelines during patient care. All the focus groups agreed that non-compliance is influenced by factors such as lack of resources and support.

Conclusion: Nurses are still visibly committed and willing to render their services, though circumstances impede them and keep them from demonstrating their competencies. Recommendations and conclusive statements serve as the basis for recommendations to the Free State Health Department so that they can attain their departmental goal, to NEI's and to nurses in practice.

Key words: non-compliance, attitude, enrolled nurses and clinical practice, multi-skills setting, patient care,

OPSOMMING

Agtergrond: Die Vrystaatse Departement van Gesondheid stel 'n lang en gesonde lewe vir alle Suid-Afrikaners in die vooruitsig as een van die departement se doelwitte. Ten einde hierdie doelwit te bereik, het die departement die verbetering van pasiëntsorg geprioritiseer as 'n manier om die gesondheidsstelsel effektief te versterk. Tog rapporteer die media steeds gereeld swak kliniese dienste en pasiëntuitkomst. Pasiëntsorg by openbare instellings is gebaseer op 'n multi-dissiplinêre benadering wat deur opgeleide personeel uitgevoer word. Binne hierdie stelsel lewer verpleegkundiges 24-uur dienste, en as sodanig is verpleegaksies gewoonlik die mees identifiseerbare oorsake van swak uitkomst. Die doelwit van die studie was om die faktore wat die nakoming van die prosedure riglyne deur ingeskreweverpleegsters belemmer, te ondersoek en te beskryf en om aanbevelings te formuleer om nakoming van prosedurele riglyne gedurende pasiëntsorg te bevorder.

Metode: Die studie het 'n ondersoekende, beskrywende, kontekstuele kwalitatiewe ontwerp gevolg. Die steekproef het ingeskrewe verpleegkundiges wat onlangs (2008-2012) gekwalifiseer het vir inskrywing uit die Thabo Mofutsanyana distrik van die Oos-Vrystaat by openbare klinieke en hospitale ingesluit. Data is ingesamel deur middel van vier (4) fokusgroepe met $n=34$ deelnemers. Data-analise is uitgevoer deur die navorser en 'n onafhanklike mede-kodeerder volgens die beginsels van inhoudsanalise.

Resultate: Sewe temas met sub-temas het na vore gekom as verklarings vir die nie-nakoming van prosedurele riglyne gedurende pasiëntsorg. Al die fokusgroepe het saamgestem dat nie-nakoming beïnvloed word deur faktore soos die gebrek aan hulpbronne en ondersteuning.

Gevolgtrekking: Verpleegkundiges is steeds sigbaar toegewyd en gewillig om hulle dienste te lewer, alhoewel omstandighede hulle verhinder daarvan om hulle bevoegdhede ten volle uit te leef. Aanbevelings en samevattende opmerkings dien as die basis vir aanbevelings aan die Vrystaatse Departement van Gesondheid sodat hulle hulle departementele doelwit kan bereik, aan verpleegopleidingsinstellings en aan verpleegkundiges in die praktyk.

Sleutelwoorde: nie-nakoming, houding, ingeskrewe verpleegkundiges en kliniese praktyk, multi-vaardigheidssituasie, pasiëntsorg, prosedurele riglyne

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APP	Annual Performance Plan
CEO	Chief Executive Officer
CPD	Continuous Professional Development
DoH	Department of Health
EFS	Eastern Free State
EN	Enrolled Nurse
ENA	Enrolled Nursing Auxiliary
FSDoH	Free State Department of Health
MDMNH	Mosby's Dictionary of Medicine, Nursing and Health Professions
MEC	Member of Executive Council
HIV	Human Immunodeficiency Virus
NEI	Nursing Education Institution
NSDA	Negotiated Service Delivery Agreement
OALD	Oxford Advanced Learner's Dictionary
OSD	Occupation-specific dispensation
PHC	Primary Health Care
SA	South Africa
SANC	South African Nursing Council
UK	United Kingdom
WIL	Work-integrated learning
WHO	World Health Organization

TABLE OF CONTENTS

PREFACE AND DECLARATION.....	I
DEDICATION	III
ACKNOWLEDGEMENTS	IV
ABSTRACT	VI
OPSOMMING	VII
LIST OF ACRONYMS.....	VIII
LIST OF ANNEXURES	XIV
LIST OF TABLES	xiv
SECTION 1: OVERVIEW OF THE STUDY.....	1
1.1 BACKGROUND AND OVERVIEW OF THE STUDY	1
1.2 PROBLEM STATEMENT.....	8
1.3 RESEARCH AIM.....	9
1.4 RESEARCH OBJECTIVES.....	9
1.5 RESEARCH PARADIGM.....	10
1.5.1 Meta-theoretical assumptions	10
1.5.1.1 Human beings	11
1.5.1.2 Health	12
1.5.1.3 Environment	12

1.5.1.4	Nursing	13
1.5.2	Theoretical assumptions.....	14
1.5.2.1	Central theoretical argument	14
1.5.2.2	Concept clarification	15
1.5.3	Methodological assumptions	17
1.6	RESEARCH METHODOLOGY	18
1.6.1	Research design.....	19
1.6.1.1	Qualitative.....	19
1.6.1.2	Explorative and descriptive.....	19
1.6.1.3	Contextual.....	20
1.7	RESEARCH METHOD	20
1.7.1	Population	20
1.7.2	Sample	22
1.7.3	Sample size	22
1.8	DATA COLLECTION	24
1.8.1	Methods of data collection.....	25
1.8.1.1	Focus group interviews.....	25
1.8.1.2	Trial run	27

1.8.1.3	Field notes	29
1.8.2	Setting	31
1.9	DATA ANALYSIS	33
1.10	LITERATURE INTEGRATION	35
1.11	ETHICAL CONSIDERATIONS	36
1.11.1	Principle of respect	38
1.11.2	Principle of beneficence	39
1.11.3	Principle of justice.....	40
1.12	TRUSTWORTHINESS	41
1.12.1	Truth value	41
1.12.2	Neutrality	42
1.12.3	Consistency	43
1.12.4	Applicability	44
1.13	DISSEMINATION PLAN	44
1.14	REPORT OUTLINE.....	45
1.15	CONCLUSION	46
SECTION 2:	MANUSCRIPT	47
	Author Guidelines –HSAG	49

ABSTRACT	66
OPSOMMING	67
INTRODUCTION	68
Focus and background of the study	68
Problem statement	71
Research aim and outcomes	72
RESEARCH DESIGN	72
Research approach	73
Research methods	73
Data collection and recording methods	73
Data analysis	77
Ethical considerations	77
FINDINGS AND DISCUSSIONS	79
Theme 1-4: Factors influencing compliance with procedural guidelines during patient care	80
Theme 5-7: Recommendations to comply with procedural guidelines	91
CONCLUSIONS AND RECOMMENDATIONS	97
Recommendations for nursing practice	97
Recommendations for Nursing Education	97
Recommended Nursing Research	97
Limitations of the study	98
CONCLUSION	99

**SECTION 3: EVALUATION OF THE RESEARCH STUDY, LIMITATIONS AND
RECOMMENDATIONS FOR RESEARCH, NURSING**

	EDUCATION AND NURSING PRACTICE.	108
3.1	INTRODUCTION	108
3.2	CONCLUSION	108
3.2.1	Conclusion statement for Theme 1-4: Identified factors	108
3.2.2	Conclusion statement for Theme 5-7: Forwarded recommendations	109
3.3	RECOMMENDATIONS TO NURSING PRACTICE, NURSING EDUCATION AND NURSING RESEARCH.....	109
3.3.1	Recommendations for nursing practice	109
3.3.2	Recommendations for nursing education	111
3.3.3	Recommendations for nursing research.....	112
3.4	EVALUATION OF THE STUDY	112
3.5	LIMITATIONS OF THE STUDY	113
3.6	SUMMARY	114
	REFERENCE LIST FOR SECTIONS 1 AND 3	116

LIST OF ANNEXURES

ANNEXURE: 1:	ETHICAL APPROVAL FROM THE NORTH-WEST UNIVERSITY	124
ANNEXURE: 2:	APPROVAL FROM THE RESEARCH COMMITTEE: FACULTY OF HEALTH SCIENCES AFTER REQUEST FOR TITLE REVISION AND CHANGE	125
ANNEXURE: 3:	REQUEST FOR PERMISSION (FSDoH)	126
ANNEXURE: 4:	INFORMATION LEAFLET	128
ANNEXURE: 5:	INFORMED CONSENT FORM FOR FOCUS GROUP PARTICIPATION	131
ANNEXURE: 6:	PERMISSION FROM THE (FSDoH).....	132
ANNEXURE: 7:	REQUEST FOR PERMISSION (EFS PUBLIC HOSPITAL INSTITUTION)	133
ANNEXURE: 8:	APPROVAL FROM DIHLABENG REGIONAL HOSPITAL.....	135
ANNEXURE: 9:	REQUEST FOR PERMISSION (EFS PUBLIC PRIMARY HEALTH CARE INSTITUTION)	136
ANNEXURE: 10:	APPROVAL FROM PHC	138
ANNEXURE: 11:	INTERVIEW TRANSCRIPTS (FOCUS GROUP).....	141
ANNEXURE: 12:	FIELD NOTES	173

LIST OF TABLES

Table 1-1:	EN's-population ratio (SANC, 2008 & 2012).....	6
Table 1-2:	Sampling frame	23

SECTION 1:
OVERVIEW OF THE STUDY



SECTION:1

OVERVIEW OF THE STUDY

1.1 BACKGROUND AND OVERVIEW OF THE STUDY

In the current South African setting, the media often reports that a patient who had been admitted for a simple diagnostic procedure or a normal delivery in a public hospital unexpectedly had to be admitted to an intensive care unit or had died (South African Human Rights Watch, 2011:1-4; Malan, 2015:1-5). The families of patients often attribute this unexpected outcome to poor clinical services. Khalane (2013:2) has accentuated that this issue of poor service delivery at public hospitals is widespread and is not a problem that is limited to one district. Dr B Malakoane, the Free State Member of Executive Council (MEC) for Health, confirmed this state of affairs during his unexpected visit to public health facilities (Moloi, 2013:2-3). This situation is also emphasised by the public comment made by the Lusikisiki community in the Eastern Cape about poor care at public institutions (Stuurman, 2013:4; Mapumulo, 2013:10).

The above-mentioned complaints led the Department of Health (DoH) to address the state of nursing in South Africa. Following the Nursing Strategy Conference in 2008, a turnaround strategy was formulated to focus on the main issues that have impacted service delivery and to establish if nursing care is rendered as expected, and if not, why not? (Department of Health, 2008:8).

Patients depend on nurses who deliver 24-hour services for care. For the purpose of this study, a nurse is defined as someone who has been specially trained in the scientific basis of nursing and who meets certain prescribed standards of education and

clinical competence to care for the sick (Oxford Advanced Learner's Dictionary (OALD), 2006:1002; and Mosby's Dictionary of Medicine, Nursing and Health Professions (MDMNH), 2013:1246). In South Africa, nursing training is provided by nursing education institutions (NEI's) that are accredited and approved by the South African Nursing Council (SANC). SANC is the statutory body that determines the duration of training, provides the training guidelines relating to the scope of practice and issues certificates to competent nurses who had been enrolled in terms of the Nursing Act, 2005 (Act No. 33 of 2005) on completion of their training.

Training in the nursing profession requires both theoretical and practical competency (SANC, R.2175 of 19 November 1993)(SANC, 1993b). Candidates should be prepared for examinations following the said statutory body's guidelines. This study focuses specifically on enrolled nurses (EN's). Regulation R.2175 of 19 November 1993 stipulates the course regulations leading to enrolment as a nurse and states that during training, pupil nurses are placed in clinical areas for work-integrated learning experience (WIL) as part of their practical training, preparing them for clinical competency. The above-mentioned regulation further states that clinical exposure takes up the larger part of the allocated 2000 clinical hours to assure competence on completion of the training course. Regulation R.7 of 8 January 1993 (SANC, 1993c) regarding the examinations of the South African Nursing Council stipulates that for candidates to pass and be enrolled as a nurse, they need an average mark of 50% for both the theoretical and practical examination. Only those candidates who are deemed competent according the scope of practice will be enrolled as a nurse and released to practice.

In an effort to cultivate competence, nursing educators clinically accompany nurses during a structured process to provide assistance and support to the student nurses in the clinical facility to ensure that they achieve the programme outcomes (SANC, R.171

of 8 March 2013)(SANC, 2013). During accompaniment learners are also trained to be concerned, compassionate, competent and comprehensive nurse practitioners (Searle, 2006:143). Despite the comprehensive training offered, the question remains whether this training is sufficient for job practicalities and to nurture competence. According to Calman (2006:412) and Smith (2012:175), competence is defined “as a learned ability to practice adequately, safely and effectively without the need for direct supervision”. Teodorescu (2006:27) and Smith (2012:175) have added that students should gain knowledge, skills, and values (attitudes) and then practise it during work integrated learning.

In order to understand the perception of a competent nurse from the patient’s perspective as the recipient of care, Calman (2006:413) has explored patients’ views of nurses’ competence by interviewing 27 Scottish patients. The interviewed patients failed to give a definite explanation of a competent nurse. However, they listed their personal expectations of the behaviour of a nurse who renders patients with care. This included having communication skills and dedication, as well as being friendly and kind. However, Calman (2006:415) has also indicated limitations in her study. She observed anxiety and difficulty when questioning the trust patients had in nurses. The conclusion of the critical analysis of findings is that patients’ responses may have been biased as patients were in fear of hurting the feelings of the nurses they still needed. No current studies were obtained on patient expectations of a competent nurse except Lee and Yom (2006:549) who outlined that patients’ expectations on the other hand is perceived to include reliability, empathetic and responsive nurses, meaning being there when needed.

Higgins *et al.* (2010:499-508) have conducted a review to explore the experiences of the newly qualified nurses in the United Kingdom (UK). The experience of stress during

the transition from being a pupil nurse to a qualified EN was one of the main findings (Higgins *et al.*, 2010:501). The study identified an increase in personal and professional development, as well as a feeling of being inadequately prepared for the new role and a lack of support once qualified (Higgins *et al.*, 2010:501). Shortage of nurses especially in public institutions has been a topic of a while (Saari & Jugde, 2004:404) and (George *et al.*, 2013:7). Unfortunately it has brought increased burn out and workload to nurses (MacKusick and Minick, 2010: 337; Delobelle *et al.*, 2010:378) and government interventions of skillmix was the option to address the above problems as piloted in the Free State province and is continued though no feedback is yet published on its effectiveness.

According to Jooste and Jasper (2012:59) who assessed current position and challenges in health service management and education in nursing ,skill mix has compromised patient care as time spend is reduced and this was supported by Westbrook (2011:8) that, as observed during an observational study of time management, time spend with patients accounted to 37% (Westbrook *et al*, 2011:3).

Kekana *et al.* (2007:24-35) have highlighted factors such as heavy workload, including the pressure under which nurses work, a lack of support and supervision, poor pay and fringe benefits, as well as a lack of opportunity to be included in improving the work methods in hospitals. The above was also identified by more than 60% of the study participants in this study as dissatisfying components. The allocation of a reasonable workload and greater support from management in maintaining good interpersonal skills were the recommendations forwarded (Kekana *et al.*, 2007:34). Job dissatisfaction, inadequate remuneration, poor working conditions, excessive workload and lack of personal growth are some of the negative factors as identified by South African nurses. As a result, some emigrate to other countries according to Oosthuizen and Ehlers

(2007:14). Unfortunately, emigration plunged South Africa into a greater nursing shortage (Joubert, 2009:19).

Furthermore, Wildschut and Mqolozana (2008:1-82) have conducted a case study on South African nurses to determine whether the nursing shortage was relative or absolute. They concluded that the poor distribution of nurses in certain provinces (between rural and urban areas, and between the private and public sector in certain provinces) rather than staff shortage is a cause for concern. They found the patient-nurse ratio of 1:336 in 2005 (Wildschut & Mqolozana, 2008:61) and 1:208 in 2012 (SANC, 2012) to be far removed from the minimum standard norm of 200 nurses per 100 000 population as recommended by the World Health Organization (WHO) (Wildschut & Mqolozana, 2008:61; Joubert, 2009:3). Despite this report, Joubert (2009:19) has insisted that South Africa indeed has a shortage of nurses and states that it is not adequate to concentrate on the patient-nurse ratio, but that the complexity of each nursing task should be considered as well, since the disease burden is increasing and more people are becoming dependent on hospitals, consequently adding to the workload. Joubert (2009:19) has further accentuated that the South African Health Department should create a more satisfying work environment and each hospital should implement its own ratios voluntarily. Welton (2007:1) has also emphasised the voluntary option as he claims that the mandatory nurse-to-patient staffing ratio may exacerbate rather than correct the imbalance between patient needs and available nursing resources. The above-mentioned findings are relevant to this study as these factors can possibly influence the lack of competence and comprehension of procedural guidelines of newly qualified EN's.

Statistics, as seen in Table 1.1, indicate a shortage of EN's according to the geographic nurse-population ratio for all provinces (SANC, 2008 and 2012 geographic population ratio).

Table 1-1: Enrolled nurses-population ratio (SANC, 2008 & 2012)

Province	Category	2008 nurse-population ratio	2012 nurse-population ratio
Limpopo	EN's	1:1649	1:1060
North West	EN's	1:1566	1:1269
Mpumalanga	EN's	1:2024	1:1514
Gauteng	EN's	1:944	1:848
Free State	EN's	1:1911	1:1393
KwaZulu-Natal	EN's	1:639	1:489
Northern Cape	EN's	1:2588	1:2541
Western Cape	EN's	1:1062	1:988
Eastern Cape	EN's	1:2396	1:1486
TOTAL	EN's	1:1114	1:882

These statistics include EN's both in private and public institutions. It should also be noted that the SANC register does not provide the actual statistical number of nurses in practice because many nurses are still registered and/or enrolled even when they are out of the country or not currently practicing (Subedar, 2005:89).

The above figures forced the government to formulate a comprehensive approach to address the challenges faced by the nursing profession and the country at large. A nursing strategy conference was held by the Department of Health to address the state of nursing in South Africa (Department of Health, 2008:8). Following the nursing strategy conference, the Minister of Health, Dr A Motsoaledi, signed a negotiated

service delivery agreement (NSDA) with President Zuma during 2010, which prioritised the four health care outputs as follows: increasing life expectancy; reduction of maternal and child mortality rates, combating Human Immuno deficiency Virus (HIV) and Acquired Immuno deficiency Syndrome (AIDS); decreasing the burden of disease from tuberculosis and strengthening the effectiveness of health systems by 2015. The four envisioned outputs aim to provide a better quality of life, to increase the safety of patients and to advise on indicators for a NSDA for the period 2010-2014 (Department of Health, 2012a:11).

Following the NSDA's goal to increase the life expectancy of people, the Free State Department of Health (FSDoH) instructed its health facilities to conduct patient satisfaction and staff attitude surveys. The purpose of conducting these surveys was for employers to obtain valuable feedback from their staff that will assist management to focus on those issues that negatively impact on productivity, performance and profitability (FSDoH, 2012). The result of the surveys indicated that staff shortage is still a challenge. Staff shortage in South Africa was addressed in a threefold manner: occupational-specific dispensation (OSD), a skills mix model and training of more nurses. The above is explained as follows:

- Firstly, the government introduced an OSD in 2007 with its implementation roll-out starting with nurses. OSD was introduced as an integrated career development plan comprising remuneration and career progression (Department of Health, 2008:3).
- Secondly, skills mix is presently being piloted in the Bongani Hospital for the Free State Province. According to Buchan and Dal Poz (2002:575), skills mix refers to the “combination of activities or skills needed for each job in the organisation”. In nursing it can refer to the mix of staff skills in their workforce or the demarcation of roles and activities among different categories of staff population per qualified nurse. The

model was introduced in 2009 with the intention of achieving and maintaining an adequate supply of nursing professionals who are able to meet the needs of South Africans. The model is aligned to the revised scope of practice, aiming to reduce workload of mainly professional nurses through task shifting and to improve the nursing satisfaction rate.

- Thirdly, to improve human resources for health nationally, the Department of Health has instructed NEI's to increase the number of professionals training as nurses, irrespective of the category (FSDoH, 2012-2013:39) and indeed the figures of trained EN's have increased annually from 11179 in 2008 to 16424 in 2012 according to the SANC's Geographic Statistics (SANC, 2008-2012).

1.2 PROBLEM STATEMENT

The FSDoH has embarked on a campaign to increase the number of nurses. Basic training in the Free State Province ranges from a course leading to enrolment as a nursing auxiliary (R.2176 of 19 November 1993) (SANC,1993a); enrolment as a nurse (R.2175 of 19 November 1993) (SANC,1993b) to a comprehensive nursing course leading to registration as a professional nurse (General, Psychiatric and Community) and Midwife (SANC, R.425 of 22 February 1985) (SANC,1985). To accomplish competency, nurses are clinically accompanied by educators and guided through their procedural guidelines according to their scope of practice. The clinical accompaniments in the clinical facility are continued to ensure the achievement of the programme outcomes. As said, only those candidates that are deemed competent according to the scope of practice will be ready for enrolment to practice as EN's (SANC, R2175 Of 19 November 1993b). However, the attitudes of nurses as they interact with patients and provide nursing care seem to be inhumane when observed as nurses lack genuineness and empathetic understanding of their patients (Van den Heever, 2013:6). They display

an “I don’t care” attitude that does not recognise the person in front of them as a human with a body, mind and spirit. Despite training, they continue to practice in non-compliance with the clinical environment. As mentioned above, the challenge of health care services remains, and the quality of care rendered to the public is deemed lacking due to nurses not following their scope of practice. The issue of poor health care is blamed on the nursing staff’s inability to comply with the given procedural guidelines. Despite nurses receiving intensive training, I observed a tendency among nurses in public institutions enrolled in terms of SANC, R.2175 of 1993 (SANC, 1993b) to regress to pre-training skills during care rendering. This prompted the following research questions:

- What factors influence EN’s compliance to procedural guidelines during patient care?
- What recommendations can be made to promote compliance to procedural guidelines during patient care according to the EN’s scope of practice?

1.3 RESEARCH AIM

The aim of the study is to explore and describe factors influencing the compliance of EN’s (enrolled in terms of R.2175 of 1993) to procedural guidelines during patient care.

1.4 RESEARCH OBJECTIVES

The research study aim leads to the following objectives:

- To explore and describe factors influencing compliance to procedural guidelines of nurses enrolled in terms of R. 2175 of 19 November 1993 during delivery of patient care; and

- To formulate recommendations to promote compliance to the procedural guidelines according to the EN's scope of practice to improve patient care.

1.5 RESEARCH PARADIGM

Kuhn (1970), as cited by Brink *et al.* (2012:24) has defined a paradigm as “a discipline’s specific method of structuring reality”. Stommel and Willis (2004:23) have defined it as an attempt to research certain assumptions about the nature of reality. According to Brink *et al.* (2012:40), a research paradigm consists of statements embedded in the thinking and behaviour of a researcher that are taken for granted or considered true even though they have not been scientifically tested. The implication is that they influence the logic of the study, the way in which a discipline’s concerns are viewed and the design and interpretation of findings (Brink *et al.*, 2012:24).

The researcher’s assumptions in this study are divided into meta-theoretical, theoretical and methodological assumptions.

1.5.1 Meta-theoretical assumptions

Botma *et al.* (2010:187) have noted that these assumptions comment more on the philosophical orientation of the researcher. It refers to the researcher’s belief about the person as a human being and the nature of research.

Firstly, the researcher is a Christian and believes that man is created in the image of God and that there is only one God (Holy Bible, 2010:3). The researcher believes that although all people are created in God’s image, each person’s personality traits differ from others so that each person is unique. The study is furthermore guided by the pragmatic view as contained in Jean Watson’s theory of human caring (Cara, 2003:51-61). According to this theory “caring” is an endorsement of nurses’ identity (Cara,

2003:51) and the person (EN's) has three spheres, namely the mind, body and spirit (Cara, 2003:55).

1.5.1.1 Human beings

I believe that a human being is a spiritual being (Holy Bible, 2010:3) that is in need of spiritual guidance and comfort (Vlok, 1991:8). As said, I am strongly influenced by the application of Jean Watson's theory of human caring. As such, my perception of a human being is influenced by Watson's explanation of transpersonal relationships and the nurse's moral commitment to protecting and enhancing human dignity during caring moments (Cara, 2003:53). The mutual relationship between the nurse and the patient in the process of searching for wholeness depends wholly on the creative use of their own persons (Cara, 2003:52). Despite the fact that God created human beings in his image, each individual is unique and they will shape their world in the manner they perceive it.

My personal perception of a human being, as a researcher, is further influenced by the value that Watson attaches to a person. She states that to be fully embodied a person has to have unity of mind, body and spirit. The well-being of a person depends on caring for more than just the person's physical well-being (Cara, 2003:53). I believe that although the best spiritual comfort for a person depends on their religious beliefs and provider, when a person is spiritually abandoned, the quest for wholeness cannot be achieved.

Watson's carative factor is based on the principle of being sensitive to the self and others. Whether you are male or female, in need of or rendering care, all persons have a body, mind and spirit that interact in an integrated manner to achieve the quest for wholeness (Watson, 2007:133). One's fate is determined by oneself, so nurses should be aware of their emotions so that they can acknowledge the emotions of patients in the

process of building towards and achieving the quest for wholeness. For the purpose of this study, the view human beings referred to above applies to a competent nurse, enrolled under R.2175 of 19 November 1993, who should render quality care to patients according to procedural guidelines and who should be aware of forces that may impede transpersonal relationships as care is rendered.

1.5.1.2 Health

From patients' perspective, health means being able to perform and cope with the daily living activities independently (Paap *et al.*, 2014:9). This definition is used in congruence with what Watson believes and has defined health. According to Watson (cited in Cara 2003:56), health corresponds to harmony and balance within the mind, body and spirit. Following this philosophy, Watson believes that the higher the level of physical, mental and social well-being, the more absent illness is. Health in this study refers to the kindness, love and concern (affective mode of learning), as well as the confidence, competence and knowledge (cognitive mode of learning) the nurse should possess when rendering quality care and promoting the health of patients. The nurse should also have sound mental, physical and spiritual well-being.

1.5.1.3 Environment

In Roy's adaptive model environment is defined as "all conditions, circumstances, and influences surrounding and affecting the development and behaviour of persons or groups" (George, 1983:309). According to George (1983:302), Roy acknowledged that the environment consists of internal and external stimuli, necessitating a behavioural response, and that the environment is constantly changing, stimulating man to adapt accordingly during the response. For this study, Roy's adaptive model is considered and integrated with the researcher's beliefs. The internal environment refers to the mind,

body and spiritual response, and the adapted readiness attitude the nurse should display during care rendering. The external environment refers to the circumstances or working conditions the nurses are exposed to during the provision of comfort and care during patient care. Watson (Anon, 2010:6) believes in the use of the self during the provision of care and this should not be influenced by circumstances nurses find themselves in, but rather promote caring moments and intentions. Therefore, the EN's should adapt to changing circumstances for growth and development and forever strive to create a supportive and protective environment that will enhance trusting-helping relationships with patients (George, 1983:315).

1.5.1.4 Nursing

Nursing is concerned with the promotion of health and caring for the sick. According to MDMNH, (2013:1248), nursing is the practice in which a nurse assists individuals in the performance of those activities that contribute to health or the patient's recovery that an individual is unable to perform due to ill health. A common understanding is that most individuals choose nursing as a profession because of their desire to care for other individuals and that nurses are obligated to meet the needs of those who are unable to manage their health without help. The goal of nursing according to Watson's theory (Watson, 2007:129-135; Anon, 2010:1) centres on helping the patients as holistic beings to gain a higher degree of harmony of the mind, body and soul. She argues that caring may occur without curing, but curing cannot occur without caring (Watson, 2007:129-135). Since most individuals choose nursing as a profession because of their desire to care for other individuals, Watson identified 10 interventions referred to as carative factors that nurses should use in the delivery of health care (Watson, 2007:131). These factors provide a framework for the profession of nursing to foster the evolution and deepening of humankind to sustain humanity (Watson, 2007:135).

Watson has used the term 'carative' instead of 'curative' to distinguish between nursing and medicine. Curative factors aim to cure the patient of the disease, whereas carative factors aim at the caring process that helps the person to attain or maintain health (Watson, 1985:7, as cited in Cara, 2003:52).

I used the above-mentioned philosophical views as a guide in formulating assumptions about man, health, environment and nursing.

Following Watson's philosophy (Anon, 2010:1-7), the belief is that holistic health care is central to caring in nursing, and that the care rendered should always be compassionate. In this study, nursing is reflected as the attitudinal acts nurses display that should be considered and the awareness of their feelings as they deliver care (Cara, 2003:53).

1.5.2 Theoretical assumptions

Botma *et al.* (2010:187) have referred to theoretical assumptions as the researcher's knowledge of existing theoretical or conceptual frameworks. The theoretical statement of this research includes the central theoretical argument and conceptual definitions of the core concepts applicable to this study.

1.5.2.1 Central theoretical argument

The attitudes of nurses as they interact with patients and provide nursing care seem to be inhumane when observed (Van den Heever, 2013:6). They display an "I-don't-care"-attitude that does not recognise patients as a human with a body, mind and spirit. Despite their training, they continue to practice with non-compliance to the clinical environment. The exploration and description of factors that influence EN's non-compliant attitude during clinical practice are aimed at the formulation of

recommendations to promote compliance to the procedural guidelines according to the EN's scope of practice.

1.5.2.2 Concept clarification

The following concepts are defined as they are used frequently in this study:

1.5.2.2.1 Compliance: The OALD (2006:296) define compliance as “the practice of obeying rules or requests made by people in authority”. According to the South African Department of Health’s national core standards (Department of Health, 2012b), compliance is defined as “conforming to an agreed set of criteria on accepted norms and standards, procedures and guidelines, practices, legislation, prescribed rules and regulations of a contract”. The Department of Health’s core standards were developed as an attempt to maintain consistent compliance during nursing practice. Non-compliance then means not conforming to a rule. In this study it refers to adherence to procedural guidelines as set within the scope of practice of the EN as stated in R.2175 of 19 November 1993.

1.5.2.2.2 Competence: There are many forms of competence, like for instance cultural, professional and communicative competence. Smith (2012:175) has explained that it can be attributed to individuals, social groups or institutions when they possess or acquire the conditions for achieving specific developmental goals and meet important demands presented by the external environment. Nevertheless, competence is well explained as “a learned ability to adequately perform a task, duty or role” (Smith 2012:175). Restricting our definition to nursing, competence means “the ability of an EN to integrate the professional attributes including, but not limited to, knowledge, skills, judgements, values and beliefs required to perform in all situations and practice settings” (SANC, R.171 of 8 March 2013). Refining the definition to clinical practice,

clinical competence directly relates to patient care. In this study, it simply reflects sufficiency of knowledge and skills that enables the EN to perform a specific role.

1.5.2.2.3 Multi-skilled setting: According to French *et al.* (2011:4), a multi-skilled setting is an environment that involves various health care skills from different health care professionals performed on patients in pursuit of optimizing patient care. In this context, a multi-skilled setting refers to an approach where nurses are expected to perform various tasks, some even falling outside their scope of practice.

1.5.2.2.4 Clinical nursing practice: Clinical practice is defined as a model of practice that involves those activities with and on behalf of patients, especially those activities completed in the patient's presence and with the patient's collaboration (OALD, 2006:265). In this study it refers to a practice-based observation and active performance of nursing actions in the clinical setting to integrate learnt theory and involves a direct relationship with a patient. The model can be practised in all health care facilities like hospitals and health care clinics that render active performance of nursing actions so that patients may attain, maintain, or recover optimal health and quality of life (MDMNH, 2013:1248).

1.5.2.2.5 Enrolled nurse: EN's are pupil nurse candidates enrolled by the South African Nursing Council in terms of section 45 (1) of the Nursing Act, 1978 (Act No 50. of 1978) after undergoing a training programme for at least two years at an accredited NEI's and after having been declared competent according to R.2175 of 19 November 1993. An EN provides patient care under supervision of a registered nurse (Searle, 2006:71).

1.5.2.2.6 Procedural guidelines: Guidelines are derived from a verb "to guide". The OALD (2006:663) has defined guidelines as rules or principles put forward to set

standards or to determine a course of action. In this study, procedural guidelines refers to statements or other indications of policy or principles that are given to EN's during and after training to set standards of quality care during patient care.

1.5.2.2.7 Patient care: Patient care is a service rendered by members of the health profession (Meyer *et al.*, 2010:175). MDMNH (2013:1345) has defined a patient as a recipient of health care services, ill and/or hospitalised, whereas in Watson's theory (cited in Cara, 2003:51) involves nurses' identity with caring. Patient care is a combination of two concepts to explain a service rendered by health care professionals. A caring behaviour, according to MDMNH (2013:311) includes such actions as sensitivity, comforting, attentive listening, to name a few, and the patient becomes the recipient of such health care services.

1.5.2.3 Methodological assumptions

According to Botma *et al.* (2010:189) methodological assumptions refer to what the researcher believes good practice is, and includes the researcher's understanding of the manner in which scientific research should be planned, structured and carried out to comply with the demands of a study.

Nursing activities, as presented within Botes's model (1995:37), are arranged on three levels in accordance with the research aims.

The first level represents the practice of nursing and what phenomenon the researcher is exploring, that is, to explore and identify factors influencing the compliance of nurses enrolled in terms of R.2175 of 1993 to procedural guidelines during patient care which forms the research domain. Nurses are trained to provide competent nursing care, irrespective of the circumstances they work in. In this study, the focus is on clinical nursing practice and patient care where EN's working within the Thabo Mofutsanyana

district public institutions are to promote, maintain and restore the health of patients in need of health care.

The second level represents the methodology adopted. In this study the focus is on the description and exploration of the EN's non-compliant contributory factors to procedural guidelines during patient care with the aim of recommending improvements as anticipated by the people involved. After the data have been analysed and the available literature has been consulted, captivated and represented, recommendations are formulated that will promote compliance with the procedural guidelines during patient care according to the EN's scope of practice and subsequently improve health care. It will also provide a basis to set standards quality assurance (Brink *et al.*, 2012:12).

The third level represents the paradigmatic perspective within which this research is undertaken. In this study the meta-theoretical and theoretical statements are kept within the framework of Jean Watson's theory (as discussed in sections 1.5.1.1, 1.5.1.2, 1.5.1.3 and 1.5.1.4 above).

1.6 RESEARCH METHODOLOGY

Research methodology, according to Brink *et al.* (2012:24), refers to a particular way of knowing about the reality. The above overview of this study offered the introduction and problem statement, the objectives and the paradigmatic perspective adopted within this study. Below follows a detailed description of the research methodology, with special attention to the research design, research method, ethical issues applicable to this study, as well as the trustworthiness of this study.

1.6.1 Research design

The term “research design” refers to the plan of how a researcher puts a research study together to answer a question or set of questions (Creswell, 2009:4).

In order to achieve the objectives of this study, an explorative, descriptive, contextual, qualitative design was chosen with the aim of exploring factors influencing EN’s compliance to procedural guidelines during patient care.

1.6.1.1 Qualitative

According to Denzin and Lincoln (2005:3) qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. For this study qualitative research will be used to explore detailed views from EN’s experiences on the factors for non-compliance to procedural guidelines during patient care (De Vos *et al.*, 2011:308).

1.6.1.2 Explorative and descriptive

According to Burns and Grove (2009:12) and Grove *et al.* (2013:60) description involves identifying and understanding the nature of specific phenomena, and, sometimes, the relationships among them. Through research, the researcher is able to (1) describe what exists in practice, (2) discover new information, (3) promote understanding of situations, and (4) classify information for use in the discipline. The researcher will use the emic approach that involves studying behaviours from within the culture. The culture in this research study is EN’s perceptions based on experience during patient care. The researcher will explore and describe by means of semi-structured focus group

interviews of EN's' experiences on the factors for non-compliance to procedural guidelines during patient care.

1.6.1.3 Contextual

The research context refers to the place where the research is done. According to Klopper (2008:68) qualitative studies are always contextual in nature, as the data is only valid in a specific context. In the description of a contextual study it is important to include a description of the context or setting in which the research will be conducted. As indicated in the back ground, the context for this study is the EN's' who had recently qualified for enrolment, who through intense training, understands and had just recently revisited procedural guidelines during their training, but resist/fails to demonstrate improved knowledge gain and non-compliance to procedural guidelines during their patient care practices from public clinics and hospitals within the Thabo Mofutsanyana district of the Eastern Free State is observed. The factors to be explored may influence the outcome of the study but the researcher will/intend to report data (factors explored) and forward recommendations just as expressed without transforming the data.

1.7 RESEARCH METHOD

The methods congruent with the research design employed in this study include decisions regarding the study population, sampling, methods for data collection and data analysis (Brink *et al.*, 2012:55). The subsequent paragraphs provide a brief description of the research method.

1.7.1 Population

According to Brink *et al.* (2012:130), population refers to the entire group of persons that are of interest to the researcher. Due to the feasibility of the study in terms of time,

funding and the availability of participants, a qualitative researcher sets boundaries (criteria for inclusion) and conducts their study with an accessible population (Brink *et al.*, 2012:131). In order to remain focused on the objective of a study, Botma *et al.* (2010:200) have stressed that the researcher should establish explicit criteria for selection of participants. In this study, the accessible population was all EN's (EN's) who had passed the progression test (bridging) from Enrolled Nursing Auxiliary (ENA) to an EN according to SANC (R.2175 of 1993) within the five years preceding the study period (2008-2012), N=71, in the Eastern Free State Province of South Africa.

The inclusion criteria included only those EN's in the Thabo Mofutsanyana district employed at public hospitals and clinics who had undergone formal training within the five years preceding the study period (2008-2012) and those candidates who had passed the progression test (bridging) from ENA to EN according to SANC. The criteria included no restrictions related to age group or gender due to the size of the population and to optimise participants.

A sampling frame was drawn (see Table 1.2) comprising a list of all EN's in the Thabo Mofutsanyana district working at public hospitals and Primary Health Care (PHC) clinics. The relevant information was obtained from the relevant institutions. After information sessions to explain the purpose of the study and obtaining informed consent, participants were grouped into focus groups per municipality.

Although the research problem is not limited to EN's, this category of nurses was chosen because:

- their development from ENA to EN showed a passion for the profession; and
- the staff nurse, as the mid-level worker in nursing, is an essential component in the rendering of nursing care with full responsibility and accountability for nursing care in

a unit of a health facility or service under supervision of a registered nurse (Brannigan, 2010:4). The implementation of skills mixing while there are limited human resources puts these nurses on the forefront, and factors that impede quality care should be explored.

1.7.2 Sample

According to Brink *et al.* (2012:131), a sample refers to a subset of a larger population selected by the researcher to participate in the research study. The purpose of sampling in a qualitative study is to develop a rich holistic understanding of the phenomenon of interest (Botma *et al.*, 2010:199). According to Botma *et al.* (2010:199), the two guiding principles for sampling are appropriateness (use of participants who can best inform the researcher) and adequacy (enough data to develop a full and rich description of the phenomenon).

For the purpose of this study, the researcher chose a purposive sampling method. It is purposive in that the researcher chooses participants who can give the best information about the topic and only those who meet the criteria set by the researcher are needed (Polit & Beck, 2012:392). Only those who responded to the invitation were randomly grouped to form focus groups.

1.7.3 Sample size

Brink *et al.* (2012:143) have stated that although there is no fast and hard rule for the sample size in qualitative studies, just choosing a convenient number can also give misleading results. Though the number in qualitative studies is not necessarily an indicator of adequate and reliable results, enough information should be collected. Botma *et al.* (2010:200) have identified the two criteria for enough data as sufficiency

and saturation. They have stressed that what determines the saturation and size of the sample is the quality of the data.

In the study these criteria were considered as follows:

- **Sufficiency:** The amount of participants indicated as the population suggested that four focus groups would be the most suitable number (see Table 1.2). This is a large enough number so that the results would reflect the range of participants and the sites that makes up the total population. Six municipalities were involved in the four focus groups.
- **Saturation:** At the end of the focus group interviews, data saturation occurs as there was no new or relevant data that emerged and themes started to repeat.

Table 1-2: Sampling frame

Tabulated statistics of candidates in hospitals and clinics around Thabo Mofutsanyana district (App 2012/2013: 26&96)	Public hospitals	PHC clinics	Total number of facilities	EN's trained within five years before the start of the study period (2008 – 2012)
MAL A	3	40	43	44
SET B	2	15	17	1
NKE C	1	9	10	3
DIH D	2	13	15	16
PHU E	1	6	7	6
MAN F	-	6	6	1
Total	9	89	98	71

1.8 DATA COLLECTION

Data collection refers to the process of selecting subjects and gathering data from the participants (Grove *et al.*, 2013:523). For the purpose of this qualitative study, the focus was on exploring the factors influencing nurses enrolled under R.2175 of 19 January 1993 who are not compliant to procedural guidelines during patient care according to their scope of practice.

Prior to data collection the researcher requested written approval to conduct the study and received approval letters from the different institutions. This includes the Chief Executive Officers (CEOs) of the public hospitals, the district managers of the public Primary Health Care (PHC) clinics and the heads of the nursing departments within which participants were working in the selected area Thabo Mofutsanyana district, the FSDoH and from the Health Research Ethics Committee of North-West University, Potchefstroom Campus. All institutions were requested to send the names and contact details of those nurses who qualify for inclusion in the study in accordance with the criteria set out to the researcher. Having received a list of prospective participants, the researcher, with the assistance of a facilitator arranged a meeting and requested attendance to orientate the target population regarding the research project. This request was in writing and the letters were delivered to each institution electronically. Data collection only included those participants who consented in writing, confirming their willingness to participate, and who gave their permission for the use of an audio-recorder during interviews. Appointments for data collection were subsequently arranged telephonically by the researcher. Participants who gave their consent to be interviewed were reminded of the appointment three days in advance.

1.8.1 METHODS OF DATA COLLECTION

Semi-structured focus group interviews were selected as the data collection method.

1.8.1.1 Focus group interviews

Stommel and Willis (2004:301) have explained focus group interviews as a powerful means of exposing reality because they include interactions among participants who often share the same experiences and feelings and, therefore, they express themselves freely in the presence of people who they perceive to be like them in some way. Botma *et al.* (2010:210) have further added that rich information of a broader range of feelings can be generated from group participation.

The method was chosen because data could be collected while participants interacted with one another as a group (Polit & Beck, 2012:360-362). It was appropriate for the purpose of exploring perceptions and thoughts from participants. This method of data collection was used to gain the detailed picture of participants' perceptions and account on the chosen topic. Through semi-structured interview, the researcher intended to obtain all information while still allowing participants the freedom to respond in their own words (Stommel & Willis, 2004:300; Botma *et al.*, 2010:209-2011).

The method helped in that it enhanced the freedom of expression and the group got a feeling of safety as the clarity of the views depended on the group rather than on the individual like in one-on-one interviews. This group dynamic also helped people to express and clarify their views in a way that was less likely to occur in a one-on-one interview and eventually authentic information was collected. The researcher acted as a facilitator and took advantage of the group dynamics to access rich information (Grove *et al.*, 2013:276).

Brink *et al.* (2012:158) have suggested that a group should range from five to fifteen (5-15) participants, whereas Botma *et al.* (2010:211), Grove *et al.* (2013:275) and Stommel and Willis, (2004:305) have maximised their groups to no more than 10-12 people. For Stommel and Willis (2004:305), deciding on the right size of the group means striking a balance between having enough to generate a discussion and not having so much that some individuals will feel crowded out. Smaller groups are preferred if participants have intense or lengthy experiences related to the topic. For this study, the groups did not exceed 10 people per group. Segmenting participants, that is sorting participants into focus groups, depended on the number of those who participated; their area of residence; their availability; and the similarities in terms of experience and social position (Grove *et al.*, 2013:275). The decision to sort 10 participants per group meant that the groups could accommodate any withdrawals so that no fewer than six participants formed a focus group. The entire accessible population was invited and recruited to participate in the study. Four focus groups were formed and interviewed.

Since different focus groups were conducted at different intervals, data saturation occurred before and none were prolonged for more than 60 minutes, because too long interviews are tiring and infringe the right to “no physical harm” (Botma *et al.*, 2010:208). The timetable for focus group interviews was designed to be convenient for both the researcher and the participants and with the schedule and group rules were discussed during the first meeting with the participants. Focus group sessions were guided in the form of semi-structured interviews. The semi-structured interview questions were written down as an interview guide so that the same questions could be asked to all groups without omitting any in an effort to ensure consistency. Though questions were directive, they were posed in such a way that participants are encouraged to provide rich details. The

researcher showed a minimal verbal response to show the participants that she is listening and interested in hearing more (Grove *et al.*, 2013:267).

Botma *et al.* (2010:213) have suggested that the researcher should possess group facilitation skills and good communication skills to encourage the participants to talk and to ensure the free flow of the interview. During data collection, the researcher used communication skills such as probing to encourage the participant to give more information; reflecting, communicating to the participant her concerns and perspectives as observed (Grove *et al.*, 2013:276); and summarising to check on what has been discussed as well as the participants' impressions if the interview.

According to De Vos *et al.* (2011:367), the number of focus group meetings necessary for a particular study varies and depends on the research aims or purpose of the study. Since De Vos *et al.* (2011:367) have stressed that too few focus group meetings may result in something being missed or premature conclusions. Data saturation occurs four focus groups were held.

1.8.1.1.2 Trial run

To ascertain if the interview would yield the intended outcome effectively, during this study a trial run as pre-test (small scale preliminary study conducted for the purpose to evaluate the sensitivity and clarity of the questions and concepts, as well as the feasibility, time, cost and adverse events of the study in an attempt to improve upon the study design prior to performance of the full scale research were implemented. Brink *et al.* (2012:174) have suggested that a trial run be conducted on participants that meet the same criteria and that would not form part of the sample during the data collection process at a later stage within the main study. Since the accessible population was not large, the first group was regarded as a pre-test. According to Brink *et al.* (2012:158),

there should be an interview guide used to initiate group discussions and elicit in-depth information for the richness of data intended. The interview guide saw to it that adequate time was allocated to protect participants from inconvenience (Brink *et al.*, 2012:174).

During the trial run and during the main study a focus group was conducted as follows: The researcher personally conducted the interviews following an interview guide. A short introduction was followed by an open discussion in the groups guided by non-leading, but directed questions that addressed the following:

- The focus groups started off with a discussion on care given at public institutions (hospitals and PHC clinics) and differences between the experiences of the different participants, if there were any. Participants were invited to elaborate on causes.
- Thereafter, participants were probed on factors that keep nurses from performing their duties according to the procedural guidelines they have been taught.
- Based on the response on question two above, if relevant, the discussion was steered to clinical facilitation to review nurses' preparation.
- Based on the above, participants were asked how best nurses can stick to procedural guidelines to improve patient care.

The questions were phrased as follows:

- What did you observe in the clinical area with regard to performing procedures as guided during training?

Based on the answers to the first question:

- What factors do you think disturb compliance with the procedural guidelines during patient care?
- How and what do you think can influence a change to maintain compliance with the procedural guidelines during patient care?

Even though the researcher guided the discussion, she had to remain objective and had to manage and set aside any preconceived opinions that she had (Brink *et al.*, 2012:122). The researcher had to possess good group facilitation skills to guard against extreme dominance or extreme passiveness from participants, since this could lead to bias or hesitation to participation (Botma *et al.*, 2010:212). The role of the researcher was to encourage participants to talk and interact with one another about the topic and to help them to recover forgotten information by focusing on the interview and building a trusting relationship. According to Botma *et al.* (2010:212) friendliness, humour and respect are valuable assets that an interviewer must possess in building this relationship when conducting focus groups.

As suggested by Brink *et al.* (2012:159), data was audio-recorded for reference during data analysis. The researcher asked for the participants' voluntary consent before using an audio-recorder. Since the researcher had to concentrate on conducting an uninterrupted interview (Botma *et al.*, 2010:214), a co-facilitator managed the audio-device and recorded all interviews. The co-facilitator handled the logistics and avoided distractions by taking preliminary field notes and managing the audio-recorder (Botma *et al.*, 2010:212).

1.8.1.1.3 Field notes

Immediately after each interview the researcher wrote down impressions on the session as field notes. The use of field notes are also recommended by Greeff (as cited in

Botma *et al.*, 2010:217), as they help the researcher to remember and explore the process of the interview. De Vos *et al.* (2011:372) have described field notes as a written account of the things the researcher hears, sees, experiences and thinks during the course of collecting or reflecting on the data obtained during the study. The goal of field notes is to provide a thick description of the participants and the events. Polit and Beck (2012:549) have added that field notes should be both descriptive (objective descriptions of observed events, conversations and information about actions) and reflective (the researcher's personal experience, reflections and progress). Stommel and Willis (2004:286) have deliberated that the field notes should contain the following:

- A description of persons in the observed setting. These include physical appearance, manner of speaking and style of interacting.
- A description of the setting itself as the layout of the physical setting may favour some types of communication and hinder others.
- A description of events, activities and interaction patterns that occur in the setting (who talks to whom or who avoids whom and how these interaction patterns promoted or impeded the communication flow).
- Short quotations or verbal exchanges that are meant to indicate language and tone.

The co-facilitator was responsible for descriptive notes while the researcher recorded her own reflective notes. The reflective notes included the researcher's personal experiences and reflect personal thoughts such as problems, emotions, preconceptions, impressions and prejudices (Polit & Beck, 2012:549). The descriptive notes, according to De Vos *et al.* (2011:372), should include seating arrangements; the order in which people speak to aid voice recognition, non-verbal behaviours such as eye contact, posture, gestures between group members, crying, fidgeting, as well as themes that are

striking; and highlighting as much of the conversation as possible. The dynamics of the group they added, should also receive attention, the control over participants be mild and unobtrusive. Stommel and Willis (2004:286) have emphasised that an awareness of the group dynamics is also important. The following were noted and described: the atmosphere in the group; the attitudes of participants – who talks most or first or who does not talk at all; what underlying feelings are not expressed; who wants to overpower the group; who leads and who follows (Stommel & Willis, 2004:286). The use of such notes assisted the researcher when compiling a report that must convey the experiences and feelings as discussed, so that the reader can develop an increased sensitivity to issues and understand the lived experience, as portrayed.

As a qualitative researcher's focus is on understanding and going deeper into an interpretation of events, the interviews were conducted and after the 4th interview data saturation was reached, in other words the point where the interviews yielded no new information (Brink *et al.*, 2012:141). The researcher arranged for a follow-up meeting with participants to check the completeness and correctness of their input. Member checking avoided misinterpretations or deviations from actual interpretations from participants and improves the truthfulness of data (Brink *et al.*, 2012:171). Botma *et al.* (2010: 211) and Stommel and Willis (2004:307) have emphasised that the crucial concern should not be the amount of data, but rather the richness of data, not the total count, but the detailed descriptions.

1.8.1.1.4 Setting

Grove *et al.* (2013:373) have defined the setting as the location where the study takes place, the specific place or places where the data is collected. As mentioned before, this research was conducted in the Eastern Free State (Thabo Mofutsanyana district), one of five districts in the province. The district was chosen for its rural characteristics. It is a

previously disadvantaged area, the second highest populated district, home to 838 246 of the total of 2 941 489 individuals living in the Free State (FS Annual Performance Plan, 2012/2013:61). The Thabo Mofutsanyana district also has more primary health care (PHC) facilities that are nurse-driven with limited support from other medical professionals and has fewer health specialists in the public sector. The Thabo Mofutsanyana district furthermore includes six local municipalities and caters for the health needs of its community with one private hospital, two regional hospitals, seven district hospitals, and 89 PHC clinics – fixed and mobile clinics were included since though the level of care from these institutions vary from primary to secondary care respectively. Mellish *et al.*, (2010:170) state that the conditions influenced the terms of referral system and on the complexity of patient care needed (FSDoH, 2012/2013:61). Consequently distribution of resources on both differ but the basic principles of patient care remains the same. The patient's Bill of rights as explained by the researcher's interpretation of this Bill, that, irrespective of level and services rendered, patients should be treated equally, with respect and non-discriminatory approach on the basis of allocation of resources.

The three most common research settings are natural, controlled and partially controlled settings. This study was conducted in a partially controlled environment, with little manipulation or modification to the environment not to influence the natural expression of feelings as experienced. The environment was made less formal and relaxed to assume a natural setting where everybody could feel free to express themselves, sit comfortably, with little noise to accommodate the use of audio-recording (Grove *et al.*, 2013:275). Data was collected in the designated place away from the hospital setting where the privacy of the interview could be secured. This allows for control over the line of questioning during focus group interviews (Brink *et al.*, 2012:158).

1.9 DATA ANALYSIS

The process of data analysis involves making sense of information in order to bring order and structure to and derive meaning from the massive data collected from the audio-recordings, field notes and researcher's notes (Brink *et al.*, 2012:193). Content analysis, according to Grove *et al.* (2013:281), is designed to classify the words in a text into categories and it is the best way to analyse data obtained from the group. This method reflects repeated ideas or patterns of thought. The researcher started analysing data during the collection process. During this phase the researcher prepared and organised all raw data. All the audio-recordings from the interviews were transcribed verbatim, field notes were typed and all the data collected from each focus group interview was transcribed. Both the researcher and the assistant facilitator read through all the data to check any misinterpretations and to get a sense of whether the information as provided by participants was correct. Self-transcribing the data was time-consuming, but it assisted the researcher in getting the correct, unaltered data down on paper.

The transcribed data was organised and coded using Tesch's eight steps of the coding process (Botma *et al.*, 2010:224). During data organisation, each transcript was divided into three columns, with the middle column being used for the interviewer and participants' verbal responses. The right-hand column was used for the themes that emerged from the responses. The left-hand column was used for analysis and gaining an understanding of the response. The coding process to organise and segment data into themes and sub-themes was done in a combination of techniques for analysis as described by Tesch (as cited in Creswell, 2009:186) and Giorgi (as cited in Polit & Beck, 2012:566). The steps were as follows:

- The researcher read through the entire transcript first to get a sense of all the experiences.
- The researcher chose one transcript that seemed to be the most interesting or the shortest.
- The researcher carefully read through this transcript again to try and establish what it is all about. The ideas that came to mind were jotted down in the left column (choosing the units of analysis or coding).
- The researcher again read through this particular transcript, this time underlining the themes, words and phrases of the participants.
- The underlined themes were written in the right-hand column.
- The identified themes were grouped into main categories, sub-categories and left-over categories.
- This process was repeated with each transcript.
- Finally, the words and phrases that marked the themes were “translated” into scientific terms.

A professional nurse who is experienced in qualitative research was appointed as an independent co-coder. Brink *et al.* (2012:67) have suggested that a person who is knowledgeable in qualitative research design, who has interest in the topic and who understands the concepts should be chosen so that such a person can judge the data from various perspectives. The transcripts, field notes and a work protocol that included the study objectives, a clear description of the data collection method and the central question asked to the participants, were sent to the co-coder.

The role of co-coder was:

- to independently analyse the data;
- to verify transcribed data to check if data is complete and correct;
- to ascertain the reliability of codes. She was requested to encode the data for both the researcher and the co-coder to check for similarities and differences on themes and sub-themes;
- to bring valid and reliable input to a follow-up meeting with the researcher in order to discuss and reach consensus on the categories that emerged from the data (Brink *et al.*, 2012:194).

Brink *et al.* (2012:127) have further suggested regular meetings between the researcher and the co-coder for consensus agreement. Follow-ups in the form of meetings where needed and as agreed upon were arranged with the co-coder to discuss and reach consensus on the categories that emerged from the independently coded data. The researcher and co-coder compared the themes they had independently reached to find the similarities and differences of categories and sub-categories, and then tables of themes and sub-sub-themes were finalised.

1.10 LITERATURE INTEGRATION

The literature review presented earlier provided a theoretical context for the study. The researcher attempted to remain uninfluenced by literature to maintain a measure of objectivity and to keep a focus on the purpose of the study (Creswell, 2009:28). However, the literature provided a strong framework to guide the researcher on what to study and how to study it. During literature integration, the research findings should be revisited as the purpose of the literature integration/control is to contextualise the

findings. The new insights gained from this research are highlighted later on in the study (Botma *et al.*, 2010:196). The researcher meta-synthetically integrated findings using the Noblit and Hare approach as described by Polit and Beck (2012:654). The approach has seven phases that overlap and repeat as the meta-synthesis progresses. The phases are as follows:

- Deciding on the phenomenon. Categories that integrate the evidence on the topic had been identified from data analysis.
- Deciding which studies are relevant for the synthesis. These were searched through electronic databases like CINAHL, EbscoHost and DARE
- Reading and rereading each study.
- Deciding how the studies are related to each other by listing key concepts/themes.
- Translating the qualitative studies into one another.
- Synthesising translations, making a whole that is more than the individual parts.
- Expressing synthesis through the written words.

1.11 ETHICAL CONSIDERATIONS

Ethics, according to De Vos *et al.* (2011:114), implies preferences that influence behaviour in human relations and that conform to a code of conduct. Grove *et al.* (2013:163) have further explained ethics as “a set of moral principles, which is suggested by an individual or group, and which offers rules and behavioural expectations about the most correct conduct towards participants, sponsors, employers and assistants”.

There are three identified principles that should be internalised by every researcher that ensure that participants' rights are upheld, namely the principles of respect, beneficence and justice. Grove *et al.* (2013:162) have emphasised that every researcher has the responsibility to recognise and protect the rights of human research subjects. Human rights that require protection in research include participants' rights to self-determination, privacy, anonymity and confidentiality (based on the principle of respect), fair treatment (based on the principle of justice) and the right to protection from harm and discomfort (based on the principle of beneficence) (Grove *et al.*, 2013:162-174). In an effort to protect participants' rights, ethical approval was requested from the Health Research Ethical Committee of the North-West University, Potchefstroom Campus (NWU HREC-00157-13-S1) (see Annexure 1). The relevant authority in the jurisdiction where the research took place, the FSDoH, was informed to request consent as well (see Annexure 6). The Chief Executive Officers (CEOs) of the different institutions and provincial hospitals where the participants were working at the time were also be informed and asked for approval (see Annexures 7-10). All requests were in writing.

Adequate information about the research topic and purpose were provided to participants before the commencement of data collection, and they were informed of their right to voluntarily accept, reject or withdraw their participation at any time without judgement and fear of harm. Their rights to privacy, confidentiality, and anonymity, as well as their right to complain if they suspect any unfair treatment or emotional harm were emphasised. During the same meeting the participants were offered the opportunity to ask questions that were answered honestly so that all uncertainties were cleared up and they were ensured that there will be no penalties if they do not wish to participate (Botma *et al.*, 2010:15). Prior the interviews consent was requested in writing from all participants (Botma *et al.*, 2010:15) (see Annexure 5).

1.11.1 Principle of respect

The principle of respect for a person emphasises the control participants have over their destiny and they have to be treated as autonomous agents who have freedom (Brink *et al.*, 2012:35). The process of getting consent and assuring participants of their rights addresses the matter of respect for the participants. The presence and the role of the co-facilitator were explained to participants. The researcher emphasised that the co-facilitator's presence will not influence their right to confidentiality and anonymity and requested the permission of the participants to include the co-facilitator as part of the team. All members of the research team signed a confidentiality pledge (De Vos *et al.*, 2011:117). The use of audio-recordings during the focus interview was explained, together with the measures to keep transcripts safe to secure anonymity. The researcher asked for the permission of the participants to use an audio-recorder. The participants were assured that anonymity will be maintained in presentations, reports and publications. Pseudonyms will be used instead of the real identity, and each participant identified a code that they prefer to be identified with. Members of the focus group had to agree to keep the shared information confidential. A data analyst and auditors assisted during the data analysis to secure the truth value of findings, but all members of the research team signed a confidentiality pledge. Access to confidential information has been limited to those who are directly involved with the research. This rule of confidentiality extends even to the institutions where participants work because their managers will only receive a report. Consent forms and the master list with their real names have been kept in a safe place and not with data collection sheets. Data has been stored in a computer that are password-protected and have virus and spyware protection. After data analysis the original data was deleted from the computer. All tapes and other identifiable data will be kept save locked in a steel cabinet in the office of the

research focus area (School of Nursing Science North-West University, Potchefstroom Campus (NWU) and locked behind an office door for seven years in case proof of research is asked. It will then be destroyed by shredding (Botma *et al.*, 2010:26).

1.11.2 Principle of beneficence

The principle of beneficence emphasises the maximisation of benefits with any possible risks minimised. This principle holds that the researcher does good and “above all, do no harm” (Brink *et al.*, 2012:36; Grove *et al.*, 2013:174).

1.11.2.1 Risks/ Discomforts

According to De Vos *et al.* (2011:115), participants can be harmed emotionally, financially or physically. The principle stresses “no harm”, thus the risk-benefit ratio had to be calculated and the research would have been stopped if the risks outweighed the benefits. The risks and benefits to participants and right to protection from harm were addressed as follows as indicated by Botma *et al.* (2010:22).

The participants were thoroughly informed beforehand about their right to complain if they feel any discomfort. Low foreseeable risks that might be experienced include emotional discomfort and mild anxiety during the interviews. Privacy might be lost during the interviews and a partial break in the trust relationship due to group discussions and the use of voice recordings, but your name/ clinical facility will never be made known and your data will be handled as confidential as possible. No individual identifiers will be used during voice recordings or in any publications resulting from this study and only the team of researchers will work with the shared information. All sensitive information will be protected by locking it up and storing it on a password protected computer, in a steel cabinet at the research office, School of Nursing Science-NWU).

The contact number of the persons who should be consulted to lodge a complaint if any of the participants' rights had been violated, was provided. The researcher arranged to provide professional assistance as debriefing opportunities to be available if the participants had experienced any psychological discomfort or harm in any way or if they wish to withdraw from participation to the research due to the experience of any discomfort.

1.11.2.2 Benefits

Participants improved skill in group dynamics and semi-structured focus group interviewing as well as the boost of their self-esteem as participation enhanced personal worth due to the information contribution they made to better health care delivery in health care facilities. Participants will bear no cost as a result of participation to the research. Transport cost to focus group-sessions (@ R 15.00 per one way trip), a light meal and refreshments for the day was supplied by the researcher as well as a token of appreciation per participant at the end of data collection.

1.11.3. Principle of justice

The principle of justice emphasises the fairness of the study with regard to the selection of participants and the equal treatment of all with no preferences (Brink *et al.*, 2012:36). Respect to the participants' right to fair treatment was addressed as follows during the information session and throughout the interviews:

- The researcher explained the sampling process and that the reasons for selecting certain participants were based on the nature of the problem.
- Participants were assured that any withdrawal from the research will have no implications and that they should express their right to self-determination.

- The researcher assured the participants that the data analysis would be truthful because a deceitful researcher can jeopardise research integrity. The report findings should be honest and without any manipulations that support the researcher's point of view.
- Participants were safeguarded from dominance or intimidation from other participants (Botma *et al.*, 2010:27).

1.12 TRUSTWORTHINESS

Qualitative researchers saw the importance of developing criteria to ensure the trustworthiness of research findings without sacrificing the relevance of the research. Whereas Grove *et al.* (2013:58) have referred to rigour in qualitative research as openness, relevance, epistemological and methodological congruency, and thoroughness during data collection, Lincoln and Guba (as cited in Polit & Beck, 2012:584) proposed a model for assessing the trustworthiness of data in order to ensure the quality of a research project. The model was based on the identification of four criteria of trustworthiness that are relevant and important for increasing the trustworthiness of qualitative studies. These criteria, which are truth value, neutrality, consistency and transferability, are supported by Kloppe (as cited in Botma *et al.*, 2010:234) for their use to ensure trustworthiness in the research. A discussion of these criteria and the strategies that were implemented to achieve them follow below.

1.12.1 Truth value

The qualitative approach to this criterion is credibility, and according to Polit and Beck (2012:584) this concept has to do with how confident the researcher is with the truth of the findings. The following strategies were applied to give the study credibility:

- Member-checking – in this study the data was collected and captured through the use of an audio-recording. The recordings were transcribed verbatim. The researcher arranged a follow-up meeting with groups to review the data collected, to establish whether it is real and authentic, and to allow them to validate the researcher's interpretations and conclusions.
- Prolonged engagement and persistent observations during the interviews – the researcher engaged with her participants for a sufficient period of time to exclude reactive effects.
- Triangulation – data collection involved interviews, the use of audio-recordings and field notes to ensure that collected data is accurate, vivid and comprehensive.
- Peer review – the supervisors were requested to review transcripts and codes while the co-coder checked the themes and sub-themes.

1.12.2 Neutrality

The qualitative approach to this criterion is conformability, which refers to the potential for congruency of data in terms of accuracy, relevance or meaning (Brink *et al.*, 2012:173). This criterion is concerned with establishing whether the data represents the information provided by the participants and that the interpretation of the data was not fuelled by the researcher's imagination.

- The criterion was met by doing the following:
- Data triangulation – different methods were used for data collection, in other words the use of audiotapes during the focus group interviews, field notes capturing and to compile a thick and rich description of findings

- The researcher used an interview schedule and remained aware of her own beliefs. She withheld her own assumptions (bracketing) to maintain the objectivity of the study.
- A co-coder (researcher who hold a PhD. with experience in co-coding) was used for data analysis and for the verification of transcripts and codes. A co-coder helps to reduce the bias of the researcher. In this case the co-coder took note of verbal and non-verbal cues during the interview as captured in the field notes and checked if data was completely netted.
- Enquiry audits were done by an audit expert.
- Quotes that reflect participants' voices are included in the findings.

These strategies enhance the released findings to reflect the voice of the participants.

1.12.3 Consistency

Dependability, according to Brink *et al.* (2012:172), refers to the provision of evidence so that if the research is repeated with the same or similar participants (focus group participants) in the same context, the findings would be comparable.

During the data analysis dependability was safeguarded by the use of audit enquiries. The researcher sent the interview schedule to the supervisor to check the face- and content validity. This procedure increased the objectivity of the assessment of the study and the accuracy of findings. Checking the validity ensures that the interview measures and collects the real and precise data.

1.12.4 Applicability

The applicability of qualitative research is measured by the transferability of the findings. According to Brink *et al.* (2012:173), transferability refers to the ability to apply the findings to other contexts or to other participants. Findings in qualitative research tend not to be generalised, but another researcher should be able to use the findings, or even the population studied. Transferability was ascertained through the following:

- Data triangulation – different methods were used for data collection, in other words the use of audiotapes during the focus group interviews, field notes capturing and to compile a thick and rich description of findings
- Reduction of researcher effect – since the researcher has to explain the purpose of each focus meeting to participants, she had to let go of any preconceived judgements and remain neutral.
- The researcher held regular meetings with the co-coder to reach consensus and to discuss and cross-check the analysis.

1.13 DISSEMINATION PLAN

Communicating results is vital since additional research problems can be identified. Grove *et al.* (2013:602) have added that by presenting data and publishing findings, researchers advance knowledge and promote critical analysis of previous studies, encouraging further identification of additional problems. The feedback report was sent back to the focus groups (participants). The fully approved written report will be sent to the institutions where the research was conducted. Copies of the report will be sent to the NEI's within the district and to the FSDoH. Another written and approved report will be sent for publication in electronic accredited databases.

1.14 REPORT OUTLINE

The report was written in the form of the article model, Rule A.7.5.7 of the NWU. The Master's candidate, Mrs DMV Msimanga, conducted the research and wrote the manuscript. Dr A.C van Graan and Dr B. Scrooby acted as supervisors and auditors by providing valuable guidance during the research process and critically evaluating the process of research report-writing, thereby adding expertise and enhancing the quality of the research. One manuscript was written and submitted according to criteria for the "Health SA Gesondheid". The references and appendices are at the end of the report.

The research report is structured as follows:

Section 1:	Overview of the study	
Section 2:	Manuscript: Submitted for publication	
	Objective 1	To explore and describe factors influencing compliance to procedural guidelines of nurses enrolled in terms of R. 2175 of 19 November 1993 during delivery of patient care; and
	Objective 2	To formulate recommendations to promote compliance to the procedural guidelines according to the EN's' scope of practice to improve patient care.
Section 3	Evaluation of the research study, limitations and recommendations for research, nursing education and nursing practice.	
Bibliography of section one (1) and section three (3)		
Annexures		

1.15 CONCLUSION

This section provided an overview of the intended research report. The background and problem statement that aroused interest in the dilemma of factors influencing EN's' non-compliant attitude during clinical practice was explored and the meta-theoretical, theoretical and methodological assumptions, which directed the study were discussed. The section concluded with a brief description of the research design, research methods, ethical considerations and an outline of the report.

SECTION 2:
MANUSCRIPT



MANUSCRIPT

Factors influencing the compliance of EN's with procedural guidelines during patient care

Submitted to "Health SA Gesondheid"

GUIDE FOR AUTHORS.

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State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results. The introduction should include the following:

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This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature. Conclusions, Limitations & Recommendations for Future Research The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

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If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

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Article title: Factors influencing the compliance of EN's with procedural guidelines during patient care

Full author details:

Dimakatso M.V. Msimanga
Free State School of Nursing (Eastern Campus)
E-mail: makimsimanga@gmail.com

Dr Anna C. van Graan

School of Nursing Science, North-West University (Potchefstroom Campus)
E-mail: Anneke.VanGraan@nwu.ac.za

Dr Belinda Scrooby

School of Nursing Science, North-West University (Potchefstroom Campus)
E-mail: Belinda.Scrooby@nwu.ac.za

Corresponding author:

Dr Anna C. van Graan
School of Nursing Science,
North-West University (Potchefstroom Campus)
Private bag X6001
Potchefstroom, South Africa 2520
Tel: 082 6869659
E-mail: Anneke.VanGraan@nwu.ac.za

Authors' Contributions

The report was written according to the article model, Rule A.7.5.7 of the NWU. The Master's candidate, Mrs DMV Msimanga, conducted the research and wrote the manuscript. Dr A.C. van Graan and Dr B. Scrooby acted as supervisors and auditors by providing valuable guidance during the research process and critically evaluating research report-writing, thereby adding expertise and enhancing the quality of the research. One manuscript will be written and submitted according to criteria for the "Health SA Gesondheid". The references and appendices are at the end of the report.

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ABSTRACT

Patient care is a multi-disciplinary approach, but patients are in reality largely dependent on the 24-hour care rendered by nurses. In the current South African health care setting the media often reports that patients' rights have been infringed, and families often attribute unexpected outcomes to poor clinical services. The heavy load of nursing activities, irrespective of patient-nurse ratio per nursing unit, have forced nurses to shift patient-orientated care to task-orientated care. Studies identified increased stress levels during role transition from a pupil nurse to an enrolled nurse (EN). Insufficient guidance or support results in a lack of self-confidence among nurses during patient care delivery. The study aimed to identify and describe the factors that influence EN's' compliance to procedural guidelines during patient care. An explorative, descriptive contextual qualitative approach was followed. Participants (n=34) were purposively selected according to set criteria from public hospitals and primary health care clinics within the district of Thabo Mofutsanyana in the Eastern Free State and voluntarily interviewed in semi-structured focus groups. Data from four (4) focus groups were analysed according to principles for content analysis. Seven (7) themes and associated sub-themes were identified. The study identified feelings of being inadequately prepared for the new role and a lack of support once qualified. Non-compliance was acknowledged and recommendations for effective communication, improved resources and continued in-service training were recommended for quality improvement on patient care.

Key concepts: factor influence, patient care, compliance, EN's, procedural guidelines

OPSOMMING

Pasiëntsorg berus op 'n multi-dissiplinêre benadering, maar in realiteit is pasiënte grootliks oorgelewer aan die 24-uur sorg van verpleegkundiges. In die huidige Suid-Afrikaanse opset berig die media gereeld van pasiënte wie se regte geskend is, en naasbestaandes skryf ongewensde uitkomst dikwels toe aan swak kliniese dienste. Die swaar lading van verpleegaktiwiteite, ongeag die pasiënt-verpleegkundige verhouding per verpleegeenheid, noop verpleegkundiges om pasiënt-gerigte sorg te verskuif na taak-georiënteerde sorg. Verskeie studies rapporteer verhoogde stresvlakke na die rolverskuiwing van 'n leerlingverpleegster na 'n ingeskrewe verpleegster. Ontoereikende leiding en ondersteuning veroorsaak dat verpleegsters min self-vertroue het gedurende pasiëntsorg. Die studie het faktore wat ingeskrewe verpleegkundiges se nie-nakoming van prosedurele riglyne gedurende pasiëntsorg beïnvloed ontgin en beskryf. 'n Verkennende, beskrywende, kontekstuele, kwalitatiewe benadering is gevolg. Deelnemers (n=34) is doelgerig uitgesoek volgens vooropgestelde kriteria uit openbare hospitale en primêre gesondheidsorgklinieke in die Thabo Mofutsanyana-distrik van die Oos-Vrystaat en vrywillig betrek by semi-gestruktureerde fokusgroeponderhoude. Die data van vier (4) fokusgroepe is geanaliseer na aanleiding van die beginsels van inhoudsanalise. Sewe (7) temas en verwante sub-temas is geïdentifiseer. Die resultate toon dat verpleegkundiges voel dat hulle onvoldoende voorbereid is vir die nuwe rol en ervaar 'n gebrek aan ondersteuning nadat hulle gekwalifiseer is. Deelnemers het nie-nakoming bevestig en aanbevelings gemaak vir effektiewe kommunikasie, verbeterde hulpbronne en voortgesette indiensopleiding om die kwaliteit van pasiëntsorg te verbeter.

Sleutelwoorde: faktorinvloed, pasiëntsorg, nakoming, ingeskrewe verpleegkundige, prosedurele riglyne

INTRODUCTION

The scope of practice of enrolled nurses (EN's) and the factors that influence compliance to procedural guidelines during patient care delivery in a specific context was investigated in this study. There are a limited number of studies available on ENs compliance to procedural guidelines and this matter therefore needed investigation.

Background

In the current South African health care setting, the media often reports that a patient had been admitted for a simple diagnostic procedure or normal birth delivery in public hospitals, but next of kin were unexpectedly informed that the patient has been admitted to an intensive care unit or has died (South African Human Rights Watch, 2011:1-4; Malan, 2015:3-5). The families of patients often attribute this unexpected outcome to poor clinical services.

Patient care is a multi-disciplinary activity, but patients are basically dependent on the 24-hour services rendered by nurses. A nurse is someone who is specially trained in the scientific basis of nursing and who meets certain prescribed standards of education and clinical competence to care for the sick (Oxford Advanced Learner's Dictionary (OALD), 2006:1002; Mosby's Dictionary of Medicine, Nursing and Health Professions (MDMNH), (2013:1246). The Nursing Act of 2005 (Act No. 33 of 2005) defines a nurse as a person registered within a category in order to practice nursing (South African Nursing Council (SANC), 2005:6). In South Africa only persons that are enrolled or registered with SANC can perform patient care to the extent that their scope of practice allows.

MDMNH, (2013:1248) defined nursing as concerned with the promotion of health and caring for the sick. Similarly, SANC defines nursing as a caring profession that enables

and supports the patients, ill or well, at all stages of life, to achieve and maintain health or where possible, cares for the patient so that he can live in dignity until death (SANC, 1992:1). Gwagwa (2014:8) has added that nursing as a profession requires compassion, a deep commitment and the ability to develop warm interpersonal relationships with patients and other team members while rendering health care.

SANC stipulates that a person needs formal training to practice as a nurse. The council as a statutory body determines the duration of training and provides the training and guidelines relating to the scope of practice. SANC issues certificates to nurses on completion of training and enrolls them in terms of R.2175 of 19 November 1993, Nursing Act 33, 2005) (Geyer, Mogotlane & Young, 2009:35).

Nurses can only be trained at a nursing education institution (NEI) as accredited by SANC before enrolment as a nurse (Nursing Act, 2005), (Act No. 33 of 2005) (SANC, 2005). The main purpose of nursing training is to develop the pupil nurses personally and professionally. Training is aimed at the cognitive, affective and psychomotor development of the student nurse, with the outcome of theoretical and clinical competency (R.2175 of 19 November 1993) (SANC, 1993).

According to Grossman (2007:28), pupil nurses are assigned to particular clinical settings and are formally and informally guided by professional nurses through their experiences over a predetermined period of time as stipulated by the scope of practice (R.2175 of 19 November 1993) (SANC, 1993). This enables pupil nurses to become empowered and to develop personally and professionally in a caring, collaborative, cultural, religious sensitive and respectful environment (Grossman, 2007:28). Regulations relating to the scope of practice of persons enrolled under R.2598 of 30 November 1984, as amended (Nursing Act, 1978 as Government Notice, R.2598 of 30

November 1984), states that EN's, as the focus of this study, should be working inter-dependent and under the supervision of a registered nurse (SANC, 1984).

The conditions under which nurses work in a multi-skilled setting experience, including staff shortages and subsequent task overload, exposes nurses to being overworked and working beyond their scope of practice (French, Du Plessis & Scrooby, 2011:5). This has unfortunately made the environment intolerable. Teng, Hsiao and Chou (2010:282) have indicated that nurses experience continuous time pressure that may hinder patient perceptions of nursing care quality.

On evaluating quality of care, Teng *et al.* (2010:276) have found that time pressure creates negative emotions associated with poor quality care, as it reduces nurses' ability to assess risks. Duffield, Diers, O'Brien-Pallas, Aisbett, Roche, King and Aisbett (2011:253) have supported the above statement and added that the mentioned increased workload increases adverse events and the deterioration of patient care. Gwagwa (2014:8) has highlighted that quality patient care also depends on self-motivated personnel, personnel capable of hard work and effort without the need for encouragement to support a positive working environment (OALD, 2006:1326). Awases, Bezuidenhout and Roos (2013:7) have supported the view that a positive and conducive work environment can strengthen the commitment observed among nurses irrespective of constraining problems identified in the workplace. A positive environment has subsequently been further recommended and presented by Klopper and Coetzee (2014) and Gillespie (2014) at different South African Nursing research conferences.

George, Atujuna and Gow (2013:7) as well as Saari and Judge (2004:395-407) have compared employee attitudes and job satisfaction among other factors influencing competence, and have stressed that the work circumstances themselves were often

overlooked when addressing job satisfaction. Kekana, Du Rand and Van Wyk (2007:24-35) have highlighted that factors such as high workload and increased work pressure/stress, a lack of support and supervision from management, poor pay and fringe benefits, as well as poor opportunities for professional growth influence staff satisfaction and consequently patient care (Malan, 2015:3-5). As indicated, more than 60% of the participants from a Limpopo community hospital identified the factors above as dissatisfying components (Kekana *et al.*, 2007:24-35). Oosthuizen and Ehlers (2007:14); Duffield *et al.* (2011:251) and Joubert (2009:19) have supported the above-mentioned statements as some of the negative factors identified by South African nurses that lead to an increased emigration rate to other countries, which contributes to the mentioned shortage of nurses and the deteriorating work environment.

Problem statement

Kekana *et al.* (2007:29) have found that a high load of nursing activities have forced nurses to shift patient-orientated care to task-orientated short-cutting. A nurse who is task-orientated focuses on the completion of a task within the shortest possible period of time, irrespective of patient-nurse ratio per nursing unit (Booyens, 2010:310). Higgins, Spencer and Kane (2010:499-508) have identified that nurses experience increased stress levels as they enter their new role on transitioning from a pupil nurse to enrolment as a nurse. The study identified feelings of being inadequately prepared for the new role, as well as lack of support once qualified (Higgins *et al.*, 2010:501). Durrheim and Ehlers (2001:15) have indicated that nurses experience a culture shock, with result that the allocated tasks are either delayed or not performed at all. In pursuit of complete daily patient care despite poor staffing and heavy workload, Booyens (2010:311), supported by Teng *et al.* (2010:282) has further mentioned that the tasks nurses have to fulfil become repetitious and boring. Nurses then tend to ignore or fail

interpretation of the significance of patients' reactions, which directly compromises patient care.

Despite intensive training and facilitation to deliver comprehensive and holistic care-rendering nurses, including nurses enrolled under R. 2175 of 19 November 1993, nurses in public institutions have lost their enthusiasm and they tend to be ignorant to patient-nurse interpersonal relationships, aseptic hand washing/infection control, patient safety measures principles, tasks related to basic nursing care such as comforting, communication as explanation of procedures and obtaining consent prior to procedures/care rendering. Unfortunately, quality patient care has been negatively influenced (Teng *et al.*, 2010:282).

Research aim and objectives

Considering the above problem statement, the aim of this study was to explore why EN's don't comply with procedural guidelines during patient care. In order to address this aim, the following two (2) objectives were identified:

- To explore and describe factors influencing compliance to procedural guidelines of nurses enrolled in terms of R. 2175 of 19 November 1993 during delivery of patient care; and
- To formulate recommendations to promote compliance to the procedural guidelines according to the EN's' scope of practice to improve patient care.

RESEARCH DESIGN

The below description outlines the research methodology with special attention to the research approach, design, research method, ethical issues applicable to this study, its trustworthiness and the limitations of this study.

Research approach

An explorative and descriptive, contextual qualitative design was followed to discover the factors influencing compliance to procedural guidelines during patient care.

Research methods

The methods congruent with the research design employed in this study included decisions regarding the study population, sampling, methods for data collection and data analysis. The subsequent paragraphs provide a brief description of the research method.

Population, sampling and research setting

The population of this study included all EN's (EN's) in the Thabo Mofutsanyana district of the Eastern Free State Province of South Africa (N=71) who have passed the progression test from Enrolled Nursing Auxiliary (ENA) to EN over a period of five years preceding the study (2008-2012). The period was extended to five years in order to increase the sample size for sufficient data to be collected. A *purposive sampling method* was used in this qualitative research because of the fact that the chosen category had to have a nursing background. The researcher needed typical and divergent data, which made this category of nurses suitable, although the problem is not just specific to EN's (Botma, Greeff, Mulaudzi & Wright, 2010:201). This category of nurses was chosen because:

- Their drive to progress from ENA to EN shows passion for the profession; and
- The staff nurse, as the mid-level worker in nursing, is an essential provider of nursing care with full responsibility and accountability for their nursing care under the supervision of a professional nurse (Brannigan, 2010:4).

A sampling frame (as seen in Table 1) comprised a list of all EN's, but only the ENs in the Thabo Mofutsanyana district from public hospitals and clinics were drawn. The relevant information was obtained from the institutions.

Table1: Sampling frame

Tabulated statistics of candidates in hospitals and clinics around the Thabo Mofutsanyana district (App 2012/2013:26&96)	Public hospitals	PHC clinics	Total number of facilities	EN's trained over the last five years (2008–2012)
MAL A	3	40	43	44
SET B	2	15	17	1
NKE C	1	9	10	3
DIH D	2	13	15	16
PHU E	1	6	7	6
MAN F	-	6	6	1
Total	9	89	98	71

The study sample comprised EN's who complied with the following inclusion criteria:

- EN's in the Thabo Mofutsanyana district employed at public hospitals and Primary Health Care (PHC) clinics;
- EN's who have undergone formal training within the previous five years (2008-2012);
- EN's who have passed the progression test from ENA to EN according to SANC;
- EN's who gave their permission that interviews may be audio-recorded;

- EN's who were prepared to participate in focus group interviews through medium English; and
- No restrictions to age group and gender were stated due to the size of the population and to optimise participants.

Data collection

Data was collected from EN's using audio-recorded semi-structured focus group interviews (Grove, Burns & Gray 2013:269; De Vos, Strydom, Fouché & Delport, 2011:359). Purposeful sampling was used, including EN's who complied with the inclusion criteria. The method was semi-structured in that the researcher had an interview guide (Botma *et al.*, 2010:209) for consistency over all four groups interviewed. All interviews were conducted in focus groups for the sake of group dynamics. It enabled the participants to share, compare and produce large amounts of concentrated, authentic data in a non-threatening but interactive setting within a short period of time (De Vos *et al.*, 2011:362; Grove *et al.*, 2013:274).

Following information sharing, an interview timetable was created to accommodate participants at a time convenient to them as per instruction from the department. Thirty four (n=34) participants took part in the focus group interviews voluntarily and consent forms were signed on the interview date prior to the interviews. Focus group interviews were conducted in a private, comfort room away from the clinical institutions. As the district is made up of six municipalities and the sample had to include all districts, the researcher interviewed participants in four separate focus groups varying from 6-10 participants per interview. Based on guidelines found in literature (Grove *et al.*, 2013:276; Polit & Beck, 2012:538), the same questions were asked to all groups based on an interview guide. The questions were specifically aimed at *exploring, identifying*

and *describing* factors influencing compliance to procedural guidelines during patient care delivery.

All interviewed groups were similar to each other in work experience (they were all in the same nursing category- EN's) and characteristics (as open mindedness in terms of the work environment) to facilitate open discussion (Grove *et al.*, 2013:274). All the interviews were conducted by the main researcher, using such communication skills as probing and reflections (Grove *et al.*, 2013:271). Questions were rephrased and repeated as applicable and facilitative communication techniques were used to ensure exploration of the topic (De Vos *et al.*, 2011:361). The prolonged time spent with data collection contributed to the richness of the data collected. Interviews were stopped when repetitious data was emphasised by participants (Botma *et al.*, 2010:211). Questions were asked later if issues had not been spontaneously clarified. Each interview lasted almost an hour, with the co-facilitator managing the audio-recorder and keeping field notes (De Vos *et al.*, 2011:373). The co-facilitator made reflective notes and these were discussed immediately after the interview as suggested by Stommel and Willis (2004:286) and Botma *et al.* (2010:224). The researcher reflected on her personal experience later after the interview with the co-facilitator. All the audio-recorded interviews were analysed immediately after each interview. Data was sent to an independent transcriber for verbatim transcription. Transcripts were validated by the researcher through prolonged engagement the researcher re-listened to each tape while reading and comparing the transcripts for completeness (Brink, Van der Walt & Van Rensburg 2012:172).

Data analysis

Interviews were stopped when data saturation was reached (i.e. when no more new themes could be identified) (Brink *et al.*, 2012:141). The transcripts, field notes and a work protocol that included the study objectives and a clear description of the data collection method and the central question asked to the participants were sent to the co-coder. Themes were identified by the researcher and the independent co-coder (Grove *et al.*, 2013: 281).

Data saturation was clear when data was analysed. The transcribed data was organised and coded using Tesch's eight steps of the coding process (Botma *et al.*, 2010:224). When organising data, each transcript was divided into three columns, with the middle column being used for the participant's verbal responses. The right-hand column was used for the themes that emerged from the responses. The left-hand column was used for analysis and writing the insight that became evident from the response. The coding process to organise and segment data into themes and sub-themes included a combination of techniques for analysis described by Tesch (as cited in Creswell, 2009:186) and Giorgi (as cited in Polit & Beck, 2012:566). The co-coder's findings were triangulated with the findings of the researcher and consensus was reached on themes and sub-themes.

ETHICAL CONSIDERATIONS

Permission to conduct the study was granted by the Health Research Ethics Committee of the North-West University, Potchefstroom Campus (NWU HREC- 00157-13-S1), (the title adjusted as requested by the NWU, Faculty of Health Sciences research committee), the Free State Department of Health (FSDoH) and the heads of the relevant institutions in Thabo Mofutsanyana district. Participants were requested to give

their consent in writing after adequate information about the research topic and purpose had been provided. Information to the participants included their rights to accept, decline or withdraw participation at any time without judgement and fear of harm. Their rights to privacy, confidentiality, and anonymity, as well as their right to complain if they suspect any unfair treatment or emotional harm (Botma *et al.*, 2010:11-27) were also stressed.

Trustworthiness

The principles of trustworthiness as described in Lincoln and Guba's model were used (Grove *et al.*, 2013:419-421). In an effort to ensure credibility, dependability, conformability and transferability, the following procedures were followed:

Credibility was ensured by means of the following measures:

Sufficient time, an hour at most, was given for each focus group interview. The researcher included a trial run to test the clarity of the questions asked during the focus group interviews. This assisted the researcher in rephrasing questions in the interview guide to be clearer and non-leading. Adequate data was sourced through focus group interviews, field notes, and national and international literature on the topic. The use of audio-recordings ensured that the researcher did not forget or misinterpret the participants' words and field notes to ensure that no significant observations would be forgotten. Data was verified with participants to ensure that data had been adequately captured and an expert in data analysis assisted with coding (De Vos *et al.*, 2011:420).

Dependability was ensured through the central questions posed to all participants. The research plan, method and implementation was checked by the study leader and checked against the available literature. All audio-recorded focus group interviews were

transcribed by an independent transcriber and the transcripts were validated by the researcher. Data was accounted for through literature control and linked to existing research findings (Botma *et al.*, 2010:196).

Transferability, was assured by means of the technique used to select participants. Purposive sampling was used to select EN's who meet the set criteria and the content analysis process used by researcher provided detailed and thick findings that can be transferred to other settings where there is a desire to change the undesired practice discussed in background. The findings are auditable through member-checking. Each participant got feedback in the form of a report to verify the data provided before being finalised. Data was also accounted for by means of a literature control and linked to existing research findings (Botma *et al.*, 2010:196).

Conformability was ensured as the researcher kept the original interview schedule and the audio-recordings, as well as the transcripts and notes to provide an audit trail. The co-coder approached for data analysis is an expert in qualitative research. There was consensus between the researcher and co-coder regarding the interpretation of the data and findings. The findings are supported by verbatim quotes and related literature (De Vos *et al.*, 2011:421).

Findings and Discussion

EN's from public hospitals and PHC clinics within the Thabo Mofutsanyana district in the Eastern Free State were interviewed to reveal and exchange their viewpoints on the factors influencing compliance with procedural guidelines during patient care. During this process numerous new ideas were revealed. Data from four focus group interviews were analysed by the researcher and an independent co-coder according to the principles for content analysis as described by Tesch in Creswell (2009:185-186).

Seven themes and associated sub-themes as tabulated in Table 2 are now discussed and integrated with literature to culminate in concluding statements.

Table 2: Co-coding and themes

THEME 1: Shortage of resources Sub-theme 1.1: Human and Physical resources (Equipment and facilities)	THEME 5: Recommendations at Professional level Sub-theme 5.1: In-service training Sub-theme 5.2: Guidance/Advocacy
THEME 2: Attitudes Sub-theme 2.1: Attitudes of colleagues, patients and self	THEME 6: Recommendations at the Management level Sub-theme 6.1: Adequate supply of resources
THEME 3: Expectations Sub-theme 3.1: Expectations from colleagues, patients and management	THEME 7: Recommendations at the Provincial Government level Sub-theme 7.1: Attitude
THEME 4: Consequences of compliance to procedural guidelines Sub-theme 4.1: Workload Sub-theme 4.2: Task-orientated Sub-theme 4.3: Emotions/Feelings	

THEME 1: SHORTAGE OF RESOURCES

One sub-theme, namely a shortage of human and physical resources, was identified and is hereunder discussed and integrated with literature below.

Sub-theme 1.1: Shortage of human and physical resources (Equipment and facilities)

In all the interviews conducted, participants agreed that limited resources were the main factor influencing compliance with procedural guidelines during patient care. Participants included a lack of human, physical and material resources as having a negative impact on the nursing practice. Participants stated that the allocation of nurses to the institution according to their experience, do not correlate with the work that is expected. For example, three (3) EN's are allocated for a unit that accommodates around 30 patients, and then there is insufficient equipment for each patient's needs. All participants felt that with the limited number of nurses and the limited equipment, like dressing packs and thermometers, for instance, together contribute to non-compliance, especially given the increasing population in need of health care. This situation increases the pressure on nurses to finish their daily work with the little they have in hand. These arguments have also been supported by Malan (2015:1-5), who has added that this unfortunately deprives patients of quality nursing care. Compromising during care delivery was identified as the coping mechanism to get the work done. The participants described their experiences with comments like the following: *"there's no staff, there's not enough staff for all the surgical patients. We are only two persons at night and we are having like 28 or 26 patients and we're supposed to do everything"* (Interview 3), while others participants added *"But now if they say there is a shortage of money, then we have to compromise and take some kidney dish and do like aseptically clean procedure né"* (Interview 2).

Nurses from both clinics and hospitals share these sentiments. A clinic nurse explained: *".....at the clinic we don't have those dressing packs, it's only gauze and few receivers and solutions"* (Interview 1), while participants who work at hospitals said *"maybe when*

we do dressings, patients to be dressed eh, are like too many and the dressing packs maybe we will be having only eight or maybe five” (Interview 4). The participants even stressed that although the number of people who’s in need of services is ever-increasing, the physical resources limit them and they can no longer maintain, for example, privacy as the part of their principles of care.

Pillay (2009:7) has highlighted the impact of both human and material shortages with comparison between the private and public sectors regarding work satisfaction pillars for nurses working in these sectors. Of interest, the findings revealed that a shortage of resources not only has a negative impact on service delivery, but on patients’ recovery, as their length of stay is prolonged. This has also been accentuated by Malan (2015:3). Participants confirmed that they have to run around borrowing equipment from other units before they can perform nursing duties during patient care. In the end, due to time constraints they end up just ignoring correct procedural guidelines. They agreed that they understand procedural guidelines, but limited resources force them to divert to non-compliance. One participant said *“equipment as incubators and all other stuff are all there” (Interview 2).* The same feeling has been identified by Ball (2010:144) when investigating compliance to surgical smoke evacuation guidelines, which created serious respiratory complications in health care workers. Efstathiou, Papastavrou and Merkouris (2011:5) have accentuated that though nurses are aware of procedural guidelines, some even made to protect them, the unavailability of equipment at hand, when needed, keep them from complying to standard precautions.

THEME 2: ATTITUDES

One sub-theme, was identified and is hereunder discussed and integrated with literature below.

Sub-theme 2.1: Attitudes of colleagues, patients and self

Participants distinguished between attitudes within (the nurse's self), amongst colleagues (other category nurses and doctors), patients, and members of the community. Time pressures and the workload has changed their attitudes regarding how they should interact with each other.

Unfortunately, participants identified communication problems and conflicts with other categories of staff. The interviews indicated that poor communication, disrespect, diminishing team spirit and failing collaboration in the form of team work, were chipping away at the positive nursing attitudes the participants had once possessed. The participants stressed the "laziness" displayed by their colleagues (other nursing categories included). As expressed, *"I think we lack passion of what we do, at times ..."* (Interview 1), *"you'll find that, that the other sister is working, she's a hard worker and then the other one is lazy"* (Interview 1). One participant commented on nurses' attitudes by saying *"they are already fed-up, more especially if you have your issues from home and then when you enter the hospital....."* (Interview 1).

When patients' attitudes to nurses were probed, participants added that some patients have negative attitudes towards nurses, *"... patients, at times they will come with their negative attitude towards you."* (Interview 1), *"but the negative attitude observed from patients has been influenced by attitudes of nurses, and by poor communication amongst themselves"* (Interview 2). The impact of poor communication by other staff members (doctors) accentuates the nurses' spirit and passion.

Participants explained that poor communication contributes significantly to the attitudes displayed by patients. The participants complained that at times doctors do not communicate their orders to nurses, or some nurses are lazy to take doctors' rounds:

“you’ll end up finding that patient is being discharged without being done what he/she has been admitted for, either just because the doctors were not accompanied during their round and therefore they could not explain their reasons for cancellation of certain procedures to the level of patients understanding” (Interview 2). The participants complained that at times, due to poor communication, they only notice doctors’ orders very late, and patients get angry when the nurses still have procedural duties to perform. One participant for instance said: *“...this patient is now anxious and angry; he said he was promised to be discharge long ago when transport was still not a problem” (Interview 2).*

Participants revealed that poor communication influences team work and this makes nurses negative towards each other. Within the status quo, as expressed in theme 1, team work is a crucial strategy to limit conflict, and Ball (2010:148) has added that each member should value input and opinions of others. Pillay (2009:7) has also agreed by saying that optimal health provision depends on teamwork and multi-disciplinary cooperation and communication.

Gurses, Marsteller, Ozok and Xiao (2010:282) have emphasised that attitudes of team members, including patients, should change in a way that both health care team members and patients interact more frequently. Verhoeven, Steehouder, Hendrix and Van Gemert-Pijnen (2009:674) have accentuated that the lack of knowledge influences attitudinal behaviours negatively and that more interpersonal communication in any form, including obligatory in-service training sessions, should be recommended.

THEME 3 : EXPECTATIONS

One sub-theme, namely the expectations of colleagues, patients/community and management was identified and is hereunder discussed and integrated with literature below.

Sub-theme 3.1: Expectations from colleagues, patients and management

Different expectations of managers, patients, doctors and fellow nurses regarding patient care often cause increased tension and frustration among the nursing personnel.

Participants explained that, regardless the time of the day or the numbers of personnel on duty, the nurses working different shifts expect each team to finish allocated tasks before going off duty, while doctors also expect that their orders should be carried out. Expectations at times are irrespective of whether resources are adequate or available at hand. Participants were grateful that they have better knowledge about patient care, but feel that they are now expected even to support their subordinates. The participants expressed the expectations from colleagues as follows:

“sometimes you’re getting the new students in a ward, so most of the time there are added responsibility to show them things, to teach them how we do things in the ward and stuff” (Interview2), Another said “...when the night staff comes they will be expecting that everything must been done.” (Interview1).

In addition to patient care, participants mentioned that the records should be updated throughout. Participants complained that there is much paper work that they are expected to complete. As stated, more pressure is added when managers say “...what

is not written was not done” (Interview 3). Most of the groups agreed that they really work under pressure.

Participants verbalised that since patients are informed and know their rights to health care as stipulated in the Bill of Rights in the Constitution (Republic of South Africa, 1996, as explained by Mellish, Oosthuizen, & Paton (2010:167), nurses are under more pressure to avoid complaints. This pressure causes the participants to lose their motivation to get the job done well. Participants explained how they experience pressure from all angles in that even the patients at clinic level demand the *“first-come-first-serve principle” (Interview1)*, irrespective of nurses’ judgement to classify them according to their level of illness.

The expectations of patients are related to the Batho Pele principles. These principles were formulated as a government initiative aimed at improving service delivery to the public within the health care sector (Meyer, Naude, Shangane & Van Niekerk, 2009:140) by providing guidance on how individuals should behave and treat one another. If the definition is well understood, the guidelines were intended to create a kind of common practice. The perception is that in the new democratic South Africa, by now, South Africans know and understand their rights, their responsibilities and even that they have to respect the rights of others, but it seemed from the interviews that in practice, the acute focus on rights turns out to create patients that are too demanding. This puts the most strain on nursing personnel who do bedside nursing and who work directly with patients.

James and Miza (2015:4) have evaluated the perceptions of health care personnel after the introduction of the Batho Pele principles in state hospitals, and according to their participants, the objective of these principles was good, but the implementation lacked

proper planning. The principles in the end did not result in the set positive objective of providing quality services or developing competent, committed and professional health care workers for whom patients come first. As expressed by the participants during this study, it created patients who want to hear what they want to hear.

Meyer *et al.* (2009:277) have identified the above as sources of stress that result in tension, anger, frustration and low group cohesion. Participants agreed that the increased stress levels and high expectations of patient care that EN's are faced with have resulted in work related fatigue, which can even increase morbidity among nurses (Vasconcelos, Marqueze, Araujo, Fischer & Moreno, 2012:3735).

THEME 4: CONSEQUENCES OF COMPLIANCE TO PROCEDURAL GUIDELINES

Three (3) sub-themes, namely workload, task- orientated and emotions/feelings were identified and are hereunder discussed and integrated with literature below.

Sub-theme 4.1: Increased workload

Participants agreed that when they first finished their training, they thought that with the knowledge they have gained and by working according to the scope of practice of an EN's, they would have a positive impact on nursing practice and consequently on the treatment of patient care. Instead, they found that their extended knowledge has impaired their practice. Reasons for this hampering of practice include factors like that they are expected to know more and even to perform certain activities that are out of their scope of practice. The feeling was that once knowledge increases, so does "burnout". The participants verbalised the following... "*just because the staff nurse understands infection control...you are going to leave your work to be the cleaners and take the mop to clean the place that has been messed (Interview 2); "....sometimes you*

are doing work of the sisters helping with issuing of medication, with the doctors rounds.” (Interview 2); “...we do everything which is not within our scope.” (Interview 3).

Brady, Malone and Fleming (2009:691) have highlighted that multi-tasking can cause multiple interruptions during delivery of patient/health care. These interruptions include poor control of nursing activities and medication errors. Participants noted “... *being under stress, you make the wrong decisions, as during medicine administration*” (Interview 3).

Sub-theme 4.2: Task-oriented

With increased expectations as explained in theme (3) and increased workload in (sub-theme 4.1), EN's have less time to work procedurally or to explain nursing interventions to their patients. Participants' perception was that the more informed you are at work, the more under pressure you have to work. Participants revealed further they no longer care about the consequences of their actions during patient care. Holistic and affective care has been replaced by “task-orientated”, unsupervised care.

Workload and pressure from colleagues and management to complete allocated tasks within a certain time continues, resulted with that, the issue of adherence to procedural guidelines is ignored. Participants verbalised as follows:

“There is a lot of that work and the patients have to be seen not tomorrow, no matter what time is it” (Interview 4); “.....because now we are doing a lot of work at one time” (Interview 2). This was found to be a contributory factor to poor relationships among staff members, which increases stress. As earlier highlighted (Brady, Malone and Fleming, 2009:691), a link between multi-tasking and multiple interruptions during delivery of patient/health care involves interruptions include poor control of nursing

activities and medication errors. Such phrases were noted by participants during interviews “... *being under stress, you make the wrong decisions,*” (Interview 3).

Despite the work environment that increases non-compliance, Awases *et al.* (2013:7) have identified commitment among nurses irrespective of the challenges observed. Their findings confirm what participants reported in this study, “*you really want to finish allocated tasks you are doing at some small time, so you’ll speed up other things, you do things like you are in a hurry you see*” (Interview 4). Lomaz, Naranjee and Karodia (2014:55) have confirmed that an unmanageable workload has a negative connotation in that staff feels they are not coping with their daily duties, which in turn leads to exhaustion. For patients, there is a risk of treatment not being rendered according to protocol.

Sub-theme 4.3: Emotions

Some of the comments, when interpreted alongside the participants’ tones of voice, sounded like nurses who are exhausted, depressed, with symptoms of burnout. Pillay (2009:1-10); Bezuidenhout and Cilliers (2010:1-10) and Klopper, Coetzee, Pretorius and Bester (2012:686) have all agreed to the presence of burnout among nurses and have expressed that it leads to job dissatisfaction. According to Bezuidenhout and Cilliers (2010:6), increased job demands reduce professional efficacy and nurses are becoming detached from interpersonal relationships. In today’s practice, nurses’ humanistic caring goal has turned into what Coetzee and Klopper (2010:240) have referred to as compassion fatigue where they are physically rendering patient care, but lack endurance, enthusiasm and apathy. Vasconcelos *et al.* (2012:3735) have also statistically and significantly associated overtime hours worked, to mental strain and

high morbidity among nursing personnel. Brady *et al.* (2009:691) have accentuated that even medication errors are exacerbated by mental exhaustion.

Conclusion statement for Themes 1-4 (Identified factors)

Participants were aware of procedural guidelines and acknowledged the need to use them, though they identified key factors that prevent them from adherence to procedural guidelines and remaining committed to patient care. All the participants agreed that there is non-compliance to procedural guidelines during patient care and they site factors mostly intrinsic to work-related circumstances such as resource shortages, a negative attitude, and insufficient communication. Efstathiou *et al.* (2011:9) have identified that time constraints and a heavy workload with limited personnel, especially in emergency situations or where many tasks have to be done at the same time, and the participants agreed to that. Participants added that irrespective of the number of nurses on duty per day, all patients expect to be seen on that specific day under such pressure. These situations inhibit nurses' adherence to procedural guidelines during patient care.

With above mentioned factors, the following themes were identified to address the problems experienced by EN's related to complying with procedural guidelines during patient care.

Participants offered recommendations to address the problems experienced by EN's related to complying with procedural guidelines during patient care. The recommendations are divided into recommendations at the professional level, the managerial level and at the government level.

THEME 5. RECOMMENDATIONS AT PROFESSIONAL LEVEL

Two (2) sub-themes, namely in-service trainings and guidance were identified and are hereunder discussed and integrated with literature below.

Sub-theme 5.1: 1n-service trainings

Participants recommended support, guidance and the use of a mentor. Data analysis revealed that support, even in the form of more in-service training, could help nurses to remain updated and within good practice. Participants stressed that institutions should have in-service training sessions or workshops. As verbalised, *“these things like in-service training...”* (Interviews 1 & 3) *“...and they should demonstrate more often on how it should be done”* (Interview 4). They reinforced the importance of strict attendance to in-service training and a positive mind set or attitudinal change regarding continued education. This was a common perception among all the participants interviewed and all agreed that positive thinking should be intrinsic, as education or training cannot change one’s personality. Pertaining to the continuity of education in any form, participants further added that *doctors should be included in teachable moments “....Yes I think we should include them and not have separate meetings”* (Interview 2).

Post-training there is a common expectation from both patients and staff in the clinical area that nurses should be competent and be able to provide optimal care. Ball (2010:144) has emphasised the need to increase the knowledge of individual nurses continuously through training. It can even become part of an orientation programme. French *et al.* (2011:7) have also agreed and recommended more in-service training as nursing is dynamic and strategies have to be enhanced to promote the emotional well-being of nurses.

Sub-theme 5.2: Guidance /advocacy

For guidance, mentorship was emphasised. Participants' comments: "*A mentor, we are in need of her to clarify some things...*" (Interview 3), demonstrated a desperate need from them for someone to guide them, provide continuous reassurance for skill improvement as they gain independency. As Ball (2010:144) and French *et al.* (2011:7), Garside and Nhemachena (2012:4-5) analysed the concept *competence*, they identified that competence requires the ability to replicate a skill. Ploeg, Skelly, Edwards, Davies, Grinspun, Bajnok and Downey (2010:242) have also suggested the development of champions who can take the role of an educator, facilitator, mentor and a leader to continuously disseminate information to nurses, including EN's, for delivering better patient care. Jokelainen, Turunen, Tossavainen, Jamookeeah and Coco (2011:2854-2867) in their systemic review of mentoring have accentuated that in pursuit of strengthening professionalism, adequate support in terms of mentoring in the context of supervision, teaching and reinforcement of positive emotional aspects should be extended to all nurses.

THEME 6: RECOMMENDATIONS AT MANAGEMENT LEVEL

One sub-theme, namely increased supply for resources, both human and material resources was identified and is hereunder discussed and integrated with literature.

Sub-theme 6.1: Adequate supply of resources

As mentioned, the shortage of resources was identified as one of the factors that contribute to nurses' non-compliance during patient care. Recommendations in this regard included statements such as "*so the management, when the budget is been done, they should 1st prioritise things needed mostly, like screens, to assure patient*

privacy, as really 1st priority” (Interview 2).” Different technologies have been introduced into the work environment to reduce the workload. Verhoeven *et al.* (2009:695) have found that equipment has reduced workload, but as participants said, there should be enough equipment as (Electronic blood pressure apparatus and Dyna-maps, ECG machines and intravenous line sets for IVAC's) so that stress is not added by running around borrowing from unit to unit before work can be done. A further recommendation related to equipment was that staff should not just receive once-off training during the first delivery of such equipment. Managers should advocate for continuous guidance, for each form of equipment has its own new guidelines and managers should support continuous inductions and reinforcement for new personnel. Bahtsevuviet, William, Stoltz and Ostman (2010:520) have explained that in nursing, each procedure has its equipment and guidelines that require adherence to increase patient safety.

All the participants agreed that there is non-compliance and they mostly identified factors that are intrinsic to the work environment. Participants suggested that managers should motivate for continuous formal & non formal trainings and provide adequate support for career development. Management should be understanding and demonstrate their managerial involvement through support at a personal level, for example, managers should make it possible for participants to become committed by organizing training and creating a supportive learning environment. Managers should encourage teamwork, have regular meetings with nurses to discuss and understand their challenges and advocate for them rather than focusing only on the expectation of complete recordings. They added that managers should motivate for employment of more personnel that includes the data capturers. They added that time spent on patient care becomes less due to the added paperwork they need to complete for each task performed. Participants are exhausted and burned out. Suggestions for support on

managerial level were verbalised as follows: *“For things like discharges and updating of admission books etc...maybe if we are nursing patients, we’ve got somebody in your consulting room who is doing the paperwork and then you concentrate on the patient”* (Interview 4).

Both French *et al.* (2011:6-7) as well as Jooste and Ntamane (2014:245) have accentuated that nurses feel motivated, empowered and competent to face challenges if they feel supported while being acknowledged for developing and implementing solutions to their problems. French *et al.* (2011:6-7) have further explained that it’s only with personal coping mechanisms such as task orientation, self-motivation and mutual support from colleagues (nurses and health care givers), that work related-stress is alleviated. Klopper *et al.* (2012:694) and Jooste and Ntamane (2014:244) have identified that employees who perceive a high level of support from the organisation are more likely to feel an obligation to repay the organisation in terms of affective commitment. Klopper *et al.* (2012:694) have recommended that a healthy, motivated workforce should depend on managers who ensure adequate staff to deliver safe and effective care to prevent burnout episodes, rather than motivating for overtime/long working hours. Coetzee and Klopper (2010:241) have also suggested establishment of an employee assistance programme in every health care institution to relieve stress and burnout symptoms and have added that inclusive techniques to deal with compassion fatigue should be included.

THEME 7: RECOMMENDATIONS AT PROVINCIAL GOVERNMENT LEVEL

A change in attitude or the way the provincial government perceive workload and quality care was a subtheme and a recommendation. This sub-theme is hereunder discussed with integrated literature.

Sub-theme 7.1: A change in attitude

It is evident that a shortage of material and human resources has a great impact on how patient care is rendered. The shortage of resources was for instance picked up by a health care user who complained in the Mail & Guardian newspaper (Malan, 2015:3-5). The specific case makes it evident that government interventions and the strategic plans for staff retention have to be reviewed. Participants recommended the provision of more resources in the form of providing enough equipment and employing and training more nurses. Kirwan, Mathews and Scott (2013:260) and James and Miza (2015:70) have pointed out that an increase in nursing staff levels and funds for hospitals decrease nurses' workload and increase quality patient care, and participants agreed with them. Participants said *"...they must hire more people ...uhm the government they must help us"* (Interview 1). The participants suggested that the government must also think about the increasing population, as these are the health care users. *"When I was appointed in re-engineering I was working in the community, we were all allocated for something like eh a ward and then we have to compile a profile, there was something like 556 people, but after a year when we go back to recompile, we found that the population there is, double, but then the staff is not there for those people"* (Interview 4).

Many researchers are comparing the work conditions in the public and private sectors by looking at several indicators (see Kondilis, Gavana, Giannakopoulos, Smyrnakis, Dombros & Benos, 2011:11 for a Greek perspective). Pillay (2009) and Klopper and Coetzee (2014) have studied the South African context, and though public hospitals in Greece were performing better in terms of working conditions, nursing staff and patient care than public institutions in South Africa (SA), burnout is escalating in public

institutions in both countries, possibly due to the workload demand influence by the increased population. Participants suggested that exhaustion and burnout should be addressed by offering better working conditions in terms of the provision of enough human and material resources. Bezuidenhout and Cilliers (2010:7) have emphasised in this regard that if burnout symptoms are not managed effectively and contained in the workplace here in South Africa, nurses will continue to emigrate to find better work conditions and wages (Pillay, 2009:7).

As said, participants recommended that the government's strategies to increase and retain nurses should be reviewed. At the moment, the efforts of training institutions to increase human resources are meaningless and the energy spent during training merely contributes to a "leaking pipeline" because post-training, nurses look for employment in the private sector where there are enough resources. As participants suggested *"...I think the government must also think about population statistics"* (Interview 4). Magobe, Beukes and Muller (2010:4) have suggested in their review of poor clinical competencies within the primary health care sector that government can contribute to adequate staffing by creating a preceptor ship post for continued professional support and improved skills competency and self-confidence. Work engagement and the sense of coherence had been badly affected by burnout.

Conclusion statement for Theme 5-7 (Recommendations)

Participants showed commitment to adherence to procedural guidelines and patient care despite the occasional lack thereof. Participants suggested recommendations to government for the provision of enough human and material resources, skills adherence and continuity of care. The participants recommended that management provide supportive management through continuous in-service training and

collaborative teamwork from colleagues (doctors and other health care givers) to enhance adherence to procedural guidelines and therefore better patient care.

CONCLUSIONS AND RECOMMENDATIONS

The following recommendations, with special reference to nursing education, nursing practice and nursing research, are based on the findings of this study and should enhance the EN's' compliance with procedural guidelines.

Recommendations for Nursing Practice

Pertaining to nursing practice, it is evident that students felt empowered by the supervision rendered during training and such support should be continued post-training as part of continuous development programmes. Clinical mentors should be established in each institution to continuously teach, guide and support all nurses who need it to maintain competence, correctness and self-confidence to nurses in clinical practice.

Recommendations for Nursing Education

NEI's should continue to derive new innovative teaching strategies that will produce a cadre who pursues continued education to keep up to date with new developments. Recommendations for Nursing Education include instillation of autonomy, independence and self-confidence during training so that nurses post-training are conscientious about following the correct guidelines without being policed.

Recommendations for Nursing Research

The passion with which individuals enter the nursing profession has been damaged by demoralised personnel and some of the factors discussed in the study, but nurses are still eager to further their training. Quantitative and longitudinal research could be done

to evaluate the work conditions as reason for non-compliance as well as whether from other categories (for example from registered nurses) same reasons could be identified. In this regard, further study (quantitative or qualitative) could be helpful to:

- Explore the feeling of working in such identified factors (qualitative-phenomenological design)
- Explore the driving force: Comparison between passion and jobless or resilience against jobless for nurses to remain in the profession (quantitatively-correlational studies)
- Or even evaluate and explore from other nursing categories for example registered nurses if identified factors are concrete when supervising these category of nurses under study

Research needs to be followed and expanded to other districts and provinces as well.

Limitations of the research

The number of participants (n=34/N71) and the level of participation (48%) could be listed as a limitation as they were restricted due to conditions attached to government approval, skeleton staff and because participants were not willing to participate in their leisure time. Despite the above mentioned circumstances' data saturation occurred and rich data was obtained.

Participants felt that since their contributions could improve working conditions, they preferred to be withdrawn during their working hours and therefore in some areas within the sub-district, no focus group could be formed. The findings of the research is transferrable to all nurses, irrespective of the category under study that was invited.

Conclusion

Procedural guidelines standardise the practice of patient care. Nurses should adhere to these guidelines to improve patient care and service delivery. The purpose of the study was to explore and identify factors that influence the non-compliance of EN's with these procedural guidelines during their patient care. The findings provided insight into numerous contributory factors, which allowed for the formulation of recommendations for nursing practice and nursing education. The results showed that the shortage of resources (human and material) and unrealistic work expectations influence nurses. These factors result in negative attitudes in health care teams and consequently about the work itself. Recommendations to the Free State Health Department included addressing staff shortages and the re-instatement of clinical instructors for health care personnel, especially due to the advantage this has for continued support and guidance.

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SECTION 3:
EVALUATION OF THE RESEARCH STUDY, LIMITATIONS AND
RECOMMENDATIONS FOR RESEARCH, NURSING EDUCATION AND
NURSING PRACTICE



SECTION 3:

EVALUATION OF THE RESEARCH STUDY, LIMITATIONS AND RECOMMENDATIONS FOR RESEARCH, NURSING EDUCATION AND NURSING PRACTICE

1. INTRODUCTION

The research findings and supporting verbal responses from the participants were discussed in the previous section. The collected data was integrated with the findings from national and international research literature. In this final section, the researcher discusses conclusions and recommendations for nursing education, nursing practice and further research. Shortcomings to the study are also elaborated on.

2. CONCLUSIONS

Participants showed commitment to adherence to procedural guidelines and patient care and felt that disturbances are due to lack of resources and empowerment. Data analysis resulted in seven (7) themes and associated sub-themes relevant to nurses themselves, government and the institutions the nurses serve. Conclusions from the findings of the research study are as follows:

2.1. Conclusion statement for Theme 1-4: Identified factors

Participants were aware of procedural guidelines and that they need to remain committed to using them to prevent any medico-legal hazards that may negatively affect their reputation as nurses, their professional career and to institutions they serve. However, all participants agreed that there is non-compliance to procedural guidelines during patient care and the factors mostly identified as influencing this are resource

shortages, and negative attitude among nurses, and insufficient communication amongst health care team members (doctors and managers) and consequently a heavy workload. Despite the above, they acknowledged the need for adherence to procedural guidelines during patient care.

2.2. Conclusion statement for Theme 5-7: Forwarded recommendations

To improve service delivery participants made recommendations to nurses and colleagues, to nursing management and to the Free State government. Recommendations to government include the provision of enough human and material resources. They recommended that management follow a supportive management style and advocate for collaborative teamwork between colleagues to enhance adherence to procedural guidelines and better patient care.

3. RECOMMENDATIONS TO NURSING PRACTICE, NURSING EDUCATION AND NURSING RESEARCH

Participants acknowledged non-compliance. The findings reveal some gaps that the government and the public health institutions in the Eastern Free State should address for the sake of their public servants. The following recommendations, with special reference to nursing education, nursing practice and nursing research, are based on the findings of this study.

3.1. Recommendations for nursing practice

The researcher agrees with participants that more resources should be available so that there is enough staff and equipment to facilitate nurse's adherence to procedural guidelines. The researcher therefore recommends that governments support institutions through increased provision of human and material resources.

Given that the economy dictates that there is often a shortage of human resources, the researcher acknowledges the strategic plans and interventions that the government has already pursued with regard to the increasing burden of disease, high levels of tuberculosis, lifestyle related non-communicable diseases, to name the few, and recommends the following additive to its interventions to strengthen health care effectiveness:

Government should empower nurses by employing greater numbers of nurses and by creating a category for clinical preceptors specifically to support nurses post-training within the institutions.

The researcher recommends that the clinical department be re-instated in each institution for continued clinical support and empowerment when the continuous professional development (CPD) point system suggested by SANC is introduced. The researcher further recommends that clinical mentors should be employed by each institution to teach and guide all nurses in need of support so that they maintain their competence, correctness and self-confidence during patient care after training. The role of the clinical department should be to:

- facilitate a positive learning environment, focusing on reinforcing previous learning and skills that are considered less important, but that carry a high probability of potential harm to patients if done incorrectly;
- plan specific learning experiences that correlate with each unit's competencies; and
- provide an environment where effective use of self is customised, that is an environment where nurses' enthusiasm and passion is reinforced.

Robinson and Griffiths (2009:11) and Jooste and Ntamane (2012:244-245) have identified that students, including pupil nurses, felt empowered when they are supervised during their training. If such an action can be extended post-training, nurses will be determined to function correctly even without being policed.

3.2. Recommendations for nursing education

Nurses are expected to function within the legal and ethical framework as stipulated in regulations to provide scientific patient care at the highest possible standard (SANC, 1984). It is the mission of training institutions to instil in nurses the cognitive, psychomotor and affective domains of learning so that they are released fully knowledgeable and fit to practice in the real working environment. To achieve this, during training, students are accompanied and supervised so that they may become knowledgeable, skill full, accountable and conscience nurses and the researcher recommends that during training, NEI's should include the instillation of autonomy, independence and self-confidence so that nurses post-training are conscientious about continuing and maintaining correct procedural guidelines even without being policed. Self-determination and a sense of accountability and conscience should be increased in preparation for the real working environment. NEI's should instil a sense of independence in nurses so that they would undertake activities correctly even when they are under pressure. This will happen if they develop critical, analytical and innovative creative thinking, irrespective of the levels at which students are being trained for as long as it's within the scope of practice (problem solving skills, participation in discussions that promote patient care, etc.).

3.3. Recommendations for nursing research

Quantitative and longitudinal research could be done to evaluate the work conditions as reason for non-compliance as well as whether other categories for example registered nurses could be identified. Research needs to be followed and expanded to other districts and provinces.

This would help to generalise the findings. In addition, the specific impact on patient care and the health system should be further examined.

Nurses have for quite a few years been given an incentive called the OSD. However, this was followed by a series of resignations by nurses to further their training so that they could return to higher salaries and better benefits. This incentive has not really improved work conditions. Further studies could be helpful to determine how to improve retention strategies and to confirm or nullify the hypothesis that nurses are furthering their qualifications to increase their salaries and not to really improve patient care.

4. EVALUATION OF THE STUDY

Patient care remains the core duty of nurses, but at the same time it is only where conditions are favourable that this objective can be met. The FSDoH embarked on its mission to increase the number of nurses and the annual qualification rate has increased. The participants excluded insufficient training as one of the reasons for non-compliance. They associated the problem with the working environment. Participants are aware of procedural guidelines during patient care and acknowledge that they should conform to these guidelines, though they identified key factors that kept them from adherence to procedural guidelines during patient care delivery.

The objective of the study was to describe and explore factors that impede EN's from rendering patient care according to set procedural guidelines and the findings provided insight into the experience of nurses during patient care. Though the study cannot be generalised due to a low response rate, the purpose of the study has been met as recommendations could be formulated. Data was collected from four (4) focus groups that covered most of the area under study and analysis was done using the principle of content analysis as described by Tesch in Creswell (2009:185-186). All the participants agreed that non-compliance to procedural guidelines during patient care is a problem and they identified work-related circumstances such as resource shortages, a negative attitude, and insufficient communication as factors that influence this. Recommendations were formulated as input towards strengthening health services (government and public institutions under study) and to improve patient care.

5. LIMITATIONS OF THE STUDY

Although the researcher managed to achieve the study objectives and participants provided rich and detailed discussion on factors that influences the compliance of nurses with procedural guidelines during their patient care, there are some limitations that the researcher should mention:

- Most of the targeted population showed interest, but due to conditions attached to the government approval, the response rate was calculated to be only 48% (N=71/n=34).
 - The number of participants and the level of their participation were limited because participants were not willing to participate in their leisure time.

- Participants felt that since their contributions could improve working conditions, they preferred to be withdrawn from duty during their working hours and therefore no groups could be formed for a focus group in some areas of the district of study.
- The researcher received no reply from some institutions on the request to conduct the study.
- Those who participated felt that they had a platform to express their frustrations as encountered during patient care and this caused interviews to sometimes lose its focus on the topic. For example, some monetary factors like OSD that are being given to a specific category of nurses was discussed, but it has nothing to do with patient care.
- The researcher's study was not funded and could therefore not be extended to all nurses in all districts, though non-compliance is not just observed in the target group. The findings can therefore not be generalised.

6. SUMMARY

This chapter evaluated the study, offered recommendations and discussed the limitations to the study. The study could contribute to further research and improvements to patient care delivery. The article proposed the reinstatement of clinical departments in public institutions and the introduction of preceptors specifically to support nurses post-training. The shortage of resources should also be prioritised. As patient care remains critical and the lack of support and engagement lead to demotivated nursing personnel, the shortage of resources should be addressed urgently. The researcher commits to giving feedback to Free State Health Department.

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ANNEXURES



ANNEXURE 1: ETHICAL APPROVAL FROM THE NORTH-WEST UNIVERSITY



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>

Dr A van Graan

Nursing

Faculty of Health Sciences
Tel: 018 299-2092
Fax: 018 299-2088
Email: Minrie.Greeff@nwu.ac.za

24 March 2014

Dear Dr van Graan

Ethics application: NWU-00157-13-S1

"Factors influencing enrolled nurses' compliance to procedural guidelines"

Thank you for the amendments made to your application. All ethical concerns have now been addressed and ethical approval is granted.

Yours sincerely



Prof Minnie Greeff
Research Ethics Committee – Humans Chairperson

Original details: Prof Minnie Greeff(10187308) C:\Users\13210572\Documents\ETIEK2014 ETHICS\NWU-00185-14-S1.docm
18 March 2014

File reference: NWU-00185-13-S1

**ANNEXURE 2: APPROVAL FROM THE RESEARCH COMMITTEE: FACULTY
OF HEALTH SCIENCES AFTER REQUEST FOR TITLE
REVISION AND CHANGE**

Susan

Ek het die onderstaande student se titel wat terugverwys is aangepas en hoop dit sal nou in orde wees.

MEV	MSIMANGA	DMV	23905034	MAGISTER CURATIONIS	Health Science Education - G832P
-----	----------	-----	----------	---------------------	-------------------------------------

Title: Factors influencing the compliance of EN's with procedural guidelines during patient care

Dankie

Anneke van Graan

>>> Susan Lindeque 03/13/15 10:37 AM >>>

Beste Anneke

Die ondergenoemde titelregistrasie is terug verwys by die NK vir hersiening van die titel (onduidelikheid oor watter guidelines). Indien die hersiende titel my teen 18 Maart 2015 bereik sal dit nog by die FR dien:

Title	Surname & Initials		Nr	Qualification	Curriculum
MEV	MSIMANGA	DMV	23905034	MAGISTER CURATIONIS	Health Science Education - G832P

Title: Factors influencing the compliance of EN's with procedural guidelines

New Title: TERUG VERWYS

ANNEXURE 3: REQUEST FOR PERMISSION (FSDoH)



Mrs D.V.Msimanga

P O Box 359

Bethlehem

9700

01 March 2014

Head office: Dr P Chikobvu

ChikobvuP@sfhealth.gov.za

Research Committee

C/V Charles & Harvey Road

Bophelo house, 3rd floor Block B East

Bloemfontein 9309

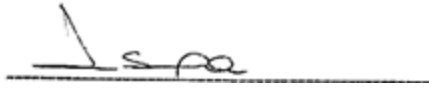
Subject: Permission to conduct research

Dear Sir

Attached please find the following documents with regard to the request for permission to conduct research at your institution. All nine (9) public hospitals and 89 clinics within the district that have participants per criteria will be involved

1. Request for permission to conduct research at institutions
2. Information leaflet to research participants (Annexure C)
3. Informed consent form for research participants (Annexure D)
4. Ethical approval certificate from the North-West University (Potchefstroom Campus no NWU-00157-13-S1)- (Annexure A)
5. The research proposal (summary)

Thank you



Dimakatso Miriam Vivienne Msimanga

Cell number: 0766169224

E-mail: makimsimanga@gmail.com



Me A Van Graan (Study supervisor)

E-mail: [Anneke.VanGraan @nwu.ac.za](mailto:Anneke.VanGraan@nwu.ac.za)



Dr B Scooby (Co-supervisor)

E-mail: Belinda.Scrooby@nwu.ac.za

ANNEXURE 4: INFORMATION LEAFLET



FACTORS INFLUENCING THE COMPLIANCE OF EN'S WITH PROCEDURAL GUIDELINES DURING PATIENT CARE

CONSENT TO BE A RESEARCH PARTICIPANT

I am Dimakatso Msimanga (student no 23905034) from the North-West University and I am working on a Master's degree (Health Science Education) with the title: Factors influencing the compliance of EN's with procedural guidelines during patient care. We would like to invite you to give consent and participate in the research. To follow is information about the study so that you can make an informed decision.

1. PURPOSE OF THE STUDY

The purpose of this study is to explore and identify factors influencing the non-compliance to procedural guidelines of nurses enrolled under R2175 of 19 November 1993 during their clinical practice in order to influence patient care.

You are being asked to participate in this study because as you are an EN's in the Thabo Mofutsanyana (TM) district employed at public hospitals and clinics, have undergone formal training within the previous five years (2008-2012) and have passed the progression test from enrolled nursing auxiliary (ENA) to a EN's (EN) according to SANC and your experiences are very valuable to us.

2. PROCEDURE

The researcher plans to conduct a qualitative research study with at least two semi-structured focus group interviews per district that comprise at least 6 members per group as data collection method. The focus group interviews will be recorded for transcription purposes to ease the data analysis process.

If you agree to participate in this study you will expected to do:

- You have to give written consent for participation. Share your experiences regarding factors influencing compliance/ non-compliance to procedural guidelines during patient

care, within semi-structured interviews. Active participation and free expression of feelings and experiences. It will take 45-60 min.

3. RISKS/DISCOMFORTS

Low foreseeable risks that might be experienced include emotional discomfort and mild anxiety during the interviews.

Some of your privacy might be lost during the interviews and a partial break in the trust relationship due to group discussions and the use of voice recordings, but your name/ clinical facility will never be made known and your data will be handled as confidential as possible. No individual identifiers will be used during voice recordings or in any publications resulting from this study and only the team of researchers will work with the information that you shared. All sensitive information will be protected by locking it up and storing it on a password protected computer, in a steel cabinet at the School of Nursing Science - NWU, Potchefstroom Campus.

Debriefing opportunities will be available if any discomfort occurs or you can withdraw immediately from participation to the research.

4. BENEFITS

Improved skill in group dynamics and semi-structured focus group interviews as well as boost of self-esteem when you feel that participation enhance your personal worth as you will contribute to better health care delivery in health care facilities.

5. COSTS

There will be no cost to you as a result of your participation in this study.

6. PAYMENT

You will receive no payment for participation. Transport cost to focus group interview meetings and a light meal for the day will be supplied by the researcher as well as a token of appreciation amounting to R25 per participant will be given at the end of data collection (example a small flash light).

7. QUESTIONS

You are welcome to ask any questions to a member of the research team before you decide to give consent. You are also welcome to contact Mrs D.M.V Msimanga if you have any further questions concerning you consent at cell 076 616 9224

8. FEEDBACK OF FINDING

The findings of the research will be shared with you if you are interested as soon as it is available.

**ANNEXURE 5: INFORMED CONSENT FORM FOR FOCUS GROUP
PARTICIPATION**



CONSENT FORM

PARTICIPATION IN THIS RESEARCH IS VOLUNTARY.

You are free to decline to be in this study, or to withdraw at any point even after you have signed the form to give consent without any consequences.

Should you be willing to participate you are requested to sign below:

I _____ hereby voluntarily consent to participate in the above mentioned study. I am not coerced in any way to participate and I understand that I can withdraw at any time should I feel uncomfortable during the study. I also understand that my name will not be disclosed to anybody who is not part of the study and that the information will be kept confidential and not linked to my name at any stage. I also understand what I might benefit from participation as well as what might be the possible risks and should I need further discussions someone will be available.

Date

Signature of the participant

Date

Signature of the person obtaining consent

ANNEXURE 6: PERMISSION FROM THE (FSDOH)



health
Department of
Health
FREE STATE PROVINCE

12 May 2014

Mrs DMV Msimanga
Dr van Graan
Faculty of Health Science
North-West University

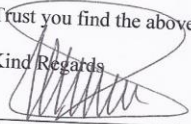
Dear Mrs DMV Msimanga
Subject: Factors influencing enrolled nurses' compliance to procedural guidelines (Thabo Mofutsanyana District)

The above mentioned correspondence bears reference.

- Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation must be voluntary.
- Written consent by each participants.
- Ascertain that your data collection exercise neither interferes with the day to day running of the health facilities nor the performance of duties by the respondents.
- Serious Adverse events to be reported and/ or termination of the study.
- Confidentiality of information will be ensured and no names will be used.
- Research results and a complete report should be made available to the Free State Department of Health on completion of the study.
- Progress report must be presented not later than one year after approval of the project to the Free State Department of Health.
- Signed permission letters from Head of Hospitals and clinics the must be obtained
- Research may not be conducted before the above conditions has/have been meet.
- Department of Health to be fully indemnified from any harm that patients and staff experiences in the study.

Trust you find the above in order.

Kind Regards


Dr D Motau
HEAD: HEALTH

Date: 15/05/2014

Head : Health
PO Box 227, Bloemfontein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and, Harvey Road, Bloemfontein
Tel: (051) 408 1646 Fax: (051) 408 1556 e-mail: khusemi@fshealth.gov.za/fshealth.gov.za/chikobvup@fshealth.gov.za

www.fs.gov.za

**ANNEXURE 7: REQUEST FOR PERMISSION (EFS PUBLIC HOSPITAL
INSTITUTION)**



Mrs D.V.Msimanga

P O Box 359

Bethlehem

9700

10 September 2014

Dihlabeng Regional Hospital

Private Bag x 3

Bethlehem 9700

Subject: Permission to conduct research

Acting CEO

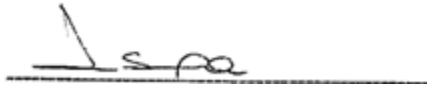
Attached please find the following documents with regard to the request for permission to conduct research your institution. All nine (9) public hospitals and 89 clinics within the district that have participants per criteria will be involved

- Request for permission to conduct research at institutions
- Information leaflet to research participants (Annexure C)
- Informed consent form for research participants (Annexure D)

6. Ethical approval certificate from the North-West University (Potchefstroom Campus no NWU-00157-13-S1) (Annexure A)

7. Approval from Free State Department of Health (Annexure E)
8. The research proposal (summary)

Thank you



Dimakatso Miriam Vivienne Msimanga

Cell number: 0766169224

E-mail: makimsimanga@gmail.com



Me A Van Graan (Study supervisor)

E-mail: Anneke.VanGraan @nwu.ac.za



Dr B Scooby (Co-supervisor)

E-mail: Belinda.Scrooby@nwu.ac.za

ANNEXURE 8: APPROVAL FROM DIHLABENG REGIONAL HOSPITAL

Ira Kearns <KearnsSJ@fshealth.gov.za> 9/15/14

To me

Good morning

I hereby grant you permission to conduct research at Dihlabeng Regional Hospital.

Please ensure that all the conditions are adhered to.

Good luck.

Dr SJ Kearns

Clinical Manager

Dihlabeng Regional Hospital

e-mail: kearnssj@fshealth.gov.za

Tel. 058-307 1000

Cell 083 630 2076

**ANNEXURE 9: REQUEST FOR PERMISSION (EFS PUBLIC PRIMARY
HEALTH CARE INSTITUTION)**



Setsoto local area manager

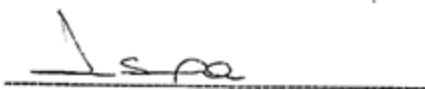
Subject: Permission to conduct research

Dear Madam

Attached please find the following documents with regard to the request for permission to conduct research to nurses in the local clinics within your area. All nine (9) public hospitals and 81 clinics within the district that have participants per criteria will be involved:

1. Request for permission to conduct research at institutions
2. Information leaflet to research participants (Annexure C)
3. Informed consent form for research participants (Annexure D)
4. Ethical approval certificate from the North West University (Potchefstroom campus no NWU-00157-13-S1) (Annexure A)
5. Approval from Free State Department of Health (Annexure E)
6. The research proposal(summary)

Thank you

A handwritten signature in black ink, appearing to read 'Dimakatso', written over a horizontal line.

Dimakatso Miriam Vivienne Msimanga

Cell number: 0766169224

E-mail: makimsimanga@gmail.com

A handwritten signature in cursive script, reading 'A Van Graan', written over a horizontal line.

Me A Van Graan (Study supervisor)

E-mail: Anneke.VanGraan @nwu.ac.za

A handwritten signature in cursive script, reading 'B Scooby', written over a horizontal line.

Dr B Scooby (Co-supervisor)

E-mail: Belinda.Scooby@nwu.ac.za

ANNEXURE 10: APPROVAL FROM PHC

>>> Maki Msimanga <makimsimanga@gmail.com> 2014/09/10 09:28 AM >>>

Request to conduct research at your clinics

Maki Msimanga

Attachments6/30/14

Good day Madam Please receive the attached documents in support of my request...

Juanita Kotze <kotzj@fshealth.gov.za> 7/1/14

to M.C., me Msimanga

I am responsible for Setsoto Local Area clinics only, they are consisting of Ficksburg, Clocolan, Marquard and Senekal towns, we only have 6 EN's within our PHC clinics.

I don't know if you actually wanted to address your request to the Thabo Mofutsanyana District Manager, Mr R P G Maarohanye or to the Deputy Director: PHC, Me M C Ramokotjo

Let me know what is the expectation.

Thank you

Maki Msimanga <makimsimanga@gmail.com> 7/7/14

to Juanita

Good day Mam

Thanks for the correspondence. I did request Mr Maarohanye too as a General Manager for clinics. My request to you is specifically for Setsoto, all districts local area managers have been requested too. Together they will form a group for Thabo Mofutsanyana area

I hope I answered you well

Thank you

Juanita Kotze <kotzj@fshealth.gov.za> 7/15/14

to me Me Msimanga

We will gave the 6 EN that we have in our area the consent forms, will scan and e-mail it to you as soon as we received it back.

Juanita Kotze <kotzj@fshealth.gov.za> 7/28/14

to me Ms. Msimanga

Attached find 5 of the EN's completed consent forms. The 6th one is still on leave:

There contact numbers are as follows:

(Names and contacts deleted for confidentiality)

Believe you will find it in order.

Thank you

Juanita Kotze

Local Area Manager

Setsoto

Tel : 051 933 5603

Cell : 084 503 5329

Fax 1 : 051 933 3121

Fax 2 : 086 636 1795

e-mail : kotzj@fshealth.gov.za>>> J. Kotze (Juanita Kotze) 2014/07/15 10:05 AM >>>

Maki Msimanga 7/29/14

Thank you Matron I will inform you for the date I intent to do interviews

Maki Msimanga

9/9/14

Good morning Matron I wish to request to continue with interviews on Thursday...

Juanita Kotze <kotzj@fshealth.gov.za> 9/10/14

to me Ms Msimanga

It is fine with us if you communicated directly with them.

Good luck

Juanita Kotze

Local Area Manager

Setsoto

Tel : 051 933 5603

Cell : 084 503 5329

Fax 1 : 051 933 3121

Fax 2 : 086 636 1795

e-mail : kotzj@fshealth.gov.za

ANNEXURE 11: INTERVIEW TRANSCRIPTS (FOCUS GROUP)

Interview 1 11092014

I: Interviewer

R: Respondent

I: Good afternoon.

R: Good afternoon.

I: And how are you?

R: Fine, very well.

I: Good. My name is Maki Msimanga. I'm a master student at the University of Potchefstroom, University of North-West, at Potchefstroom Campus. As part of my Master studies I have to do practicals (a research work). As I once sent you the, the letters that was requesting you of this eh interview, not interview as such, the talk, together with the information pertaining to what specifically we'll be doing today. So today I just want to thank you for honouring the day and the time. We are just a little bit behind time but it's because of travelling and unexpected events. But the nevertheless thank you for making it the day.

R: Thank you.

I: Uhm the uhm like as I've said that I'm a master student, the study that I'm doing need a research. I'm a registered nurse that has been working at the hospital for a long time and then later on I become a lecturer. But we being near patients, what we are doing, with passion that I had in patient care, I've identified that we, we nurses, we turned to be blamed for some of negligence's that are done unto the patients later on. This being eh not only the doctors only but also the, the public also complain that if their relatives have died or whatever have happened, then it's because of these nurses. With this in mind, then I looked back and said what is it as nurses that we are also doing, why are they saying we, we are contributing to this?. So my research topic then task me to identify those factors that influences the EN's not to comply with the procedure guidelines. I've chosen you eh EN's because eh not to say that you are the only one that are doing the procedures wrongly or eh you are doing them perfectly but eh I, I, I, when, when grating you between enrolled nursing assistant and EN's I found you to be in the better position because at least you have been in the experience, eh in the nursing profession for a longer time. You are now acclimatised

with patient care, you understand the patients and you understand the role of the Nursing Council with regard to caring for them their protection towards the public. The nursing assistants they also have been taught but they, they still lack a lot of experiences, so I thought from you I will get a lot of information, a lot of eh data that I need that can help, not only in me as a researcher but also the Department of Health in trying to improve patient care. So now that I've explained myself that who I am, I will give you the latitude of each one to introduce to one another and I will be glad if one can say for how long he or she has he been a nurse. We can start we can start from, from right, from my right. Eh thank you for sitting in this way, I like the way we are sitting, not like we are school kids, so we should be free to talk. I also have snacks so that if you feel like eating, that is enough here's some drink too we can, we can eat and talk eh Doc, you can start.

R: Leaving my name?

I: Yes.

R: Oh my name is Doc, I am a staff nurse for 2 years, this year I will be 3 years.

I: Uhm but as a, as a nurse in general, how long? As a, as a nurse in general, an EN's, as a, as a nurse you have been a staff nurse for 3 years, but as a nurse, for how long have you been a nurse?

R: I was eh a volunteer before I become a staff nurse.

I: Okay so you went to a 2 year program

R: Yes

I: Okay, you want to become a staff nurse. So you have 3 years in this profession.

R: Yes

I: All right thank you Doc and Yvonne

R: Okay my name is staff name Yvonne and I've been in this nursing field for 10 years. I went to school for 2 years yeah

I: And are you, are you, where are you working? I forgot to ask Doc where are you working.

R: I, I'm working eh at the clinic

I: Okay. All right, and Yvonne?

R: I'm working at the hospital.

I: At the hospital. Okay Gilbert

R: Thank you eh sister. Eh I'm a staff nurse at ++++++. I don't know whether we should eh state the place

I: +++. Uhm I don't think we are nature to can explain that. Let's just say clinic or hospital

R: Ok it's fine, at the clinic

I: Uh-huh

R: Clinic. I've been there for almost for 10 years working as a DOT supporter. Eh usually used to give medicine to eh TB, the medication at, at, at home. Then you take medication you give medication for that patient. Eh in fact eh I can't say I've experienced of being a nurse because our time completing my, my staff nurse I've worked for almost 2 years now and will be 3 years now

I: As a staff nurse.

R: As a staff nurse

I: Okay. All right thank you. Gift

R: My name is Gift and I've been a nurse for 10 years now and then I've just as an auxiliary nurse then I resigned to furthered my studies to be an EN's

I: Uh-huh

R: So I'm currently working at the clinic in ++++++.

I: Okay thank you. For how long are you been here staff nurse now?

R: It's about 3 years now

I: 3 years now.

R: My name is Sarah I'm working at the hospital and this year I have now 14 years been a nurse, 10 years as a nursing auxiliary, now 4 years been a staff nurse.

I: Okay. Thank you, thank you very much. Please feel welcome eh all of you eh I, I hope the interview that we will had will also be fruitful and feel free to, to discuss eh whatever has come up. Because earlier on you, were given the, the documents that explains as to why are we here, all of us, I will like that we set up some rules because now that we are a group when, when we talk we have to listen to one another, give one another a chance to talk and whatever topic that you'll be coming up with it will be an open thing that whoever had something to add on, she or he can add on because my aim is that at the end of this eh interview I should have been grasp as much information and rich information that can help me in identifying these factors that contribute towards not complying to eh procedural guidelines ne. So I'm also going to request that we speak loudly not shout, loudly so that as I said that we are, are going to be eh audiotaped. The purpose of audiotaping is not that eh you will be exposed to all other people but it will help me as a researcher to grasp all the information that I need and then the information will also be sent to the school so that they can also help me identify the factors to see that I've eh said everything that, that you have said during the interview. I don't know whether you, are you still comfortable if earlier I've explained that we'll be using the audiotape. Are you still comfortable with using the tape?

R: Yes

I: All right. Eh the other thing eh I should remember, I told you that eh to prevent you from harm and intimidation, I want you to be free in this interview because whatever we are going to say today it will remain within us only. It's just us that knows what has happened, not your manager will phone me or the other and instigate to say I've released somebody to, to assist you so what actually did he say. So it, it remains our thing. The information will be dispersed to others, but the information that will be dispersed won't be linked to any of one of us. That is why I suggest that we use eh different names, not our real names ne. And then should also remind you that, I also told you that eh to be part of the research is not a must. After I got your response to participate, I was so glad that you decided to come again and eh be part of the interviews, because you, you could have just said no I'm not interested and that was nothing wrong with that as you have a right to either contribute or not contribute. And even if I knew you I wouldn't have say eh no that you didn't help me on the other day I'm no more going to help you with the other. Eh participation is voluntarily with nothing attached to any ne. I don't foresee any other risk like eh emotional injuries intriguing in you, torturing you with the interviews, but if there were some eh topics that hindered you please just let me know so that we can organise somebody that will help you and comfort you again. Can I start by asking if any of us have ever have yet you are 2 years, 3 years

before being, after just after before being employed, have anyone of us ever being moonlighting at a private eh institution or not?

R: Uhm yes I have.

I: You did?

R: Uhm

I: Oh Gift has sometimes been moonlight at a private, the reason why I'm asking this is that, or let me say have you ever been admitted as patients but not in the hospital, not in the, in the public

R: Yes

I: Yes, when, when we look at the, the nursing care on both sides, could we say the care that is been given by us at a private, is the same as the care that is been given at the public institutions and if not or if yes, can you just elaborate to say what, what could be the difference between the two.

R: Yes in the private eh hospital they respect the patient and their attitude, they have a good attitude. But in the public most of nursing do not respect other nurses.

I: Any other experience.

R: And they do not respect each other.

I: They don't respect each other. So does it say when you are in the private there is a lot that say respect or why, why could it be that we have respect when we are at the, at the private and not in the, in the, in the public non – verbal cue saying, "You don't know?"

R: Oh it's the attitude.

I: It's just the attitude that you have observed.

R: Uhm what I was also going to say what I have noticed when I was admitted, maybe when the nurses comes in the morning, they will specific come to you and greet you whereas in the public we don't care we just look at you, I don't know it's because of maybe we are already feed up that, there's lot of patients, lot of work or whatever.

I: Uhm

R: But in the private, it's only private hospitals they will come to you and make sure that they, they look at you.

I: Uhm

R: Uhm

I: Is that the experience that you have all?

R: Uhm that's mine

R: We don't know whether it's because of there are white people there in private hospitals more than in government one

I: Uhm

R: Yes,.... Normally at private hospitals, there are more white people than blacks

I: Uhm

R: So we came to do the things that the, the whites are doing

I: Okay

R: Like greetings, they smile to them. At the eh Government Hospital there are, they are supposed to be greeted but they are not like in the morning after when they are taking the reports. They should be greeting the, the patient but they don't. There are few of them that are doing that.

I: Uhm

R: I like to add to what Doc is saying. I've never been admitted but I think it's because at the private hospitals there are more white people so white people they know so many things that the others black people don't know. So mostly black people go to the public hospitals and white people like to go to the private and then at the public hospitals. I think maybe they take it that, you know, that she's not paying or like maybe like what Sarah said, they are already fed-up especially like you have your issues from home and then when you enter the hospital like you just take the patient and when you like but there at the private hospital a white person, if you treat that person with attitude, you are going to get back to you but black people never do that. I think its maybe because of the lack of knowledge. Yeah lack of knowing your rights as the patient.

I: Oh I wanted to ask what do you, what do you mean when you say they know more?

R: Like white people like, like going of the knowing like especially your rights as a patient.

I: Uhm

R: But we black people like we may, when you enter the hospital there are posters written your patients' rights and when we admitted to the hospital they will be told your patients' rights and your responsibilities, something like that. So white people they take those facts seriously but we don't.

I: Uhm

R: I can be admitted at the public hospital but when I get out of the hospital, if you ask me what your rights are, I don't know.

I: Okay.

R: Yeah, I forgot but when I was admitted I was told my rights.

I: Okay.

R: Me myself I've never been admitted at a private hospital but I was admitted it was in 2008, and I remember well I was admitted at public hospital at general, but the way they treated me, to me it was good. Maybe it's because some of the nurses knew me, uhm as I was the volunteer of so many years, you know they treat, they treated me very well and even the doctor, my doctor who was attending me was a very nice person.

I: Uhm

R: Yes

I: So you want to say you were well treated

R: Yes because they know you

I: Oh....It was because they know you

R: I, I, that's why I can say because most of them we were volunteers by that time

I: Uhm

R: Yes

I: Uhm okay. All right. But then I liked, I liked, I liked that you could identify such and as present staff nurses, the development of going from being a nursing assistant to a, a nursing assistant to EN's, to some of you I have understand to you except Gilbert and Doc you were just giving 2 year program but Yvonne, eh Gift and Sarah they were once nursing assistants and their passion developed them to be nurses and they went further to say maybe if I can go to, to school that nurses would not treat me well just because they know me. I want that nurses should treat each and every one equally as Yvonne has said it shouldn't be eh we don't lack understanding. If I go to school when I come back I will be knowing much better to can even explain to my patients that you have the right to, to can complain, you have the right to do 1, 2, 3, 4, 5 that, that is the reason why you those that went from ENA to staff nurses had the drive, I don't know whether I'm right or wrong.

(Moment of silent then)

R: Yeah

I: Okay so when after, after training what is happening.

R: Remember that the, the Scope of training, we are supervised ne, there are some lecturers there are clinical sisters that are guiding us to do the procedures correctly.

R: Uhm

R: Yes

I: And after training?

R: Our Scope of Practice, when I'm saying our Scope of Practice I'm saying ours as I'm EN's together with you. The Scope of Practice says that we should be eh still be under the direct and indirect supervision of the sister. There are other duties that I can do that are better off than that of enrolled auxiliary nurses, but I'm still under the supervision of the professional nurse.

I: So I just want to ask you and I wish that we can elaborate more on to say do you think nurses comply with procedural guidelines always and if they don't comply always, where do, where exactly do they not comply with. What is it, what is it what they tell where, why and any other reason that you may come up with?.

R: You know they don't comply because those they think they know the work and then at times when you do their dressings they think that yeah it's a waste of time to do those

procedures because you have to wash your hands and prepare, the trolley that is to clean up the trolley and then put the dressing pack. At times, at the clinic we don't have those dressing packs, it's only gauze and eh receivers and solutions

I: Okay

R: Yes

I: Uhm

R: At times they, they don't have enough kidney bowels/receivers for, for the dressings

I: Uhm

R: So they think that when they are doing all those procedures you are wasting your time they just do it without eh during the, the proper procedure.

I: Uhm

R: Uhm now we also say if there has been a lack of supervision like now. I don't know if is it the Department that doesn't have money, there is always a complaint of not having money like in the hospital I'm working surgical, is combined with the medical ward and then she stays alone there. If I'm going to do the procedure the sister won't leave her work there to come and supervise me, so it's also lack of supervision. I, I'm not sure that I'm doing the correct thing or whatever, I just do it, do it for the sake that if the patient and because I have done this to other patient. The sisters, she can't leave what she's doing there to come and supervise me here to check if yeah they are doing the correct thing or wrong or what.

I: Do you still need supervision after training?

R: I think sometimes we think it's necessary. I am sure, we don't think it's necessary but for doing things correctly, like especially when doing some wounds, its necessary to do things and to be sterile and the like, especially when you should then do the patients' wounds.

R: You just like especially sometimes others come from operation and then those wounds are clean, so you don't think you have to come with a tray and you're just going to use gauze and sterile water just clear water and then just clean, there's no blood sometimes, you just clean that wound and then you leave the patient, yeah.

R: Uhm maybe that shortage of staff stills uhm still contribute there uhm.

R: Yeah especially shortage of staff. Especially when in the surgical wards we have the pre-op and post-op and the patients are coming like so fast and then you, you don't do things according to procedure, you just leave the patient there, you're going to attend the other one that you went to fetch and then you just

R: Like sorry to interrupting, like patient from post-op, we are supposed to do vital signs maybe 5 minutes times 4, 15 time 4, like that, we are no longer doing that because of what? Lack of staff and equipment, we have only 1 BP machine. I'll be doing this maybe at one o'clock, the other one at quarter past, the other one then when I come back, that one 5, 15 minutes of that one is over. Uhm. Lack of equipment uhm also contributes. Uhm.

I: And clinic experience?

R: Eh at the clinic we also ignore some things and like I did people who coughing more, more, more, that people maybe its Tuberculosis, instead of helping that patient, We help, help those who come first. And if we do it like that, the TB spread to other people.

I: Oh let us give Gilbert a chance.

R: The other clinic eh they'll be most of the time we, from early in the morning at eh from half past 7 maybe quarter, quarter to eight you'll be starting pumping, taking the observations. Then sometimes there is a, a long que of patients and shortage of staff and by the time we know, as nurses we have privilege of teatime. And you, you must have a push for the patient before you go for a teatime, you must be far with your patient. So at the clinic there is a lot of, of, of patients and who must be treated or given care

R: But they are ignored.

R: No they are not ignored

I: Uh-huh

R: Yes we, we, we take care of them, all of them.

I: All of them

R: Yes all of them.

I: Uhm

R: Yes

R: To add on that, on Gilbert's statement I think we lack passion of what do we do, at times we neglect patients, it's the negligence that, that I must add, you'll find that there are 2 sisters that are working in the clinic and then 1 auxiliary nurse that is doing observations of these things. Yes you'll find many people in the clinic, but at times you'll find that 1 sister is not working what she's doing, she'll only stress with that, I won't see more than 20 patients because there are more patients and then we are only 2 in the clinic. So you'll find that, that the other sister is working, she's a hard worker and then the other one is relaxed so you'll find that that is like she's comparing whether the other one is working more and then she will be telling herself that I don't know why I'm not working or whether to continue to what to do what is expected of me when others are so laxed.

I: Uhm

R: So if we could have passion for what we applied for

I: What we are doing

R: Then I think we will beat this thing, beside whether it's shortage or not, if you like something that I do, then you'll do it with passion. I think it might be something like that.

I: Doc, I'm interested in, in, in knowing more when you were saying eh the patients, you know that TB patients, TB is spread through droplets, but when the patients are in the que, it's not an issue of eh the 1st one those that are coughing, I will attend to them first. It becomes now first come first served. What stops you from, from taking that person, the one that is coughing, because now you are from school, you understand how TB is spread, what stops you from attending to this one that is having a problem before, even if she can come at 12 and the other one was there at, at 8.

R: Yes, at the beginning uhm I started with weak attitude

I: Uhm

R: Not attitude of eh nurses only, all the people, community kind, if you take her, the patient who copy eh into, to put outside to other people, the patients they were fighting for that, so nurses know that if all the patients have their right, eh they don't want to fight with the, the patient's

I: The patient's right

- R: Yes. But in my clinic they try a lot to do the correct procedure
- I: Uhm, uhm
- R: They're giving priority to the patient or they use eh the health medication.
- I: Uhm, uhm. Yes, yes Gift.
- R: We had to add on that on doc what she's doing she's saying I think since from in the clinic since that they are, we are told that every patient must be screened. I think what everything that is happening in the clinic should be explain to the patients
- I: Uhm
- R: If we are giving a, a proper health education they should know that when they see a person who's coughing and the, the condition is ill, then they know that they're fast-tracked, they are suppose to be seen before them. I think health education is the most important thing. We should give then our patients the proper health education so that they know when they see someone even if you don't see the patient they will come to you and say that I see someone's not feeling well, can you please come and help him or her.
- I: Uhm. So you want to agree with Doc to say even though you know or you have given health education, you are just afraid to, to, you are afraid of the patient.
- R: No, where I'm working we, we are not afraid of the patients
- I: Uhm
- R: For fast tracking ill patients they, they go first. The aged people and then eh the babies under 5 they are the ones who, who, we help them first. So everybody, even though if they can fake, that at least you as a nurse you know that you are doing the right thing for the patient and then they will come after. I think you eh being a nurse you know what you are supposed to do. At times you are not supposed to, to listen to the patient, just say the thing to the patient you going to see those that are very ill, then I think I think the most important thing is health education.
- I: Health education. So you want to say the, the lack information, or we, we have, do we have health education to can give to them but we are afraid to give health education to them, because of first come first serve thing.

- R: Yes we are supposed to give them health education so that they know
- I: Uhm
- R: If, if they see us a person outside the premises of the clinic they should give the patient the advice to go to the clinic and take sputum for, for TB. If they, they see any symptoms because where, when there's we screen them, there's a book that we screen for signs and symptoms they should know that it's a sign of TB.
- I: Uhm
- R: They should go to their nearest clinic.
- I: But then what causes us that the public+++++++ will continuously complain and say nurses are not rendering our care correctly. What, what stops us from doing what why is these complain that we are not doing things correctly?
- R: Sister our, you know a patient or the, the community eh she is expecting when she come to the clinic to be 1st treated and go home or at, to go at work or to go wherever she went. That, that is true that's what makes the patient to maybe to fight eh nurses because of the time at the clinic, because they want to be help 1st when they come to the clinic.
- I: So we end up being afraid that the patients are doing to fight with us. That is why we don't do the correct things, that's why we don't screen, we don't fast track them. In those cases not per se in your clinic, in eh in general because the, the problem is we don't comply. You know that you have to fast track, you take that one, but now in, in this clinic when I'm being eh transferred to this clinic, the, the philosophy of those patients they, they their rights that it's 1st come 1st served.
- R: Yes
- I: Then they say and who are you so you end up now being afraid, is that, is that the feeling that I'm getting?
- R: At times yes
- R: Yes
- R: The, the, the negative attitude of the patients, at times they will come with their negative attitude towards you. And then whenever they will talk many things. At times you'll just

feel that I'm not going to help him just because he said something negative about you then you just told yourself that you are not going to help that patient.

I: Uhm, Gilbert wanted to say something.

R: I eh I was coming to that point of saying when they come to the clinic they expecting to be 1st treated and if you, you are not looking at him or her or helping her, by, by the time she's leaded by her or by him, you are wrong to her.

R: (Sarah coming in) Uhm perhaps that we have that is +attitude towards them

R: Yes, yes they start having attitude towards you

I: And the guidelines according to TB management says fast track, so we don't comply with the guidelines just because these patients they, they will fight.

R: Yes because that one she's, she will tell you that I'm the 1st

I: Uhm

R: At the clinic, when the clinic is open I'm the 1st at the gate or I'm the 1st who enter the clinic

I: Uhm

R: So why did you take this man or this lady who is coming after, afternoon not knowing that this, this person is the one is very sick

I: Uh

R: Yes.

R: And they will tell you we are all sick, so you can't just pick someone behind me and

R: But sorry there, what I've seen in our, in, in the hospital I'm working I see it's much better we have a queue marshal then she'll be busy there on the patients in casualties. When she sees maybe eh a very sick patient or whatever, she'll walked to you and say nurse come please and help me here, how do you see this patient I, I'll sort out this one at least then she'll be the one saying people please, can you please help this patient. I know that you were here 1st, can we please start this patient in ... so that she can be seen by a doctor. Then they will, other will say yes. But I don't know is it the public that have attitude to the nurses, but if the queue marshal talk to them, they don't have that thing

- I: Queue Marshal does the explanation or the sister
- R: Matron called.
- R: Queue Marshal
- I: I don't know maybe the help of controller, it does help.
- R: Yeah even at the clinics, you go to the reception and then they write names to register, the clerk must also see if this person who go to register is okay all right and then him or her can go to the sister and tell the sister that there's a person who is sick but joh!! She came late so can you please go to public like other patients and ask them if you can take this patient 1st you see.
- R: Yeah it's not because we can, we cannot just be afraid of the public so that we cannot do things properly. Yeah we can also make an effort and go when ask. Yeah they are also people and then you can ask them.
- I: So under who's circumstances then that we do not comply, it's under who's circumstances that we find ourselves not complying with the guidelines. In the clinics the guidelines might differ, but I, I belief that the, the procedure you know that I have to do, I have to greet them all, I have to, to greet, wash hands guidelines are generally in clinics, I have to fast-track in the hospital. We know that we have to smile, we have to we have to wash our hands. What, what, in which circumstances then where we find ourselves not complying with these guidelines.
- R: Pressure and lack of staff
- I: It's pressure the lack of staff. Pressure in which way?
- R: Too much work to be done.
- R: Maybe we have maybe 10 patients who have wounds, we have to do all the wounds and when you go maybe to wash your hands aseptically clean, you'll see it's just a waste of time, you just washed aseptically clean and then you go and do the 1st one. Otherwise others are, you are going to end up not doing them or just I don't know you are not going to do that proper thing that we have been taught at school, because you see 10 patients being alone. If you, you try to wash your hands aseptically and aseptically and setting of trolley all are just a waste of time. We just try quickly as long as I'm not going to

contaminate, but all of them will be done. We just go through that tap and wash socially clean and then you go and do the 1st one, you come back you wash you go to the 2nd one.

R: But as staff nurses we know, we know South African Nursing Council very well, we know even their powers that they discipline, they, they can in, in the form of discipline, they can even remove us from, from the roll.

R: Yes

R: But what, what, what impedes us then to, to think of what if Council strikes me off with this action that I'm doing.

R: You say they don't know, even the patients don't know.

I: Oh the patients don't know also

R: Uhm

I: So the patients don't know that you are doing the wrong thing

R: Yeah

I: So they don't complain.

R: Uhm

R: That, that's interesting.

R: So how will the Council know if the patients don't know.

I: All right yeah that's a thing

R: Uhm

R: Uhm

I: And the conscience

R: Gone but at the end of the day I know that all my patients would be done. Yeah all wounds, all of them will be done.

I: Irrespective whether it was going to heal in a day or so.

R: Uhm

R: Whether to my service I'm not contaminating but the procedure I'm not following it.

I: So in all because of time, time pressure

R: Uhm

R: Because of that shortage of staff he'll be allocated to the wounds alone with that lot of patients.

R: Uhm

R: And then maybe I'll doing 7/7 then the night staff comes they will be expected that everything must be done. You can't say you were here from 7 in the morning till 7 at night and didn't do all the other wounds. So you try by all means that when they come, everything's done.

I: Uhm it's very bad ne.

R: Uhm

I: But we think we can change this. We are from school guys eh passionately we want to be the same as in, in, in private, in private they smiles. So even the smile is gone!!

R: Uhm

I: What makes the smile to go, this pressure

R: Uhm the pressure

I: The greetings halloooooo, did you sleep well, they are gone. Is that so?

R: I think to have to me to have in-service training yeah, facilities

R: Uhm

R: To remind you, to remind us where we come from.

R: Uhm

R: In-service trainings

I: In-service trainings. But do we, do we have a room to change? Do you see ourselves we have I, I, I we must have passion and we must do you think if 1, 2, 3 can be corrected eh

then maybe the situation can turn upside down, downwards, upwards then I know when I go to my patients I will smile and I will greet this patient. If, if, if nursing, if in-service trainers can say eh nursing is a continuous job, eh I will do the job, I will do the wounds up to wherever I am. Eh if it's 7, I need the other one who will continue, then will that say I will smile, I will wash my hands aseptically, I will, I will, I will correctly as procedurally should be done. That's, that's, that's my core

R: Uhm there's a room we can change as long as we must if you are a person take it as well, if this one was my child or my mother or my father and then we as colleagues learn to accept each other, if you come and tell okay here I didn't do this, then don't fight with me or do whatever, just say okay I'll go, I'll go on you can go, then I'll go I'll continue the work.

R: But the person must have a, a concrete reason

I: Uhm

R: To tell you I didn't do this, it's because of this and this and this, that's why I didn't finish with my work. So can you please continue and not like no I didn't do this because there were so many with attitude you know, no can just ask.

I: So what I'm getting from you, you want to say that the staff itself they, we are having attitude towards one another.

R: Yes

R: A lot

R: Others are lazy

R: So I was, I was about to say that there are wheelbarrows you have to push them.

I: Uhm there are wheelbarrows.

R: And it's just, our government also can try but, but always not to have, not to have shortage of material issues.

I: Uhm

R: Because where I would give eh when I'll be need dressings, some patients will tell you I, I can see you are very much busy so would you please give me some packs I will do at home.

I: Okay

R: Give me something that I can do at home, but then those things can be things prescribed by a doctor in his or her file

I: Uhm

R: Yes

R: But if I can say to I there, there is no gauze, there is no gloves, there is no even

I: Bandage

R: Bandage

I: Uhm

R: Or the Betadine or everything that is being, she become cross to, to me

I: Uhm

R: She thinks as if I'm not I, I'm not wanting to, to help him.

I: Doc do you want to add or say something?

R: About that issue of Gilbert, I don't know what can I say, but the, the shortage cause service and I was thinking sometimes between the colleagues because in some clinic there are 3 people inside the clinic, it's the cleaner, it's the staff nurse and it's the sister. Cleaner working as a cleaner and a clerk staff nurse working as a staff nurse, doing the observation, eh wound, dressing and also sister sent the staff nurse eh like eh I don't know what can I say and eh she's, she's sits at the table and call staff nurse by saying give me the what, what, give me what, the people become unhappy at the work

I: Uhm

R: And the patient, other patient suffered.

I: So you're saying there's no co-operation between the manager or the sister and the, the nurse. They don't work together, there's no team spirit.

R: The co-operation is there, but the problem is that there are shortages of eh, eh, eh staff

I: Shortage of what....uhm to be doing errands and rechecking our patients?

- R: Eh because sister were diagnosing only
- I: Okay
- R: And also prescribing the medication. She called the staff nurse in from other side ward/room, "come and give me a FDC or what, what or what, what, we are helping them too, but the wound just is only staff nurse the, staff nurse was busy and not assisted
- I: Observation? Why cant they be done procedurally?
- R: The observation also, is also the staff nurse nearby. If, even if the cleaner is not here the staff nurse is eh the person who cleans the clinic.
- R: Just because you know factors that harbours micro-organisms, to prevent infection
- R: For control purposesyes
- I: And sometimes now these sisters they are also calling even if you are busy, busy with the wounds.
- R: They are expecting you to go.
- R: I think everything is blamed on nurses
- I: Uhm
- R: If there are no medication the nurse is blamed for, for, for making medication not to be there. If the like eh Doc is saying the clinic is not clean, the nurse is the one who's to be blamed why is the clinic not clean whereas there is a cleaner, there's supposed to be a cleaner. If we can get enough staff I think everything will be fine.
- I: Uhm, then you can comply to our procedure, I'm just worried that we, we don't do things correctly and not necessarily that we are the only one to be blamed. Care for a patient it's about the team, but mostly just because nurses are there 24 hours, should the patient die, nurses, should the patient vomit and they find the patient vomited down, eh it's nurses, just because the floor is dirty, nurses
- R: Yes, yes, uhm
- R: Even if, in, in the clinic if the patient has to be transferred to hospital, they call nurses to arrange for their transport they order some medication to the pharmacist.

- I: Uhm. So in all that time to say the pressure that you are getting you had time to give me factors as to what causes the pressures of ignoring the guidelines. I don't have time now anymore to do the procedure correcting because I've been called, I'm a clerk, eh I'm a cleaner, eh the patients also they are complaining
- R: Also when the pharmacist is not there, then you are going to pharmacy and give the medication to the patient like myself
- I: Do you want to say in private these things uhm are very much differently, I've never been in a private hospital unfortunately
- R: In a private hospital I think they're enough staff because they know an assistant nurse, she knows her work what to do. An EN's she knows what to do eh registered nurse, she knows. They are been allocated accordingly
- I: Uhm
- R: according to their categories
- I: Uhm
- R: When, then the patient is coming for admission, an assistant nurse knows what to do, they are giving the medication, they're admitting the patient. Everyone, it's the team work, everyone work together.
- I: Uhm the teamwork.
- R: I think the government hospital will end up maybe as a staff nurse doing everything
- R: Everything (all of them laughing)
- R: Because the shortage of staff you don't want to calls I'll come and do this, you end up doing everything to only one patient.
- I: Everything as in ...
- R: I won't say maybe the patient maybe it's an accident, I won't say maybe the assistant nurse must come and do the only, as a staff nurse I do everything and end up admitting the patient, putting the patient into bed, living it, everything being done to the patient.
- I: So all nursing activities they are now been placed on one person

R: On one person uhm

R: Let us say rather uhm in the private hospitals everyone was that if a patient comes, I'm going to do the observations then the sister will come with the medication that one will come with these things then. In the government hospital everything is done by you

R: But that wasn't helping with nursing your patient in totality and knowing your patient in totality.

I: If I can vital signs, if I can admit and then do the wounds and do when, when Doc comes out of that unity I say joe you look so nice, wouldn't I feel happy that I washed my hands aseptically clean, so this wound is going to be healed in 2 days eh and she's smiling, she, she, I've done I know my patient rather than this now segmented task eh that is been done Doc. The other one is going to do this, the other one is going to do vital signs. I'm taking my patient as she is and she is my patient, I'm going to do everything of her in the clinic. If my patient comes in eh I'm going to make sure that eh if she has to get the what do you call this mask

R: N95 Mask

I: The N95 mask myself I will stand up and go and pick them wouldn't it be nice and, and, and now you are complying because you know that I must use a N95 of the surgical mask. Why, why are we, are we exhausted on, on, on these factors that, that disturbs us from doing the correct things.

R: Sometimes it does helps to nurse, to nurse your patient in totality to do everything so that you know the, I need this and this and but sometimes there are disadvantages maybe like in the hospitals I'll maybe want to do everything to the patient alone. At the end of the day when they come they'll know that this was supposed to be done by a staff nurse like e.g. when I was from school I worked in maternity ward in a hospital it's, where the, also neonatal ward. I'll then see a staff nurse works in, in neonatal, then the assistant nurse herself do observations and the sister doing the delivery room, but at the end of the day, during the day I'll be in neonatal giving those prematures food and medication, all those stuff. At the end of the day when they give the report the wounds are not done outside, they will say where was the staff nurse forgetting that they allocated you in the, in the neonatal to do 1, 2, 3.

- R: Yeah and you can say if you are allocated to do the wounds for the day, stick to the wounds. If the, the registered nurse is allocated to do the medication or, stick to what you are allocated to, don't move around yeah
- I: Ja! That can help
- R: Yeah
- I: And then you can continue doing your procedurals
- R: Yeah you can
- R: Yes
- I: I'm just worried of procedurals
- R: Then you can do observations, then you'll do, I'll do my wounds then I'll do, give medication and those premature babies and that was then all done. I, I'm in those premature, thinking that you are doing the, the observation out or the what, the observation outside. Then when in the late, in the evening the nurse staff comes this and this is not done, they start calling you, you are supposed to do this it's not done. At least if this one is allocated to do this, you are allocated to do this, you are allocated to do this.
- R: I think when it comes to that even if you are been allocated to what you are supposed to be doing. If you don't have the passion to do that, you won't do it, you won't do it. Even at the hospitals you have seen some, when I was a student there were people that maybe the student was allocated for doing the dressings, you'll find that student will draw up the, the curtains, thinking that the, that person is doing the wounds only to find out she was sleeping in that, on that, so if you don't have passion of doing what you are supposed to do, then you'll be a wheelbarrow for the rest of your life.
- I: Uhm so we want to say some are just there
- R: Yes
- I: For the sake of being eh working not necessarily that they wanted to, to do this, they wanted to be nurses.
- R: Yes
- R: Uhm like you said there everything they had their advantages and disadvantages.

R: Uhm

I: Do you think there is anything else that we can, we can add, we can, we can elaborate on?

I: (moment of silent) Is there, I think we have exhausted all

R: I've captured _____

I: Yes

R: If somebody is working at the clinic where there's no eh data capturer, it's only the cleaner, eh staff nurse and a sister and 35/40 patients, what can we do about that patient and the patient who gives us the sputum, maybe 10-11 a day, what can we do about that situation and there are, there are other patient who must transferred to ... hospital

I: Uhm

R: And the transport must, we must give the, the patient the transport.

I: Uhm

R: And you, you go to work at eh 20 part or quarter past 7 until eh 5 past or quarter past eh 4.

I: So you are passionate, you are doing everything, actually the everything is this distance, those distance that you are saying are they all they have to be done by you only because now you are just 3 or 2, there's no data capturer who can do her job. There is, there's no other one who can do this, we have to do them all

R: Yes

R: I think that the clinic matron must do something about it.

I: Something like what?

R: Giving, they, they must hire more people

R: Uhm the government they must help us

I: Remember the, the, the sisters they are just they, they are also sure that they are just as frustrated as we are. Joh! If I have to interview them, I would also have opened a can of worms

R: We must fight those people

I: Who are those people? The ...

I: Sisters will also just say as they are doing their best

R: I think the government can help us hire then more staff

R: Uhm

R: Yeah it's like a stressful situation under the hospital

I: Uhm

R: Yeah I think at the hospital there's someone who's supposed to look after all the clinics, so they should go and report and then that person should go to the government and what

I: But they are, and, and they're hierarchical order. Or what do you mean maybe

R: There is but then mm...

I: Uhm

R: At the clinic at the location there is no staff. So I went to the clinic and asked the sister who's in charge of the clinic if they want staff, maybe I can come and help I finished school

I: Uhm

R: And then she told me that I should go to hospital and there's a lady who's in charge of all the clinics here

I: Okay

R: And then I went to that lady and asked her I, I finished school and I'm looking for a job. At the clinic there were I'm living there's no staff I've seen it. But she told me that they're not hiring at the moment, but I can leave a CV here and then she'll call me. I waited almost a year

I: Uhm. So you want to say this shortage of staff eh has put us having to do other tasks that have to be done by other people

R: Uhm

I: And now that is putting us under pressure of saying let me do it because if I don't do it in any way, my colleagues are going to be angry

R: Uhm

R: Yes

I: If I, if I do it procedurally my patients are going to be angry

R: Uh-huh

I: So eventually you might just well do it

R: Uhm for, for the sake of everyone, to satisfy everyone.

I: Uhm

R: Uhm, even if I had to do the procedure, if there are no equipment, but I'll just go and do it so that if they ask who did it, she come and do this you'll say yes whereas I did not do it there were no gauzes or whatever I only used one gauze that night I did what I had to do there

I: Uhm

R: Uhm. She'll teach you of equipment it was the other problem

R: That's another problem

I: Joh so it's equipment, time versus shortage of people

R: Uhm

I: That are delegated, delegated that I want to say can be many if you are not dedicated. What about supervision, remember we are still under the supervision of, of our sisters or does it also because of shortage what, how do you experience eh supervision been directly or indirectly.

R: I have never been supervised while working. I have been just told you just do this

R: If you think why because of the shortage of staff. Uhm the sister that's why like I said she just can't leave her work there come and supervise you, time is going uhm. We should just do it, I'll see, I'll come in and supervise you tomorrow Uhm

I: What do you say Yvonne?

R: I think she will never come and see even if she said just do it and I'll come and see

R: Uhm what do you

R: You will run after her telling her that I've done this come and see she'll tell you that I'll come later, she goes home and she'll come tomorrow

I: Ey

R: Uhm there's also a lack of supervision because of shortage of staff uhm. We we had enough she'll come and help me and say do this, don't do this and then you take this and put it here, everything will be fine, everything will be done well uhm

I: My worry is that will we ever be enough, but patient care has to be improved. That was what I'm trying to say how can we do procedurally well? Is there a strategy that you can have? Eh at school do you think are you being taught well, the procedures. Do you come out of the school well conversant with whatever want to do, are you, are you sure of what you are going to do? It's only in the clinical area where, is this problem

R: Yes that's cool we are taught well.

I: Uhm, uhm

R: We come back knowing well.

I: Uhm

R: I must do this but because of the thing that we finds then they are from school there's nothing we can do

R: So we are just turning 16

R: But knowing well that this that I'm doing is wrong.

I: Uhm you know, you know it's wrong

R: Uhm I know where it's wrong but I'm doing it

I: I, I've, I've gained a lot I don't have answers, it was very interesting uhm interview and is there anything, Doc, that you want to add before I can some up and close up. I don't want

to say I, I was still in the mood to say and then you tell me that time, time, time, time, you are fine? Yvonne?

R: No I'm fine

I: Gilbert do you think you have said your mouth full

R: You know Sis, no I'm fine but in the clinics there's a lot of problems as we have mentioned some of them, but others problems we forget

I: Uhm

R: Yes but there are so many problems at the clinics

I: Those problems that forces you not to comply to the principles

R: Yes because I'm working under supervision of a, of a nurse

I: Uhm

R: A professional nurse. When we getting to at work she need me to be speed up with the queue of the patient.

I: Uhm

R: Not thinking of the procedure that must be done by me.

I: The, the very same sister

R: The very same sister

I: Gift?

R: Yes eh I'm not sure whether they'll do what the private hospitals are doing because at the private hospital everything is about money.

I: Okay

R: So I think the department always saying they don't have money whereas in private they have money because everything that happened to the patient there's a call sheet you just

I: So the resources are forever there because there is money

R: Yeah there is money

I: Okay, Sarah

R: Uhm like Gilbert said he's working under supervision of the sister. If the sister maybe wants to see more patients he's alone there, maybe he's doing those observations or whatever. He end up not doing the temperature just writing it so that the patient can go, then I can move fast you see, now I'm not doing the proper observations.

R: Uhm

R: You do a proper observation and then into the queue not moving so quickly

I: Uh-huh

R: The sister sometimes became angry that we are slow

I: Uhm

R: But I try in my duty I try a lot eh to do the proper observation

R: You try uhm

I: So you say we must just, we must just try no matter what circumstances, let's try because there's some of the programs that we are saying it's not a, a short-term problem that can be solved overnight or something that can be solved in the institution. But the reputation of us in that institution brings to the patients remains with us.

R: Uhm

I: It, it's very few that the patients will complain to the government and say you don't do 1 to the nurses, you don't do 2 you don't do 3. You don't supply the new equipment, you don't supply the new stuff, when, when every time when there's a problem they will say those nurses at that hospital or at that clinic, they're having an attitude, but we, we can change.

R: Because currently the whole clinics, there's a lot of, lot of work

I: There's lot of work

R: Especially in the observation rooms

I: Uhm

R: You have to screen the patient, every TB patient have a big register

I: Uhm

R: After that you have to do you're urine testing it takes long

I: What, to record?

R: Yes.

I: Uhm

R: Doing the observations you're interesting and then there's the screening and taking the sputum also. Where, where I'm working there's a TB room

R: It's a TB room it's where we're working with the TB

I: Uhm. So you are saying also there's a lot of paperwork and the paperwork is still subjected to you as a nurse

R: Uhm

I: But isn't part of record keeping

R: No

R: For record keeping it's the register that they, that they're having screen book, observations...

I: Uhm

R: And then the screen book

I: Uhm

R: And then the observations

I: Uhm, and at the hospitals?

R: Uhm at the hospitals I see that the person was in, in charge of those maybe for making follow-ups of the, the TB what, what. Now she gave us the job that job that let's say we are, we are, we are doing night duty. Most sputum are taken in the morning so we are supposed to go to the TB register and write their name and their address, everything in the TB register. You see now it's lot of work wherein

R: And TB only it's a lot, a lot of work

R: Eh on that register

R: TB only

R: Lot of information

I: So there's also lot of paper

R: Lot of paperwork uhm

I: Within this limited time

R: Uhm

I: Can we go away with our lunch and tea times? I'm just asking

R: No tea time, only lunch

R: Only lunch at 12:00

I: At 12:00

R: Until quarter to 1 or half past, in my, my institution

I: Uhm

R: Sister said at 12 o'clock until eh half past

I: Uhm

R: But I don't take the tea at 12 o'clock until half past, I take at the 12 o'clock until quarter, quarter to, because I was tired.

I: Uhm, uhm that's another thing ne we are, we are tired. But are we still getting our leaves eh as, as we had, as we should like I giving we are supposed to, we have, we have benefits of taking leave just for us to rest in-between or also the shortage eh has an impact on the leave that we have to take

R: Sometimes you do get then, sometimes you don't get them then the following year they will say maybe you are you are to the other ward they will say why didn't you take your leave on that ward, what happened that what they say no you take your days before June

next year. When you come to that ward they say no it's not our problem then you must know that before you going to forfeit those days of yours because you didn't take them last year, this is the new year

I: So

R: That's the other problem

I: The nurses themselves they don't have team spirit

R: Uhm

I: Anyway thank you, thank you very much, thank you for the time that you had and thank you for the valuable information it was nice eh as I said I've been only in the hospitals so and as a lecturer I was, that's why I was asking is there anything from school that maybe the lecturers are not doing so that we can also try to boost, because it also hurts that eh we hear people complaining that these nurses because we are the ones that are producing these nurses, but the experience that I get and your interactions in all of you would been in the clinical, in the clinics and in the hospitals maybe the, they've, they've highlighted a lot I, I hope with the report that I'll be writing there, there will be something, we just hope that there will be something that can be done. I'm not promising that with this interview something is going to happen, my, my, my aim was just to try and identify, let us explore these factors that impede us from doing the procedure correctly as we were taught in the books, and thank you very much

R: Thank you mam

ANNEXURE: 12: FIELD NOTES

Field notes: 1

Area: Setsoto Municipality

Date: 11 September 2014

Venue: Clocolan Nurses home

Time

- Scheduled =12h00- 13h00
- Real = 13h45-15h00
- Reasons for deviation =
 - Veld fired smoke in most area of area along the road delayed/slowed traffic
 - Time wasted waiting for participant number 6 eventually never turned up

Demographic notes

1. Participants

- Expected = 6
- Real = 5
- Reasons for deviation = announcement of sudden death of family member to participant number 6

2. Seating arrangements:

Half-moon shaped with researcher facing them. Participants identified themselves in the anti-clockwise direction (from the right to left side of researcher). They held pseudonyms on paperboards in their hands to identify themselves and for the interview.

Participants from clinics knew each other very well

Descriptive notes: Observations made

- From the researcher
 - She had paper/interview guide used to ask questions. Was somehow panicking/agitated/ afraid at the start of interview and seemed relaxed later. Uses of hands observed aiding to explain her
- Environment
 - Calm, a dining room at nurses home Newbery hospital (Clocolan) was arranged, quiet and was away from everyone's place of work. Interview table was welcoming with refreshments
- Participants
 - Relaxed, all participating actively with Doc (name) being the least soft spoken and Evon (name) more confident in her talks. No sequence on who to answer first was arranged. Communication and flow of facts was spontaneous.

Reflective notes

- Researcher: she knew exactly the content to the content to focus on and somehow leading, sometimes with closed questions, to focus on the topic
- Interview method: she probed for rich data, asking clarifications where general remarks were uttered and all participants were actively involved
- Participants: They respected the interview, researcher and one another. All were actively involved. No clues of boredom or being neglected were observed from their faces.

Personal notes:

The expected data was identified by participants though haphazardly. They tried to think of all factors/causes (using real examples to clarify their statements).probing method from researcher assisted her in reaching data she needed. Interview time was extended more than the intended period and was stopped when researcher felt facts are now repetitious.