Exploring the experiences of Enrolled Nurses regarding quality nursing care in general nursing units in the private healthcare setting

Andrea Haakestad

Thesis presented in partial fulfilment
of the requirements for the degree of

Master of Nursing Science
in the Faculty of Medicine and Health Sciences
at Stellenbosch University

Pectora roborant cultus recti

Supervisor: Mrs L. Fürst
Co-supervisor: Dr E.L. Stellenberg

December 2014

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: December 2014

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ABSTRACT

In South Africa, currently enrolled nurses make up the largest proportion of members of the nursing healthcare team. As in direct contact with patients it is essential that the practice environment supports patient and nursing outcomes. Studies confirm the complexity of the practice environment and the impact on both personnel and on the quality of nursing care provided. Job satisfaction is integrally linked to the quality and safety of care provided.

The scarcity of registered professional nurses, particularly in the South African context, has resulted in enrolled nurses being widely used to continue to deliver acute care in quite complex situations. It is well documented that the use of suboptimal nursing personnel levels or substituting enrolled nurses for registered professional nurses is associated with an increase of adverse events such as infections, pressure ulcers and unanticipated death.

The purpose of this study was to explore the experiences of enrolled nurses regarding quality nursing care in general nursing units in the private healthcare setting. The objectives being:

- The exploration of the enrolled nurses understanding of the concept of quality care
- The exploration of the enrolled nurses understanding of her value and contribution to quality care and
- The exploration of the enrolled nurses experiences (positive and negative) of quality nursing care in private health care setting

A descriptive qualitative methodology was applied. A purposive sample size of n=13 was drawn from the total population of N=387. An exploratory interview was completed. Lincoln and Guba's criteria of credibility, transferability, dependability and confirmability were applied and ethical principles were met.

Findings demonstrated that enrolled nurses experienced both positive and negative work experiences, some more negative than others. They had a very good understanding of quality care but had difficulty in reconciling the patient's needs with what they were able to deliver, due to workload pressures and resource constraints:

> P6: “I miss the quality because that patient that needs just that back rub or just to hold his hand ...the thing is with quality nursing we don’t do quality nursing on the patient anymore.”

Most participants experienced registered professional nurses absolving their clinical supervisory responsibility. This endangers the quality and duty of care of patients and is a legal liability. A recommendation is that registered professional nurses require professional development through utilising good role models. This exposure to positive learning experiences will enable their professional development and ethical behaviour. Registered professional nurses need to be taught the skills of how to be team players.

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OPSOMMING

Ingeskrewe verpleegsters maak huidiglik die grootste deel van die verplegingsspan se gesondheidsorg uit. As gevolg van die direkte kontak met pasiënte, is dit belangrik dat die omgewingspraktyk pasiënt- en verpleeguitkomste moet kan ondersteun. Navorsingsstudies bevestig die kompleksiteit van die omgewingspraktyk en die impak wat dit op beide personeel en op die kwaliteit van verpleging wat verskaf word, het. Werksbevrediging vorm ’n geïntegreerde skakel met die kwaliteit en veiligheid van sorg wat verskaf word.

Die tekort aan geregistreerde professionele verpleegsters, veral binne die Suid-Afrikaanse konteks, het tot die gevolg dat ingeskrewe verpleegsters oral gebruik word om akute sorg in taamlik komplekse situasies te lewer.. Dit is goed gedokumenteer dat die gebruik van suboptimale verpleegpersoneelvlakke of die vervanging van geregistreerde professionele verpleegsters met ingeskrewe verpleegsters, geassosieer word met ’n toename in nadelige gevalle soos infeksies, druk-ulkusse en onverwagte dood.

Die doel van hierdie studie is om die ervaringe van ingeskrewe verpleegsters ten opsigte van die kwaliteit van verpleegsorg binne algemene verpleegeenhede in die private gesondheidsorgomgewings te ondersoek. Die doelwitte is ’n ondersoek na die ingeskrewe verpleegsters se:

- begrip van die konsep van kwaliteitsorg
- begrip van hul waarde en bydrae tot kwaliteitsorg en
- ervaringe (positief en negatief) van kwaliteit verpleegsorg binne private gesondheidsorgomgewings.

’n Beskrywende, kwalitatiewe metodologie is toegepas. ’n Doelgerigte steekproefgrootte van n = 13 is geneem uit die totale populasie van N = 387. ’n Voortoets is voltooi. Lincoln en Guba se kriteria van geloofwaardigheid, oordraagbaarheid, betroubaarheid en bevestigbaarheid is toegepas en etiese beginsels is nagekom.

Bevindings het bewys dat ingeskrewe verpleegsters beide positiewe en negatiewe werkservaringe gehad het; sommige meer negatief as ander. Hulle het ’n baie goeie begrip van kwaliteitsorg, maar vind dit moeilik om aan die pasiënt se behoeftes, vanweë drukkende werkladings en beperkte bronne te voldoen.

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> P6: “Ek mis die kwaliteit want al wat die pasiënt benodig is die vryf van die rug of net die vashou van sy hand…die probleem met kwaliteitsorg is dat ons nie meer kwaliteitsorg op die pasiënt doen nie.”

Die meerderheid van die deelnemers verklaar dat die geregistreerde professionele verpleegkundiges hulle kliniese toesighoudende verantwoordelikheid afskeep. Die gedrag is bydraend tot swak kwaliteit pasient sorg en het direkte wetlik implikasies. Die aanbeveling is dat professionele ontwikkeling van geregistreedrde verpleegkundigies verbeter kan word deur gebruik te maak van goeie rol modelle. Die blootstelling aan positiewe leer ervarings en omgewing sal bydrae tot hulle professionele ontwikkeling en etiese gedragspatrone. Geregistreerde verpleegkundiges moet die vaardighede aanleer om as deel van ’n span te kan funksioneer.

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ACKNOWLEDGMENTS

I would like to acknowledge the following special people:

- My father, my rock – thank you for your patience, unselfishness and continuous support
- My daughter, Zoë and son, Bjørn, for your thoughtfulness, patience and understanding the sacrifices that had to be made

I would like to express my sincere appreciation to:

- My work colleagues who share a passion for quality, safe clinical care and who provided assistance, support and motivation to keep going and whom I cannot name for fear of leaving one out!
- The hospitals who graciously accommodated me on their premises
- The participants, who provided valuable insights in their contribution
- My supervisor and research assistant(s), Mrs L. Fürst and Mrs M. van der Heever, for your time and support
- My co-supervisor, Dr E.L. Stellenberg, for your valuable insights
- Mrs Wilhelmine Pool, for librarian support
- Ms Julia Martinelli, for professional transcribing services

Special thanks to:

- My dear friends who allowed me to be selfish and yet remained unwavering in their support

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LIST OF ABBREVIATIONS

ENA	Enrolled nursing assistant
EN	Enrolled nurse
PDSA	Plan-Do-Study-Act cycle
RPN	Registered professional nurse
SANC	South African Nursing Council

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CHAPTER 1

THE SCIENTIFIC FOUNDATION OF THE STUDY

1.1 INTRODUCTION

The South African nursing profession is facing many challenges (Strategic Plan for Nursing Education, Training and Practice, 2012:5). Nurses feel vilified, under-valued and aggrieved by public views that they have "attitudes" and are no longer seen as respected professionals (Strategic Plan for Nursing Education, Training and Practice, 2012:78). Their competence and skill is questioned when patient care does not meet the expected standards (Hughes, 2008:6).

Nurse practitioners constitute the largest part of the healthcare team (Hughes, 2008:6). Being at the "sharp end" of patient care, it is essential that the practice environment supports nursing outcomes (Kirwan, Matthews & Scott, 2012:196). Studies corroborate the complexity of practice environments and demonstrate the influence that the practice environment has upon the quality and safety of nursing outcomes; retention, burn out and job satisfaction (Hughes, 2008:2; Kutney-Lee, Wu, Sloane & Aiken, 2012:196; Coetzee, Klopper, Ellis & Aiken, 2012:163; Clarke & Donaldson, 2008:1). Notably, job satisfaction is integrally linked to the quality and safety of care provided (Pillay, 2009:2).

As a registered nurse and a project owner addressing nursing issues in a private healthcare group, the researcher, through her work, became aware of the potential negative effects that the practice environment has upon enrolled nurses' experience of healthcare. As the private sector business is profit driven and differs from the public sector, the investigation of the experience of enrolled nurses will ascertain if the profit incentive hampers the delivery of quality patient care. Through this study it was aimed to explore the enrolled nurses' experience of quality nursing care in the private healthcare setting.

1.2 BACKGROUND AND RATIONALE

The Constitution of South Africa (Act 108, 1996:1247) assures access of healthcare services to the South African population. The provision of healthcare services in South Africa is complex as there is a dual system, with a stark distinction between the public and private healthcare sector

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(Pillay, 2009:1). The key differentiators are the access to the quality of services provided and the management and administration of these two separate healthcare sectors within the healthcare system (Ruff, Mzimba, Hendrie & Broomberg, 2011:1; Pillay, 2009:2; Centre for Development and Enterprise, 2011:37).

The public healthcare sector provides free basic primary and specialised healthcare services to 82% of an indigent population, accounting for approximately 40% of the total healthcare budget spent in South Africa (Pillay, 2009:2). Furthermore, studies assert that the sector is associated with being under resourced, badly designed, inefficient and not being able to meet the public demands or provide appropriate care (Pillay, 2009:2; Centre for Development and Enterprise, 2011:35). Health outcomes are seen to be poor when compared with the outcomes in the private healthcare sector (Centre for Development and Enterprise, 2011:8).

The private healthcare sector comprises for-profit organisations, medically insured and self-financed individuals (Centre for Development and Enterprise, 2011:8). The private healthcare sector is not only limited to hospitals, but also includes laboratories, radiology and other speciality services (Centre for Development and Enterprise, 2011:15). Twenty percent of South Africa's population use private healthcare, 16% of which are medically insured (Centre for Development and Enterprise, 2011:8). Only a small minority of the population are able to afford the privilege of private healthcare, perceived to be associated with world-class facilities and the rendering of appropriate healthcare services (Pillay, 2009:2; Centre for Development and Enterprise, 2011:8).

Qualified, competent nursing personnel provide a high level of quality nursing care. Due to the size of the nursing personnel component, within the healthcare team, the nursing personnel budget has to be astutely managed (Hughes, 2008:6; Flynn & McKeown, 2009:760). The cost of nursing is determined using a model to determine the patient's care need (Chitty & Black, 2011:348). General surgical and medical nursing units, to a lesser extent, have high patient turnovers due to the various surgical (and medical) specialities which they have to service. Enrolled nurses therefore, carry the responsibility of the workload, with the registered nurse supervising patient and nursing outcomes and the administrative tasks, in alignment with their Scope of Practice (Brunetto, Shriberg, Farr-Wharton, Shacklock, Newman & Dienger, 2013:3; SANC,1984:1).

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The duties of enrolled nurses are governed by the scope of practice, contained in Regulation R.2598, as amended (SANC, 1984:1). The scope of practice lists the type of tasks applicable to the level of nursing, that registered and enrolled nurse practitioners are permitted to perform. Failing to act or omitting to act timeously, or acting out of one's scope of practice has severe consequence for patient outcomes, resulting in, but not limited to medication errors, urinary tract infections, patient falls, incomplete care or longer hospital stays (Ausserhofer, Schubert, Desmedt, Blegen, De Geest & Schwendimann, 2011: 244). Where working environments are not supportive of nurses, or where there is a shortage of a particular category of nurse, as for example registered professional nurses, other categories of nurses may be utilised to fulfil the lack of skill. Coetzee, Klopper, Ellis and Aiken (2012: 163) describes the influence of these poor working environments on nurse workforce outcomes, such as job dissatisfaction, burnout, absenteeism and adverse patient outcomes.

Globally, the shortage of qualified nursing personnel is a reality, resulting in increased workloads and deteriorating patient care (Aiken, Sloane, Bruyneel, Van den Heede & Sermeus, 2012:144; Winslow, 2001:13). The recruitment and retention of nursing personnel is costly (Mokoka, Oosthuizen & Ehlers, 2010:5). To mitigate the risks incurred by the shortages of nurses, agency personnel are utilised to fill the vacancies.

The introduction of agency personnel, to compliment the permanent employed personnel, and the addition of other support personnel, such as care workers (CWs), were introduced to assist with indirect patient care activities.

CWs are responsible for non-nursing tasks, but activity slip and blurring of responsibilities, related to lack of supervision, has compromised both the nursing and patient expectations (Dorse, 2008:16). Out of scope functioning across nurse categories exposes the nurse and patient to potential risks (Dorse, 2008:16). Studies confirm the impact that the practice environment has on the quality of nursing care influencing patient safety and patient care and nursing outcomes (Coetzee, Klopper, Ellis & Aiken, 2012:163).

Practice environments directly affect nursing outcomes (Coetzee *et al*., 2012:163; Kirwan, Matthews & Scott, 2012:254). Studies corroborate the vital link between nurses, the practice environment and patient safety outcomes (Kirwan *et al*., 2012:254; Kutney-Lee, Wu, Sloane & Aiken, 2012:196; Ausserhofer *et al.,* 2011:240).

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Enrolled nurses, comprising the largest proportion of the nursing workforce, are well placed in the practice environment to report on the quality care provided due to the integral role that they play in providing patient care (Stimpfel & Aiken, 2013:122). Against the complexity of the practice environment and the challenges faced, it is important to understand the experiences of enrolled nurses regarding quality nursing care in the private healthcare setting.

1.3 SIGNIFICANCE OF THE STUDY

Literature indicates the impact of the working environment on nursing workforce outcomes, which has consequences for the quality of care delivered, patient safety and for patient outcomes. To improve patient safety and the patient experience it is incumbent on nursing leadership to invigorate, support and guide personnel in the nursing unit, nurturing a positive, harmonious work culture and environment. The study aimed to explore the experiences of enrolled nurses regarding quality care in general nursing units in the private healthcare setting. The outcome would reflect the enrolled nurses understanding of the concept of quality care, emphasizing the perceptions and feelings experienced by enrolled nurses.

The data will illuminate the role fulfilled by enrolled nurses and clarify their position as members of the patient care delivery team and highlight their influence on the quality of care provided. The clarification of the role and responsibilities of enrolled nurses and identifying the support elements required to empower and to affirm their pivotal function would be perceived as beneficial to the participants in this study.

1.4 PROBLEM STATEMENT

The complexity of the practice environment has been highlighted in the rationale, together with the challenges that enrolled nurses face in attempting to provide quality, safe patient and nursing outcomes. The effect that the practice environment has upon nurses in general, is well documented.

The general surgical and medical practice environments are complex environments. Work opportunities, power and the skill mix directly influences what enrolled nurses are able to do and how they are able to utilise their resources (Hughes, 2008:13). For this reason it is important to explore how enrolled nurses experience quality nursing care in the general nursing units.

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1.5 RESEARCH QUESTION

What are the experiences of enrolled nurses regarding quality nursing care in general nursing units in the private health care setting?

1.6 RESEARCH AIM

The aim of this study was to explore the experiences of enrolled nurses regarding quality care in general nursing units in the private healthcare setting.

1.7 RESEARCH OBJECTIVES

The objectives of this study were to explore the enrolled nurses:

- Understanding of the concept of quality care
- Understanding of their value and contribution to quality care
- Experiences (positive and negative) of quality nursing care in private health care setting.

1.8 RESEARCH METHODOLOGY

The research methodology applied to this study will be briefly described with further detail appearing in Chapter 3.

1.8.1 Research design

A descriptive, qualitative, research design was applied. The selection of the particular qualitative method supports the enquiry process of exploring the in-depth experiences of SANC registered enrolled nurses regarding quality nursing care in general nursing units in the private healthcare setting, in the Western Cape metropolitan area.

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1.8.2 Population and sampling

A population consists of all the types of individuals or elements to be considered for a research project (Burns & Grove, 2009:343). The population of nurses identified for this study, were all enrolled nurses working in three private hospital groups in the Western Cape metropolis.

A sample represents a selected proportion of the individual or elements within a population to represent the total population (Burns & Grove, 2007:324). Purposive sampling was applied to choose the enrolled nurses working in the hospitals.

Thirteen (n=13) enrolled nurses working in general nursing units, participated.

1.8.2.1 Inclusion criteria

The hospitals included in the research study were part of privately owned for-profit hospital groups. All enrolled nurses working in adult general surgical/medical nursing units, with a minimum of six months experience working in that specific unit were included.

1.8.2.2 Exclusion criteria

Categories of nursing personnel that worked in all critical care units; paediatrics, emergency centres and operating theatres were excluded. Care workers, who are not a registered nursing category with SANC, were excluded.

1.8.3 Exploratory interview

An exploratory interview was conducted on one participant to test the suitability, order and relevance of the semi structured questionnaire and the location of the interview venue. The participant was chosen from a group of names presented by the unit managers who met the inclusion criteria. No pitfalls were revealed.

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1.8.4 Instrumentation

A semi structured interview guide, based on the study objectives and the literature reviewed, was utilised (see Appendix J).

1.8.5 Data collection

Thirteen sequential, in-depth interviews were conducted over 8 weeks, from 11 March to 3 May 2014. The researcher was assisted by two research assistants. A natural setting was provided at each hospital, with careful consideration to the location, space and comfort needs of the participants. Five different venues were utilised in total as they were dependent on availability. The venues were comfortable and non-threatening. One venue was situated in the management passage which could have influenced the responses and participation of two of the participants' response.

To avoid bias at one of the hospital groups, two research assistants were utilised to conduct the interviews. The remaining interviews were conducted by the researcher. The interviews were electronically recorded at the individual hospitals with the consent of the participants. Interview notes were taken and on completion of the interviews, the interviews were professionally transcribed verbatim and returned to the participants for review.

1.8.6 Validity of the research

The supervisor and a research assistant validated the interview guide. Both possess a master's degree in nursing. One has previously guided students in qualitative studies. In addition, the co-supervisor has a doctorate in nursing, which increases validity.

The researcher and supervisor received interview training from one research assistant. In preparation for the conduction of the interviews, the researcher read extensively and familiarised herself with the practice of conducting interviews (Pope & Mays, 2006:15). The validity of the data was assured by applying Lincoln and Guba's principles of credibility, transferability, dependability and confirmability, as described in De Vos, Strydom, Fouche and Delport (2009:346).

1.8.7 Data analysis

The interviews were transcribed and the data organised into categories using Excel and interpreted according to the Hycner's Explicitation Process, as described in Groenewald (2004:17). This approach facilitated the retrieval of data into meaningful pieces while identifying themes, recurring commonalities and inconsistencies.

1.9 ETHICAL CONSIDERATIONS

Ethical clearance and approval was obtained from the Health Research Ethical Committee at the Stellenbosch University (Reference: S13/10/193, see Appendix A). Permission for access to the hospitals was provided (see Appendices B-G). During the selection process of participants, those people who showed an interest in participating were provided with a "participant information leaflet", that explained the objectives and nature of the research. The participants were informed that the interviews will be recorded and professionally transcribed. The transcriber had signed a confidentiality clause not to discuss the transcripts with anyone other than the researcher (see Appendix M). It was emphasized that participation was voluntary and the right to withdraw from the study at any time without being penalised in any way was explained. Prior to the interview, confirmed participants were provided with an informed written consent document for signature, for both the interview and the recording thereof (see Appendix I).

The participant's, including the hospitals, right to self-determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm were upheld throughout the study. A detailed explanation of these principles is provided in chapter 3. Data received was stored in a locked secure place and will be secured for five years. Restricted access to the data is limited to only those people who have been directly involved in the study.

1.10 CONCEPTUAL DEFINITIONS

In the text of the study certain concepts were utilised which are defined below.

- **Experience:** The direct participation or observation of activities and tasks and the feelings associated with this (Coetzee, Botha, Kiley & Truman, 2012:399).

- **General nursing unit:** It is either a general surgical or medical nursing unit, also known as a general 'ward', where care is provided by general registered professional nurses, enrolled nurses and enrolled nurse auxiliaries and assisted by care workers (Van Pletzen *et al.*, 2013;10). Registered professional nurses, who have not undergone training beyond the basic nursing program, oversee the general nursing care of patients (Nursing Act, 2005:34).

- **Managed care:** Managed health care involves the management of the clinical and financial risk by funders and providers of care. Members of medical funds or medical insurers are provided different benefit options with limitations, doctor networks and dedicated hospitals where care may be received (Council for Medical Schemes, 2014:1).

- **Nursing outcomes:** These are processes that are affected, influenced by or provided by nursing personnel (Coetzee *et al.*, 2012:163; Clarke & Donaldson, 2008:1).

- **Patient acuity:** Patient acuity refers to the number of nurses required to provide safe patient care. Different patient classification systems exist, which are used to determine the type of nursing care needed to meet the patient requirements. The patient requirements are also known as the patient acuity. The patient acuity can be utilised to budget and manage nursing personnel costs, resources and quality (Jennings, 2008:1).

- **Practice environment:** The practice environment is also referred to as a work or ward environment. It contains the organisational characteristics of the work setting. These characteristics can either facilitate or constrain the professional nursing practice (Coetzee *et al.*, 2012:163).

- **Private hospital:** Is a hospital that is a wholly owned subsidiary of a private healthcare group, independent of the public healthcare sector, with the aim to make a profit (Hassim, Heywood & Berger, 2007:174). It may be listed on the Johannesburg Stock Exchange (JSE). Workers are not covered by the Public Service Coordination Bargaining Council (PSCBC) (Hassim *et al.*, 2007:324).

- **Quality nursing care:** Quality nursing care is defined as meeting a person's needs, by applying one's knowledge and skill competently, with caring and empathy. Being mindful

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when interacting and ensuring that one's actions are intentional and taking responsibility for the outcome (Burhans & Alligood, 2010:1689).

- **Registered professional nurse (RPN):** A nurse who is registered and practising in terms of section 31, of the South African Nursing Council (Nursing Act, 2005:6).

- **Skills mix:** Skills mix refers to the different skill levels of nurses that are required to provide an appropriate standard of care. It entails the ratio of registered professional nurses to enrolled and enrolled nursing auxiliaries (Welton, 2011:310).

1.11 DURATION OF THE STUDY

The study commenced on receipt of Ethical approval and extended till the 31st August 2014.

1.12 LIMITATIONS

This study was conducted in the private healthcare setting of the Western Cape. Public healthcare institutions were excluded. Enrolled nurses in the public sector may have different views to those expressed by their colleagues in the private sector.

1.13 CHAPTER OUTLINE

Chapter 1 outlines the scientific foundation of the study, including the rationale for the study, the problem statement, research aim and objectives, providing a brief overview of the research methodology.

Chapter 2 presents the literature review related to the research topic.

Chapter 3 provides a detailed description of the research methodology used in the study.

Chapter 4 presents the data analysis, interpretation of the participant's experiences.

Chapter 5 provides the conclusions and recommendations derived from the study.

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1.14 SUMMARY

Globally, nursing shortages are a reality and not easy to rectify in the short term. Patient outcomes are directly influenced through nursing intervention and outcomes. It is therefore, imperative that the nurses' working situation and what they are experiencing is understood. Studies demonstrate the impact that the practice environment has upon nursing and patient outcomes. Organisations need to develop their leadership to ensure positive, healthy work environments that support the nursing workforce, retain skilled nurses and enhance the profession and the organisation (Shirley, 2006:266; Brunetto, Shriberg, Farr-Wharton, Shacklock, Newman & Dienger, 2013:9). In respecting our nurses and listening to them, the potential of the individual and the nursing community in the ward will not only be enlightened, but promoted. Their true meaning, to the organisation, will be recognised (George, 2010:393).

1.15 CONCLUSION

In Chapter 1, an introduction and rationale to the research study was provided. A brief overview of the research methodology, ethical considerations and conceptual framework used in the study was outlined.

Chapter two will present the literature review providing an in depth understanding of the factors that influence the enrolled nurses' experience of quality nursing care.

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CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Healthcare is a dynamic environment influenced by people of different backgrounds, gender, culture, religion, value systems, beliefs and attitudes (Frenk, Chen, Bhutta, Cohen, Crisp, Evans, Fineberg, Garcia, Horton, Yang, Kelley, Kistnasamy, Meleis, Naylor, Pablos-Mendez, Reddy, Scrimshaw, Sepulveda, Sewadda & Zurayk, 2010:9). Nurses as individuals, come from various social, economic and cultural backgrounds, bringing their own values, beliefs and perceptions and freedom of choice; also expressed in their choice of profession (George, 2010:393). They search for meaning both in their personal and professional lives (George, 2010:393). Nurses are obliged as citizens of South Africa to uphold and abide by the Constitution of South Africa (Act 108 of 1996:1247). They are mandated by the Bill of Rights and the regulations and the Code of Ethics that govern the nursing profession as constituted in the Nursing Act, (Act 50 of 1978:6).

Chapter 2 presents a comprehensive literature review that supports the foundation of the intended study.

2.2 LITERATURE REVIEW

A literature review was conducted over 22 months and commenced prior to the proposal for the study. The evidence based information was reviewed, initially through a process of deductive reasoning, to gain knowledge of what was known about quality care, enrolled nurses, patient safety and workplace experiences (Polit & Beck, 2008:13). This provided insight into how other researchers had approached and investigated problems of a similar nature.

Various search engines were utilised and included: SUNSearch (Stellenbosch University library and Information Service), EBSCOhost (Elton B Stephens Company research database), PUBMED, CINAHL and MEDLINE. The majority of the publications and material used were published within the past ten years. Assistance and support was provided by the librarian and the supervisor and co-supervisor.

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On completion of this study's data analysis and findings, the literature review was extended to ascertain if any gaps existed in the research, thereby enriching the literature reviewed and providing the context for the intended study (Terre Blanche, Durrheim & Painter, 2006:19).
Key words: nurses, suboptimal nursing, quality care, scope of practice, practice environments, job satisfaction

The literature reviewed is presented under the following headings:

- Nursing as a profession
- Individualised patient care
- Quality care
- Documentation
- Legal framework for provision of healthcare in South Africa
- Health care services in South Africa
- Human Resource management of nurses
- Recruitment and retention
- Personnel planning
- Agency nurses
- Support personnel
- Practice environments
- Practice environment experiences
- Work climate expectations

2.2.1 Nursing as a profession

Nursing is the foundation of healthcare in South Africa (Breier, Wildschut & Mgqolozana, 2009:1). The profession provides a service to humanity, through a formalised scientific framework, in which knowledge is acquired that improves the nursing practice. Great emphasis is placed on theory and research as nursing has become more technical in nature (Breier *et al.,* 2009:16). Furthermore elaborating that although nurses and doctors are seen as equal in the delivery of patient care, each as a profession is self-regulated (Breier *et al.,* 2009:97). This perception is open to debate as in the public sector there is a 'professional partnership' between nurses and doctors as they are employees of the hospital. However, in the private sector, where doctors pay for their consulting rooms and theatre facilities, supplying the hospitals with patients,

doctors expect nurses to carry out their instructions as the patients belong to them (Breier *et al.,* 2009:99).

SANC acts on the public's behalf, thereby ensuring that the education and the practice of nursing is regulated. The duties of a nurse are governed by the scope of practice, contained in Regulation 2598, as amended (SANC, 1984:1). The scope of practice lists the type of tasks applicable to the category of nursing, that registered professional, enrolled nurse and enrolled nurse auxiliary practitioners are permitted to perform. Nurse practices have a direct influence on the quality of care provided and patient outcomes (Stanton, 2004:2).

2.2.2 Individualised patient care

The complexity of healthcare in sub-Saharan Africa is compounded by the high burden of disease, such as HIV and AIDS (Breier *et al.,* 2009:33). The World Health Organisation (WHO) reports that 11% of the World's population is found in this region. However, 65% of the World's HIV infections occur within this 11% (Breier *et al.,* 2009:33). The increase in the predominance of TB, specifically multi-drug (MDR) and extensive drug resistant TB (Breier *et al.,* 2009:34), coupled with the increase in lifestyle diseases, such as obesity, hypertension, cardiac disease, diabetes and trauma, impacts the variability of nursing skills required.

The level of care that a patient receives is individualized and varies according to the complexity of the type of care required. Patient needs are unique and nursing personnel are required to have the skills to care for and to deliver the care to meet the need of the patients. Both the disease profile and managed care, which does not adjust reimbursement for the variation in the severity of illness, affects the nursing intensity independently and interactively (Welton *et al.*, 2006:418). Care is also influenced by which category of nursing personnel is providing the care (Welton *et al.*, 2006:417). Actual nursing time and the effort expended on direct patient care is higher for patients who have a greater dependency for basic care needs (Welton *et al.*, 2006:417). It is this dependency on care that influences the nursing staff patterns and requirements across the nursing units in the hospitals.

Furthermore, the patient to nurse ratio determines the mean hours of care delivered on the unit. One must also consider that individual patients may require more care than the mean. It is this degree of variability of nursing intensity that will determine the number of nursing personnel

required and specifically the type of nursing category needed, to deliver the nursing care required. Where patient needs are similar one cannot assume that patients with the same diagnosis would require the same care (Welton, 2006: 417).
As detailed above, various factors in addition to the dynamic regulatory environment, places pressure on private hospital prices and salary costs.

2.2.3 Quality care

Against the complexity of the practice environment and the challenges facing nurses, it is important to understand what is encompassed in the term 'quality of care'.

The World Health Organisation (WHO) identifies six basic concepts that define the quality of outcomes that healthcare providers offer (World Health Organisation, 2006:9). Healthcare, generally speaking entails moving a person from a state of ill health to health. To achieve this change; a quality improvement process is followed. Firstly the service has to be *effective*, meaning that the care provided must be evidence based. Evidence based provides the scientific evidence to guide high quality and cost effective nursing. Secondly the care provided should be *efficient,* within resource, financial and time constraints to minimise wastage and maximise resources. Thirdly, health care should be *accessible* not only in the geographical sense, but also inclusive of the skills and resources appropriate to the setting. This is important as the care delivered must be acceptable to the patient (*patient centred)* and *equitable* despite where the care is provided and by whom. Lastly the care delivered must be done so *safely*, with the minimum of risk and without harm being incurred (WHO, 2006:10).

In addition to the six basic concepts, it is important that each of the stakeholders involved in the provision of care, clearly understand their roles and responsibilities in the quality improvement process. In the hospital environment, the managers set the stage with their leadership and management skills. Furthermore, it is incumbent on the nursing managers to contribute towards the development and execution of the organisations policies, including the implementation of legislative prescripts. Setting of goals and objectives and evaluating the performance thereof will influence the leadership and management style of the unit managers, who in turn will influence their shift leaders and personnel.

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In building a strategy for providing quality patient care, a comprehensive approach is required using the six, interrelated generic domains which are leadership; information; patient and population engagement; regulation; organisational capacity and models of care (WHO, 2006:21). Of the six domains, leadership is the most fundamental. Without strong, committed and consistent leadership support, the desired quality outcomes will not be achieved (WHO, 2006:22). Hence, leadership plays a critical role in the provision and the experiences of quality of all staff, specifically enrolled nurses who look to the unit manager for direction and support.

Enrolled nurses engage with patients and are responsible for providing the primary care. It is their responsibility for translating their commitment to quality into meaningful action (WHO, 2006:23). Monitoring patient and nursing outcomes is essential for determining the efficacy of the patient care plans and the nursing outcomes. Here, the unit or hospital goals may fall into one or more broad categories; reducing mortality and morbidity, reducing health inequalities, improving the outcomes of specific diseases and making health care safer (WHO, 2006:18).

The United States Institute of Medicine (IOM) highlighted a growing concern in 2000, for patient safety and quality of care. Various studies, notably the “Keeping Patient’s Safe: Transforming the Work environment of Nurses” (2004), highlighted the direct correlation between nursing vigilance that protects patients from care errors (Burhans & Alligood, 2010:1690).

Despite the introduction of quality improvement initiatives to improve patient safety, Burhans and Alligood (2010:1690) acknowledge that meaningful improvements are “disturbingly slow.” Furthermore, nurses when evaluating care, do so without a common shared understanding of the meaning of quality nursing care. Burhans and Alligood (2010:1690) points out an important fact in that existing literature focuses on measuring the quality of nursing care through patient outcomes and patient opinion surveys, but not specifically through the process of quality of care. Nurses are active participants in many quality improvement initiatives introduced through nursing management, however, evidence suggests that the nurses do not have input into the development of the measures (Burhans & Alligood, 2010: 1690).

Enrolled nurses as the hands-on providers of care are responsible for the majority of healthcare contributions. They implement care (under direct and indirect supervision of a professional registered nurse) and evaluate patient care needs. They administer medication and treatment while providing comfort and acting as patient advocates (Burhans & Alligood, 2010:1690). The

quality of the nursing care provided plays a significant role in patient outcomes and safety and therefore, as professionals, enrolled nurses, are ultimately accountable for the quality and systematic improvement of nursing practice (Burhans & Alligood, 2010:1690).

2.2.4 Documentation

Documentation serves a diverse purpose. Most importantly documentation and recordkeeping support the continuity of safe, quality care through facilitating information flow (Keenan, Yakel, Tschannen & Mandeille, 2008:1; Cheevakasemsook, Chapman, Francis & Davies, 2006:366). Importantly documentation can be used as evidence in legal investigations. Despite its diverse uses, documentation poses many challenges for nurses.

These challenges are not limited to the volume of documents alone. Numerous documents require completion, some formats are long, others are repetitive in nature and time consuming (Cheevakasemsook *et al.,* 2006:367). The nursing forms do not reflect the sum of care provided. Although standardised, documents may differ from one setting to another and therefore, do not support a cohesive approach, facilitating care. Workloads and the various activities involving documentation may result in documentation being lost or not accessible. This results in time wastage. Cheevakasemsook *et al.* (2006:366) indicated that the complexities associated with documentation include, disruption, incompleteness and inappropriate charting.

Inappropriate record keeping is tied to two issues; one, is incomplete documentation, the other four related elements are the nursing process, nurses' performance, daily activities and management (Cheevakasemsook *et al.,* 2006:367). The scientific nursing process provides a useful framework for a one-on-one patient and professional relationship in organising care, based on problem solving. When utilising the nursing process in the clinical setting, its effectiveness is questioned as nurses' work on multiple patient activities to coordinate care. Nurses' performance and attitudes also influence the use and completion of documentation. Insufficient knowledge to formulate nursing diagnosis can result in increased stress and feelings of insecurity (Cheevakasemsook *et al.,* (2006:368).

Studies confirm that nurses have insufficient knowledge to write good nursing care plans, which is also seen as a burden and not contributing to the planning and evaluation of care. Research confirms that 25-50% of nurses' time is spent on documentation, resulting in the loss of time

spent at the bedside or nurses having to work overtime to complete documentation (Blair & Smith, 2012:164). Workloads, increased patient acuities, personnel shortages and non-nursing activities, such as ordering of medication and feeding patients can impede the provision of quality care and the completion of documentation (Cheevakasemsook *et al.,* (2006:368). Insufficient personnel and the climate of the working environment can influence nurse note taking. Nurses value verbal communication. Consequently, documentation is seen as cumbersome and unimportant (Cheevakasemsook *et al.,* 2006:368).

2.2.5 The legal framework for the provision of healthcare in South Africa

The Constitution of South Africa (Act 108, 1996:1247) is the overarching law that provides the citizens of South Africa, despite their status, with access to healthcare services. The Bill of Rights, enshrined within this Constitution, aggrandises the rights of all South Africans, validating the democratic values of human dignity, equality and freedom (1996:3). Furthermore, the Constitution assures that every South African has the right to an environment that is not detrimental to their health or to their wellbeing (1996:6). In support of the Constitution (Act 108, 1996:1247), the National Health Act (Act 61 of 2003) provides the framework for a structured uniformed health system, promoting cooperation amongst the various sectors within the country (2003:4).

The National Health Act (Act 61 of 2003) recognises that the provision of a uniformed health system is not a current reality. This is due to the imbalances and inequalities in the provision of health services (2003:2). As previously mentioned, the provision of healthcare services is complex. However, the Act (2003:4) does promote and encourage a spirit of cooperation and acknowledges the sharing of responsibility, by both the public and private healthcare sectors.

The Nursing Act 50 of 1978 (Republic of South Africa, RSA, 1997a), as well as the Nursing Act 33 of 2005 (RSA, 2005:np) regulates and provides for matters related to the nursing profession in South Africa. Furthermore, it defines the scope of practice for all nurses according to Regulation R.2598 (South African Nursing Council, SANC, 1984:1). In terms of Regulation R.387, the Rules Setting out the Acts or Omissions, disciplinary action can be taken by the South African Nursing Council (SANC) when any form of negligence in nursing care is reported (SANC, 1985:2).

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2.2.6 Health care services in South Africa

Health care in South Africa is predominantly provided to the majority of the population by state funded facilities. Insured clients use the private hospital sector.

2.2.6.1 Public Health Service

The public healthcare sector is financed through the National Department of Health and through funds and grants received from the provincial health departments (Day *et al.*, 2013:272). Revenue is generated through the uniform patient fee schedule (UPFS) which categorizes the different fees dependent on the paying ability and needs of the patient who are able to pay for services in public sector hospitals (User Guide-UPFS 2009. Department of Health of Republic of South Africa, 2009:2). There are three categories which include full paying patients, fully subsidized patients (and partially subsidized patients) and those who receive services free. The public healthcare service accounts for approximately 40% of the total healthcare budget spent in South Africa. South Africa has a population of 52 million, of this 82% are indigent and receive free healthcare (Pillay, 2009:2).

Eligibility free health services to the indigent is stipulated in the National Health Act (Act 61 of 2003:4). Providing free health services to such a large proportion of the population is not without challenges. Studies assert to public healthcare being associated with inefficiency and not being able to meet the public demands or provide appropriate care (Pillay, 2009:2; Centre for Development and Enterprise, 2011:35). Orgill, Nxumalo, Woldekidan, Erasmus, Lehman, Goudge and Gilson, (2013:152) describe the challenges of attaining the Millenium Development Goals.

A study conducted by the Health Economics Unit at the University of Cape Town exploring community preferences for improving public sector health services, showed that communities tolerated poor quality provided that they received a thorough examination, a clear explanation of their diagnosis and treatment and the medicines they needed (Day *et al.*, 2013:259). Notwithstanding, that poor quality is attributed to the lack of appropriate human resources (no nursing cost model exists), poorly maintained or lack of appropriate facilities and lack of equipment and supplies (Day *et al.*, 2013:259).

2.2.6.2 Private Health Care

The private healthcare sector is associated with well-maintained facilities, infrastructure and accessible resources. However, this sector is not without service delivery challenges. To sustain and maintain financial viability and stakeholder confidence, private healthcare facilities are focused on cost containment to support and pay personnel, suppliers and to maintain infrastructure and equipment (Chitty & Black, 2011:349). There are two main drivers of costs. Firstly, as private hospitals may not employ doctors, this has resulted in increased competition amongst the different private healthcare providers to attract doctors and their specialised services to their specific hospitals (Centre for Development and Enterprise, 2011:16). To retain these specialist doctors, the healthcare facilities invest in specialised equipment to support the services provided by these doctors.

A second challenge is the cost of nursing personnel, which accounts for 25%-30% of the hospitals total operating budget and 40% to 50% of direct patient care costs (Welton, Unruh & Halloran, 2006:417). Similar to the public sector, the private sector also faces nursing shortages. Private healthcare facilities utilise various models to determine their actual nursing costs as there is no set healthcare industry standard (Chitty & Black, 2011:347). Due to the increased demand for qualified nurses, this high demand has put pressure on salary costs.

2.2.7 Human Resource Management of Nurses

Providing appropriate individualised and safe care to patients is underpinned by adequate numbers of skilled staff to meet patient acuity levels, the prescripts of the Basic Condition of Employment Act (Act 75, 1997:10) and within the constraints of the salaries budget.

The Basic Condition of Employment Act (Act 75, 1997:10) determines the work hours nurses may work. Nursing management is responsible to manage personnel shift lengths and overall hours worked. Nurses do have input into their own work schedule, however, variations in the approval of preferences and taking of work breaks are dependent on the individual unit managers, within the unit in which the nurses work. Work breaks are stipulated by law (Act 75, 1997:10). Stimpfel and Aiken (2013:128) confirm that nurses who do not take regular breaks, for the recommended period, result in poor productivity and diminished wellbeing, which can have

an effect on patient safety. Furthermore, it is acknowledged that the shortened length of time of the break can affect patient outcomes.

2.2.7.1 Recruitment and retention

The recruitment and retention of quality nursing personnel is costly (Mokoka, Oosthuizen & Ehlers, 2010:5). Challenges include decreasing recruitment candidate numbers to the nursing profession to meet the increasing South African healthcare demands (Mokoka *et al.*, 2010:6; Brunetto *et al.*, 2013:2). The profession does have high attrition and vacancy rates. This, coupled with an ageing nursing workforce soon to commence retirement, and a decrease in student numbers entering the profession poses a serious problem for future service delivery (Breier *et al.*, 2009:18). Breier *et al.,* (2009:22) reported that the South African Nursing Council (SANC) 2006 data indicated that the highest concentration of nurses is in the 40-49 year age group. This accounts for ⅓ of the South African nurse workforce.
In figures released by an analysis of the Personal and Salary System in the Public Service (PERSAL) database (2007), the vacancy rates in the public sector were 36% (Breier *et al.*, 2009:32). Nurses under the age of 25 comprise merely 1% of the total nurse workforce (Breier *et al.*, 2009:18). This is a grave concern as it indicates that very few young people are entering the profession. Young people do not like the unsociable hours, low wages and long shifts, coupled with the demands of the occupation that exposes and places the nurse's own health at risk (Breier *et al.*, 2009:33).

Breier *et al.*, (2009:36) reported that 73% of the health workers surveyed, experienced increased workloads, resulting in stressful working conditions and low morale. The impact of nursing workloads on patient outcomes is well documented (Sochalski, 2004:72). Of great concern is that Breier *et al.,* (2009:22) noted that the data studied indicates that young people entering the profession are commonly practising at the auxiliary level. Together with the ageing nursing workforce and the influence of the multi-generational impact on the nursing workforce, this presents its own unique challenges relating to values, needs, attitudes and work ethic (Mokoka *et al.*, 2010:6; Brunetto *et al.*, 2013:2). This highlights the disparity in the availability of adequately skilled nurses that further complicates matters as it is not known whether the current proportions of the different nursing categories are appropriate for the existing disease profile in South Africa (Breier *et al.*, 2009:18).

Exacerbating the shortages of nurses and also impacting on the recruitment of young people to the profession is the incidence of HIV/Aids on the healthcare workers. Breier *et al.,* (2009:36) report that a study conducted by the Human Research Council in 2003 indicated that 15.7% of health workers in the public and private health sector were living with HIV and AIDS. The study reported that at least 16% of healthcare workers will die, without availability to anti-retroviral therapy in certain areas. Compounding the nursing shortage problem, as discussed above, is the migration of South African nurses.

The shortage of nurses is well documented in Breier *et al.,* (2009:29). Similarly, SANC and Democratic Nursing Organisation of South Africa (DENOSA), stakeholders in the nursing field, confirm the assertions (Breier *et al.*, 2009:29). Globally, the reality is that there is a shortage of qualified nursing personnel (Breier *et al.*, 2009:29). This global shortage, together with the provision of better working conditions and higher paid salaries overseas has resulted in nurses, predominantly registered professional nurses, moving overseas (Breier *et al.*, 2009:33). By migrating, nurses also have the opportunity to gain experience, new knowledge and skill. The lure of work experience, greater safety and security is attractive and the opportunity to improve one's quality of life (Breier *et al.*, 2009:51). For this reason, in South Africa, Agency personnel are utilised in an attempt to fill the vacancies.

2.2.7.2 Personnel planning, scheduling

Private hospital nursing personnel costs as previously highlighted are determined by the skill mix, patient acuity and the level of care required (Welton *et al.*, 2006:418; Flynn *et al.*, 2009:760). The patient's care needs influence the skill mix required (Welton *et al.*, 2006:417; Chitty & Black, 2011:348).

The balancing of the skills mix is to be considered when allocating personnel to shifts. When determining the different shifts, the unit manager needs to consider what theatre cases have been booked to plan personnel accordingly in a surgical ward. In the medical units, the doctors' admission preferences (Stimpfel & Aiken, 2013:122) influence staffing requirements. Stimpfel and Aiken (2013:122) report on mounting evidence that points to long shift hours, exceeding 10 hours, contributing to poor patient outcomes, such as infections and medication errors. Furthermore, occupational injuries, such as needle stick and musculoskeletal trauma occurs.

In scheduling and planning nursing personnel to meet patient care needs and to meet the minimum salaries expenditure, hospitals would like to provide the highest quality of care at the lowest cost (Welton, 2011:310). As highlighted by Welton *et al.,* (2006:417), nursing care represents a substantial amount of financial resources. Due to salary cost pressures, hospitals focused on the ‘‘bottom line’’ may reduce their overall nursing personnel compliment or utilise lower categories of nurses to replace registered professional nurses. The use of suboptimal nursing personnel levels or substituting enrolled nurses for registered professional nurses is associated with an increase in adverse events such as infections, pressure ulcers and unanticipated death (Welton, 2011:310).

Welton (2011:310) highlighted studies that have conclusive evidence that utilising more enrolled nurse categories in the place of registered professional nurses negatively affects the quality of inpatient care. Studies showed that enrolled nurse categories had difficulties in meeting patient needs due to insufficient staffing levels and poor skills mix (Twigg, Duffield, Bremner, Rapley & Finn, 2012:2712). Furthermore, indicating that utilising a workforce predominantly of registered professional nurses provides a greater quality of care. Twigg *et al*., (2012:2711) reported on studies that identified enrolled nursing categories being associated with a lower quality of care, and deteriorating patient care (Aiken, Sloane, Bruyneel, Van den Heede & Sermeus, 2012:144; Winslow, 2001:13).

In addition, lower levels of education and the scope of practice of enrolled nurses to that of the registered professional nurses is also responsible for poorer patient outcomes (Welton, 2011:310).

2.2.7.3 Agency personnel

The use of nursing agency personnel to relieve the pressure of staff shortages brings its own challenges. According to Page (2008:1), agency personnel who do not regularly work in the same unit or hospital on more than one occasion, are often not included in the healthcare team as they are less familiar with the nursing units’ policies and practices. This may impact on their ability to coordinate, organise and prioritize work. Page (2008:1) discussed the influence of not providing adequate orientation or training for agency personnel, which exacerbates the lack of continuity of work and impacts on the delivery of care provided. Secondly, the education level of agency personnel may vary, due to the variability of the nursing education quality and

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contamination by working in institutions whose standards may be suboptimal. Furthermore, because they may not work in one institution regularly, they cannot be held accountable for their omissions or quality of care.

The management of hours worked is complicated as some permanent employees work overtime through nursing agencies. Regulating the number of agency hours worked by full time personnel is complex, as they may belong to more than one nursing agency. Communication amongst the different nursing agencies is not limited to the hours worked by their members. Therefore, nursing agencies may be unaware of members that have exceeded the legal required number of hours worked. Overworked personnel, who are not known to nurse managers, provide unique challenges as nurse managers need to ensure the skills mix of nurses meets the patient needs to ensure patient safety (Page, 2008:2).

In harsh economic times, the first cost reduction effort is aimed at decreasing the number of nursing personnel or substituting with lower paid personnel (Chitty & Black, 2011:347). The combination of workforce planning, professional judgement, higher acuity and short length of stays can influence the nursing workload and optimum staffing levels, affecting the quality of nursing care (Flynn *et al.*, 2009:763; American Association of Critical-Care Nurses, 2004:3). Twigg *et al.,* (2012:2716) corroborated these findings by determining that nursing skills mix can have a substantial impact on some patient outcomes. Furthermore they confirmed that a skill mix of 88%-90% of registered professional nurses to enrolled nurse or enrolled nursing auxiliaries is an appropriate target.

In contrast to the perception described above, Hassan, McKenna and Keeney (2012:2) reported on some of the benefits to part-time nursing employment. In addition to meeting financial needs it provides an opportunity to consolidate nursing skill, expand clinical experience and develop confidence.

What is appropriate, given the current local and global economic environment, is not a realistic target in the current South African context due to the shortage of suitably qualified nursing personnel and the prohibitive cost.

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2.2.7.4 Support personnel

Ensuring the optimal use of the ENAs time is a requirement to maintain high quality standards of care (Dorse, 2008:16; AACCN, 2004:3). The introduction of support personnel to assist with indirect patient care activities was introduced, known as care workers (CWs). An example of indirect care would entail washing a patient's hair or assisting an ENA with pressure care and then providing feedback to the registered professional nurse, who might not have been present in the room at the time of the activity. CWs are responsible for non-nursing tasks, but activity slip and blurring of responsibilities, related to lack of supervision compromises both nursing and patient expectations or outcomes (Dorse, 2008:16). The use of CWs also adds additional supervisory responsibilities for the EN and the registered professional nurse, who it could be argued should be at the bedside (Stanton, 2004:5).

Studies confirm the impact that the skill mix, patient acuity and level of care, in conjunction with the practice environment and the quality of nursing care, can have on the quality of patient safety and patient care outcomes (Coetzee, Klopper, Ellis & Aiken, 2012:163).

2.3 PRACTICE ENVIRONMENTS

Healthcare is a dynamic environment. Due to the complex interactions that occur within the practice environment, the registered professional nurses' ability to coordinate and integrate the multiple aspects of care is a critical link in the provision and supervision of care (Hughes, 2008:3; Brunetto *et al.*, 2013:2). Quality practice environments correlate positively with a high level of job satisfaction, productivity and patient and nursing care outcomes (Shirley, 2006:257).

Positive practice environments are characterised by visible leadership and managerial skills with the unit manager playing a pivotal role in maintaining or implementing the principles of a healthy work environment (Brunetto *et al.*, 2013:2; Coetzee *et al.*, 2012:163; Kirwan *et al.*, 2012:254; Shirley, 2006:257). A health environment respects and values the opinions of the individual (and of the professional). There is a strong trust relationship between the management and personnel. A culture of collaboration and open communication exists and personnel are provided with a work environment in which they feel physically and emotionally safe (Shirley, 2006:258). A unit manager that nurtures this environment is considered an authentic leader (Shirley, 2006:258).

Authentic leaders have five characteristics that differentiate them from other leaders. They understand their own purpose, have values, lead with their heart, foster enduring relationships and are self-disciplined (Shirley, 2006:260). Unit managers who embody authentic leadership have a positive, optimistic outlook on life. They demonstrate this commitment by mentoring themselves and others, by engaging with their workforce and fostering good working relationships and are at the point of care (Shirley, 2006:266). Sharing of information is promoted and personnel are encouraged to participate in the decision making process, creating a positive, collaborative and healthy work environment (Shirley, 2006:258). Cultural competence and sensitivity is promoted ensuring that personnel appreciate and understand the various cultures that they interact with namely their colleagues and the patients. Studies confirm that patients, who perceive personnel as being culturally aware, positively influence health outcomes (Tucker, Marsiske, Rice, Jones & Herman, 2011:2). Within the South African context, numerous cultural and beliefs exist. In addition, professional nursing principles, forming the foundation of the work ethic are upheld (Coetzee *et al.*, 2012:163). On the contrary, practice environments which do not support personnel, flounder, creating a toxic environment for personnel to work in.

Practice environments that lack affirmation of good leadership are characterised by poor work performance, decreased morale, burn out, lack of job satisfaction and poor patient and nurse outcomes (Coetzee *et al.*, 2012:163; Kutney-Lee *et al.*, 2012:196; Pillay, 2009:2; Strategic Plan for Nursing Education, Training and Practice, 2012:78). Without active leadership, supervision and invested management, out of scope functioning across nurse categories can expose the nurse and patient to potential risks (Dorse, 2008:16). Failure to intercept the errors of others (near misses) or identifying patient deterioration can result in an adverse event or an unintended consequence of patient care occurring (Hughes, 2008:3).

Numerous studies corroborate the vital link between nurses, the practice environment and patient safety outcomes (Kirwan *et al.*, 2012:254; Kutney-Lee, Wu, Sloane & Aiken, 2012:196; Ausserhofer *et al.,* 2011:240).

2.3.1 Enrolled Nurse Practice Environment Experiences

Van Bogaert, Meulemans, Clarke, Vermeyen and Van de Heyning (2009:2176) highlight the importance of optimal professional nursing practice environments. These environments are characterised by quality leadership and management, adequate staffing with positive team

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relationships, reasonable workloads and working conditons. Furthermore, Van Bogaert *et al.,* highlight the influence the wellbeing of nurses can have on patient care essential to consistent and sustained quality patient outcomes (2009:2176).

Zangaro and Soeken (2007:446) corroborate the negative correlation between job satisfaction, job stress, burn out, emotional exhaustion and work frustration. These experiences negatively influence retention and team cohesion (Zangaro *et al.*, 2007:447). Furthermore despite the environmental influences that can affect personnel experiences, the disruptive behaviours of personnel and team members can contribute to poor patient care. Zimmerman and Amori (2011:5) confirm the effects of ‘insidious workplace behaviour’ and how it can affect the organisational culture. Gossip, passive aggression and avoidance that can negatively affect communication and morale are just some of the behaviours that can disrupt the organisational culture (Zimmerman & Amori, 2011:6). As insidious in nature, these behaviours grow slowly. Inconspicuous intimidation may refer to an individual with a strong personality. These personalities may overwhelm other personality types resulting in personnel adopting avoidance behaviour known as ‘work rounds’ and short cuts to safe practice to avoid interaction.

In addition, cultural diversity needs to be considered due to the multiple cultures that are present within South Africa. Currently there are eleven recognised official languages. Ghyoot (2001:125) wrote that language provides the frame within which an individual thinks and expresses themselves, shaping oneself and the environment.

Cross cultural care and education of nurses is therefore, essential (Allen, 2010:314). It is noted that although culture and antiracism are to be included in training, gaps may exist. It is important that transcultural nursing addresses the differences and similarities between cultures, which will enable and empower nurses to identify the care requirements of patients, taking into consideration their cultural values, creating a cultural competence model (Allan, 2010:315).

2.3.2 Performance appraisal

The performance appraisal process provides the opportunity for a unit manager to interact with staff members on a one-to-one individual basis. Essentially demonstrating the unit managers’ commitment to grow and develop people to achieve the business objectives (Shaw, 2013:3; Wheeler, 2001:1). Personnel performance and the quality of their work are documented, which

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assists in identifying professional developmental needs. It provides for constructive engagement in which a staff member's performance can be acknowledged. This enables a staff member to gauge their worth. Positive praise and support enable personnel to grow and development and motivates personnel improving productivity and job satisfaction. On the other hand, a lack of positive feedback and a performance appraisal process that is not consistently applied can result in negative behaviours wherein victimisation and humiliation can undermine personnel, resulting in bullying, belittling and isolation (Shaw, 2013:4). Poor performance that is not addressed can negatively influence the work environment, decrease morale and affect job satisfaction.

2.3.3 Work Environment

Nurses are care givers and their practice is regulated by the scope of practice (SANC: 1984:1). Enrolled nurses work under the direct and indirect supervision of the professional registered nurse. As providers of care, within a multidisciplinary team, the workload amongst the nursing team members should be realistic. Findings demonstrate that where there is an imbalance in the individuals work expectations, job stress and work frustration impact negatively on the quality of care provided (Zangaro & Soeken, 2007:446). Nurses, who face increased workloads and pressure, are prone to burn out (Teng, Chang & Hsu, 2009:2088).

Enrolled nurses have lower levels of education as they receive two years of training in comparison to the four years of the professional registered nurse. The lack of a comprehensive and a deep knowledge base, with only a few years of clinical experience, places the enrolled nurse at a unique disadvantage. According to Zangaro and Soeken, they are not equipped to adequately deal with the autonomy that is expected of them (2007:453).

Autonomy evolves out of years of experience and through supportive leadership (Zangaro & Soeken, 2007:453). Changes in the composition of the nursing workforce over the past decade and the recent generational differences, has impacted upon nursing autonomy and job satisfaction. Zangaro and Soeken (2007:453), note the challenges of having three generations in the work place, namely Baby Boomers, Generation X'ers and Next'ers. Each seeks different levels of autonomy, which is challenging in organisations where nursing practice is changing due to organizational restructuring and technological advancements.

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Technological advancements are complex as the change brings various levels of stress and tension to the employee. These changes, in addition to increased workloads, coupled with the complexity of the practice environment, affects job satisfaction ultimately impacting on patient and nursing outcomes.

2.4 SUMMARY

The literature reviewed describes the complexities of the nurses working practice environment. Enrolled nurses are duty bound to comply with the South African nursing professions' regulatory requirements, as defined and governed by the Scope of Practice. Despite this, the published literature shows that out of scope functioning occurs. Furthermore, studies confirm that utilising lower category nursing personnel, such as enrolled nurses, in place of registered professional nurses, either due to lack of availability or as a cost containment measure, is associated with an increased incidence of adverse events and patient safety related issues.

Studies also corroborate the pivotal role that visible management and leadership skills displayed in the unit manager plays in the establishment and maintaining of healthy work environments, personnel morale, job satisfaction and good nursing and patient outcomes.

2.5 CONCLUSION

Chapter two has presented a discussion on the various aspects that influenced the experiences of enrolled nurses and their understanding of quality nursing care. Quality nursing care was defined and the key factors that affect and influence optimal patient care, such as skill mix, working relationships and the environmental influences were discussed.

Chapter 3 will explain the research methodology used to explore the experiences of enrolled nurses regarding quality care in general nursing units in the private healthcare setting.

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CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter three describes the research methodology that was applied in this study to explore the experiences of enrolled nurses regarding quality care in general nursing units in the private healthcare setting. Included are the aim and objectives of the study, the research design, population and sampling methods, the data analysis and the interpretation process used (Burns & Grove, 2007:106).

The research methodology refers to the specific stages in the research process (Burns & Grove, 2009:719).

3.2 RESEARCH PURPOSE

The research purpose arises from the problem and indicates the type of study to be conducted, and identifies the aim of the study (Burns & Grove, 2009:38). Once the research problem and the purpose have been identified, the research methodology is determined (De Vos, Strydom, Fouche & Delport, 2009:71).

3.3 THE AIM OF THE STUDY

The aim of this study was to explore the experiences of enrolled nurses regarding quality care in general nursing units in the private healthcare setting.

3.4 RESEARCH OBJECTIVES

The objectives of this study were to explore the enrolled nurses:

- Understanding of the concept of quality care
- Understanding of their value and contribution to quality care
- Experiences (positive and negative) of quality nursing care in the private health care setting.

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3.5 RESEARCH DESIGN

The research design directs the researcher providing the strategy for planning and implementing the study (Burns & Grove, 2009:218). A descriptive, qualitative approach was used.

3.5.1 Basis of Descriptive Design

A descriptive method of inquiry was applied in order to gather information about the experiences of enrolled nurses within the general nursing units of the private hospitals included in the study. This approach would provide a picture of the enrolled nurses situation as it occurs within the general nursing unit environment (Burns and Grove, 2007:240). It is important that the researcher's perceptions, thoughts, imaginations and emotions are bracketed against bias, to support impartiality (Reiners, 2012:1).

The researcher's own understanding and worldview (epistemology) is important as this affects and influences the researcher's ability to see the 'whole picture' (Ryan, 2006:18). The researcher had to reflect carefully on her own perceptions and assumptions of clinical practice and involvement on projects to remain as neutral as possible so as not to introduce bias into the research. Therefore, the researcher declares her own reality and experience at the outset in order to "disclose the essence of a phenomenon in its purity untainted by the researcher's preconception of the phenomenon (Priest, 2004:5)". The researcher trained in a public institution, where an altruistic work ethic emulated pride and resulted in immense job satisfaction. The researcher's experience of the practice setting was the catalyst to explore the worldview of enrolled nurses as related to quality care in the general nursing units.

Insight into the underlying assumptions one uses, to make sense of one's day-today life is important when engaging and considering people's values; noting that one has to open one's own assumptions to scrutiny. How people know and think what they know, their beliefs, assumptions and ideas, constitutes their epistemological framework (Ryan, 2006:15). This demonstrates the complexity of the interaction between the researcher and the participants. The researcher cannot assume to know the answers, instead, the truth is revealed through dialogue with the participants. This illuminates the 'organised complexity', the participant's reactions and 'artistic imagination' (Ryan, 2006:17). This philosophical perspective acknowledges the 'web-like and cyclical thinking' process rather than it being defined in a linear manner. Ryan (2006:17)

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further describes the researcher as assuming a learner rather than a testing role, recognising the common humanity connection that exists between the researcher and the participants.

The connection emphasises the researcher's immersion with the participant, where the researcher is 'learning *with* them, and not conducting research *on* them' (Ryan, 2006:18). It is important to note that the identified problem does not necessarily require solving, instead conclusions can be drawn which can be modified and amended accordingly (Ryan, 2006:19).

The qualitative, descriptive approach guided the researcher's exploration of the phenomena of the lived experiences of enrolled nurses regarding quality nursing care in general nursing units in the private healthcare setting, thereby giving meaning to their experiences of quality nursing care (Flood, 2010:8).

The descriptive methodological approach was used to extract, analyse and present the data is appropriate to the chosen design.

3.5.2 Population and sampling

The term population describes the elements that meet the sample criteria for inclusion in the study (Burns & Grove, 2007:40). The population included N=387 enrolled nurses who were working in the private healthcare setting.

A target population is defined as the entire set of people who meet the inclusion sampling criteria (Burns & Grove, 2009:244). The target population is representative in terms of the work environment, demographics, gender and experience (Burns & Grove, 2009:345).

The sampling plan is defined as the process of selecting the sample (Burns & Grove, 2009:343). A detailed sampling plan denoted the framework:

- The introduction of the intended study to hospital management,
- Meet and greet the unit managers,
- The identification of the proposed participants according to the inclusion criteria,
- The selection and recruitment of participants,
- The scheduling of interviews,
- Conducting of interviews,

- Transcription period,
- Member checking of the participants

3.5.2.1 Inclusion criteria

The inclusion sampling criteria included enrolled nurses working in general surgical and medical nursing units, with a minimum of six months working experience in the respective units. One of the enrolled nurses worked in a general surgical nursing unit that included cardio-thoracic patients, together with orthopaedic and spinal patients. Their participation was included as one could not exclude them due to the combination of surgical disciplines that were permitted in the respective general surgical unit.

3.5.2.2 Exclusion criteria

- Categories of nursing personnel that worked in all critical care units, paediatrics, emergency centres and operating theatres were excluded.
- Care workers, who are not a registered nurse category with SANC, were excluded.

3.5.2.3 Selection of the participants

The selection and recruitment of the participants proceeded without impediment. The respective hospitals were contacted and permission to conduct and proceed with the research was obtained. A meeting was scheduled with the respective nursing managers, who were responsible for personnel recruitment, selection and appointment and unit allocation. On the introduction of the proposed study to each of the nursing managers, meetings were then scheduled with the respective unit managers of the general medical and surgical nursing units.

Purposive or judgemental or selective sampling is where the researcher consciously selects certain the participants to be included in the study (Burns & Grove, 2009:355). Purposive sampling is used in qualitative research to gain insight or to obtain a deeper understanding of a complex experience (Burns & Grove, 2009:355). Thirteen participants, including the exploratory interview participant, all meeting the inclusion criteria, were chosen from the off-duty schedules of the nursing units (Terre Blanche *et al.,* 2006:50; Burns & Grove, 2009:355; De Vos *et al.*, 2009:202).

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The participants were chosen by the researcher, according to the inclusion requirements and by their willingness to participate in the study. The potential participants were approached and the intended study was outlined. Those who verbally consented to participate were then scheduled for an interview. Five participants came from one hospital, and four respectively from the remaining two hospitals.

Using the three individual hospitals to gather data, sequential one-to-one interviews were conducted using a semi-structured interview guide. Sequential interviewing entailed one interview per hospital, then repeating the sequential cycle of the hospitals until data saturation was achieved. This enabled the researcher to gain insight from the respective participants of each hospital.

Individual interviews were conducted with the following personnel:

- Seven permanently employed ENs working in the general surgical nursing units and
- Six permanently employed ENs working in the general medical nursing units

Data saturation was achieved by the eighth interview. However, to ensure the richness and depth of information 13 interviews were conducted, including the exploratory interview, as originally proposed. A small sample was identified, which is permitted when using a homogenous sample group (Terre Blanche *et. al.,* 2006:289). The sample size is determined once redundancy is achieved (Terre Blanche *et al.,* 2006:50). Semi-structured interviews were used to explore and understand the experiences of enrolled nurses regarding quality nursing care in general nursing units in the private healthcare setting.

To avoid bias in one hospital, which was known to the researcher, the two research assistants conducted the interviews. The researcher was accompanied on two interviews by a research assistant. Individual, one-to-one interviews were conducted.

3.5.2.4 Venue selection

Five venues were used in total. Three venues were used at one location, due to availability and one each respectively at the other hospitals. The venues were comfortable, private, secure and accessible with no excessive noise or movement in the corridors. One of the venues at a hospital was situated in the management suite, which could have influenced two participants

responsiveness. Bottled water and sweets were provided to create a relaxed environment (De Vos *et al*., 2009:299).

3.5.3 Instrumentation

A semi structured interview guide, based on the study objectives and the literature reviewed, was compiled, using open-ended questions to prompt or elicit information, (see Annexure J) (Burns & Grove, 2007:382). The questions and probing words were validated by the supervisor prior to the commencement of the interviews.

The questions were reviewed using reflexivity during and post interview, when listening to and reading through the transcripts. The semi structured guide is explained below.

3.5.3.1 Semi structured interview guide

The use of a semi structured interview guide provides flexibility as the questions are arranged around the topic of interest and this enables the researcher to explore emerging interesting avenues that presented during the interview (De Vos *et al.,* 2009:296). It encourages the participants to voice a range of opinions and detailed responses. The semi structure ensures that answers cannot be anticipated (De Vos *et al.,* 2009:292). Furthermore, the interview flowed like a conversation with two-way communication, as the participant provided information to the researcher, the researcher would reflect on the participants point of view and confirm the meaning (De Vos *et al.,* 2009:287).

3.5.3.1.1 Opening questions

Opening questions were asked pertaining to demographic data, to establish a rapport with the participants and to put them at ease. This aimed to create an atmosphere in which the participants were able to express themselves freely (De Vos *et al*., 2009:297).

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3.5.3.1.2 Introductory questions

Three introductory pre-determined questions were prepared to guide the interview, based on the broad range of topics that the researcher planned to elicit during the interviews. The questions were not prescriptive and allowed the researcher flexibility to follow up areas of interest that emerged (De Vos *et al.,* 2009:296). The participants were asked to reflect on their understanding of the concept of quality care and on their contributions to quality care.

The questions were expressed as topics of interest ensuring a natural flow and transition from the concept of quality care to their contributions and then to their personal negative and positive experiences of quality care.

3.5.3.1.3 Probing words

Probing words are used to probe or search for deeper meanings to increase richness (De Vos *et al.,* 2009:290). These probing words assisted the researcher in understanding the participants' perceptions and clarifying their experiences of quality care. The probing words and alternative words used are provided in Table 3.1 below.

Table 3.1 Probing words and the alternatives

Probing words	Alternative words
Quality	Degree, standards, characteristics, attributes, calibre, measure, safe, secure
Value	Quantity, worth, cost, price, importance, richness, money value, ideal, principle, consideration, measure
Contribution	Effort, offer, amount
Experiences	Feel, witness, emotions, live, life, sensations, happening, pride, change, leadership, management, personnel allocation, teamwork, voice

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3.5.3.1.4 Interviewer

The researcher received interview training from one research assistant, familiar with the qualitative approach. Role-playing exercises were conducted in order to familiarise the researcher with the interview technique required. In preparation for the conducting of the interviews, the researcher read extensively and familiarised herself with the practice of conducting interviews (Pope & Mays, 2006:15).

3.5.3.1.5 Transcriptionist

A professional transcriber that had signed a confidentiality clause was employed (see Appendix M). The participants were advised that electronic recordings were to be professionally transcribed for data collection and that the transcripts would be returned to them for review and validation.

3.5.4 Exploratory interview

An exploratory interview, as explained in De Vos *et al.,* (2009:206) is a test run of the research process to ascertain if the methodology, sampling and the instrument to be used is appropriate. It is a dress rehearsal for the proposed investigation, permitting the researcher to clarify the study design and to make necessary changes if required.

An exploratory interview was conducted with one participant that met the inclusion criteria. The unit managers were approached for potential participants, who met the inclusion criteria. A participant was chosen from this group of names and approached if willing to participate. An exploratory interview was conducted to ascertain if the intended interview questions required amendment. No pitfalls or problems were experienced. There were no amendments made to the semi structured interview guide. The exploratory interview verified the planned methodology and validated the semi structured interview approach and the semi structured interview guide.

The venue in which the exploratory interview was conducted was comfortable and non-threatening, bottled water was provided (Terre Blanche *et al.,* 2006:94). This approach was used for the ensuing interviews.

The exploratory interview was included in the data as it provided valuable insights into the experience of enrolled nurses (Terre Blanche *et al.,* 2006:94).

3.6 VALIDITY OF THE RESEARCH

In qualitative research, validity is concerned with the accuracy and the reliability of the research findings. De Vos *et al.,* (2009:345) refers to it as the soundness of the research findings. The supervisor and research assistant validated the interview guide. Both possess a master's degree in nursing. One has experience guiding students in qualitative studies. Validity was also confirmed by the co-supervisor, who has a doctorate in nursing. Furthermore, the researcher presented the research proposal in a scholarly environment whereby the proposal was critiqued by a panel of nurse academics.

In preparation for conducting the interviews, the researcher read extensively to familiarise herself with the practice of interviews (Pope & Mays, 2006:15). The researcher received interview training and participated in role-playing exercises to strengthen neutral non-verbal behaviour and listening skills (Priest, 2010:5). To ensure validity, Lincoln and Guba's criteria, as described in De Vos, Strydom, Fouche and Delport (2009:346) was used.

3.6.1 Trustworthiness

Trustworthiness was assured by applying Lincoln and Guba's principles of credibility, transferability, dependability and confirmability, as described in De Vos *et al.,* (2009:346). Important to research is that any influence or action that could possibly distort or manipulate the findings is to be avoided (Terre Blanche *et al.,* 2006:322). Research findings must be trustworthy and the quality of the research findings is dependent on the 'truth value' (De Vos *et al.,* 2009:345).

3.6.2 Credibility

Credibility was assured using the steps provided by De Vos *et al.,* (2009:353). Credibility was assured by means of member checking. The participants were sent a text, advising that the transcripts were available for verification. A date and time, convenient to the participants, was

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scheduled for reading of the transcripts. The transcripts represented the participant's description of their phenomena relating to their experiences of quality nursing care.

Through member checking the participants were afforded the opportunity to revise their descriptions (Priest, 2010:5). Member checking was conducted one to one with most of the participants. A few declined to read through their transcripts. However, they provided confirmation that the content was unconditionally accepted. Two participants did not respond to any efforts made to contact and verify the transcript content.

In addition, credibility was ascertained utilising the supervisor and co-supervisor to review the data objectively. This enabled fresh insights and perspectives for consideration (Terre Blanche *et al.,* 2006:326). It also verified if the researcher interpreted and accurately reflected the reality of the participants.

3.6.3 Transferability

Transferability, demonstrates how the findings of one study can be applied or generalised in another (De Vos *et al.,* 2009:346). This is difficult to demonstrate in a qualitative study, however, Lincoln and Guba, (in De Vos *et al.*, 2009:346) describe an alternative strategy to demonstrate transferability.

Transferability can be demonstrated by referring users of the study to the thick, rich descriptions forming the theoretical framework and the detailed database. The theoretical framework details how the participants were selected and the data collected, analysed and interpreted (Brink, 2006:119). The compilation of the detailed database is described through obtaining sufficient descriptive data, via in depth one-on-one interviews (Brink, 2006:119).

The context of the study is provided by the researcher. This enables the reader to develop a perspective of the study. Furthermore, whether the findings are transferable is dependent on the possible users of the findings and not on the researcher (Terre Blanche *et al.,* 2006:93; De Vos *et al.,* 2009:346). Auditability is provided through the thick descriptions.

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3.6.4 Dependability

In qualitative research dependability is context dependent (Terre Blanche *et al.,* 2006:51). Dependability is the degree to which the reader can be convinced that the findings did occur as the researcher has reported (Terre Blanche *et al.,* 2006:93).

Dependability is assured through the verification that sound processes were applied and followed by the researcher (De Vos *et al.*, 2009:346). It is achieved through providing a detailed account of the methodology used to source, collect and analyse the data (Terre Blanche *et al.,* 2006:94). In addition, the methodology and collection of data is peer reviewed by the co-supervisor. For this reason the data is presented logically (Tobin & Begley, 2003:392). On the strength of the data provided, auditing the process followed by the researcher authenticates confirmability.

3.6.5 Confirmability

Confirmability, establishes that the quality of the data and the interpretations of the findings are real and objective (De Vos *et al.,* 2009:347). The researcher's data and supporting documents were reviewed by external reviewers, namely, the supervisor and co-supervisor.

A detailed audit trail is available containing the raw data (field notes, memos and transcripts); data reduction and analysis notes; process notes (notes on method employed); material relating to intentions (personal notes); instrument (semi structured questionnaire) and data reconstruction (drafts of reports). The reviewer of the data confirmed the trustworthiness of the data. Therefore, confirmability legitimizes the study (Tobin & Begley, 2003:389).

3.7 ETHICAL CONSIDERATIONS

The researcher is bound by a code of ethics and is guided by the fundamental ethical principles of autonomy and beneficence (Pera & Van Tonder, 2011:25).

The Health Research Ethics Committee (HREC) at Stellenbosch University approved the study, reference number S13/10/193 (see Annexure A). Permission was obtained from the participating hospitals groups and respective hospitals (see Annexures B - F). Prior to the interview sessions,

permission for participation and to electronically record the interview was obtained (see Annexure I).

3.7.1 The principle of autonomy

The selected participant's right to self-determination and to participate voluntarily in the study was respected through assuring their privacy, anonymity and confidentiality (Pera & Van Tonder, 2011:54).

The participants were advised that they could withdraw at any stage without penalty. Written, informed consent was obtained from each participant prior to their participation, both to participate and to the audio recording of the interview.

3.7.2 Confidentiality

The participants were assured that the information shared during the interview would be kept in confidence and that there would be no unauthorised access to the data. The recordings and transcripts are stored in a locked and secure area, for a minimum of five years. Restricted access is limited to those people who were directly involved in the study, namely, the researcher, supervisor and co-supervisor.

3.7.3 Anonymity

Anonymity and privacy were assured by the participants providing the researcher with a pseudonym. The institutions under study and the recordings and transcriptions of the participants would have no personal identification. Each was assigned a number. This number enabled the researcher to distinguish the data obtained from the various participants.

3.7.4 The principle of beneficence

The principle of beneficence entails doing no harm, removing harm and promoting all that is good (Pera & Van Tonder, 2011:54). The researcher was sensitive to the needs of the participants and cognisant of the time and willingness of the participants to share their experiences.

3.8 DATA COLLECTION

Data is the material collected that the researcher uses to interpret and analyse, from which to form an opinion and draw a conclusion (Terre Blanche *et al.,* 2006:51). The principal researcher is employed at one of the facilities under study. To mitigate the introduction of bias, the researcher was assisted by two trained research assistants, both in possession of a Master's degree and not affiliated with the hospitals where the study took place.

The two research assistants conducted the interviews at the institution where the concern for potential bias was acknowledged. This enabled the participants at this institution to voice their opinions without feeling intimidated or threatened. The principal researcher and the two research assistants worked through the semi structured interview guide, identifying agreed upon probing words to ensure that the topic explored was approached in the same manner. During the interviews where both research assistants were present, one research assistant conducted the interview and the other made field notes. The field notes provided valuable observations of non-verbal behaviour and also permitted the research assistant to make a note of any strong feelings expressed by the participants (De Vos *et al.,* 2009:298). The principal researcher conducted the interviews at the other institutions, two of which were accompanied by a research assistant. When the principal researcher conducted the interview without accompaniment, field notes were documented immediately after conclusion of the interview so as not to disrupt the flow of dialogue. The interviews were electronically recorded.

The selected enrolled nurses worked either in general surgical or medical wards and were thus exposed to the same or similar work environments and conditions. Some were trained in the public sector and others received training in the private healthcare sector in accordance with the South African Nursing Council requirements. The selected participants who were willing to participate in the intended study were provided with a "Participant information leaflet" that provided an outline of the intended study together with the Ethical approval document from Stellenbosch University. The contact details of the selected participants were taken and individual interviews scheduled at a date and time that was convenient to them. There were no objections to using English as the medium for conducting the interviews.

Data was collected using individual, semi structured interviews (Terre Blanche *et al.*, 2006:286). Data collected in this manner is both intimate, rich in feelings and experiences. Sequential, in

depth interviews were conducted with the enrolled nurses working in the general nursing units. Thirteen participants, including the exploratory interview participant, ensured that a rich and deep exploration was undertaken until data saturation occurred. Data saturation or 'sampling to redundancy' is when no new information emerges over time and the information that is offered becomes repetitive and is deemed redundant (Terre Blanche *et al.,* 2006:289).

A natural setting was chosen for conducting the study (Burns & Grove, 2009:362). The participants were accommodated at a time and location convenient to them.

3.8.1 Time frame

The time frame for the actual data collection commenced mid-March, due to the availability of the researcher and the research assistants and was concluded 5th May 2014.

3.8.2 Interview duration

The interviews varied in duration from 45 to 60 minutes.

3.9 DATA ANALYSIS

Data analysis is the systematic process of comparing and analysing data and identifying emerging patterns and trends in the interviews conducted. It brings order and meaning to the data collected (De Vos *et al.,* 2009:333). The data collected during the interviews was electronically recorded. The electronic recordings were professionally transcribed. The basis of the analysis is formed by the recordings, transcriptions and the field notes.

As the researcher was indirectly involved in the nursing practice environment, every endeavour was undertaken by the researcher to remain neutral.

The electronic recordings were repeatedly listened to. This enabled the researcher to remain 'close' to the data while placing the data collected of 'real life' experiences into perspective. Furthermore, the participant inflictions and tone of voice were noted (Terre Blanche *et al.*, 2006:321). The transcribed interviews were read repeatedly by the researcher, to identify

meaningful pieces of information and thereby enabling the researcher to gain an understanding of the participant's experiences (Connelly, 2010:127).

The transcripts were analysed to organise the raw data into manageable pieces of information, thereby aiding in the data 'analysis' (Speziale, Streubert & Carpenter, 2011:205). The pieces of data were then combined into themes and subthemes (Connelly, 2010:128; De Vos *et al.,* 2009:341). The researcher was able to compare emerging themes and recurring expressions across the interviews and to validate the findings (Connelly, 2010:128).

3.9.1 Hycner's Explicitation Process

Instead of data analysis, explicitation was used to examine the data (Groenewald, 2004:17). Hycner (1985:281) purposely cautions against the use of the term 'analysis', as the essence of an experience from the perspective of the participant is central and it is important that the phenomena expressed be kept whole and treated with respect. The term analysis implies 'breaking into part' resulting in the loss of the whole phenomenon, whereas explicitation implies examining all aspects of the phenomenon whilst preserving the context as a whole (Groenewald, 2004:17).

Hycner's explicitation process was used to examine the data (Hycner, 1985:280).
This process consists of the following steps:

- Bracketing and reduction
- Delineating units of meaning
- Clustering of units of meaning to form themes
- Summarizing each interview, validating and modifying
- Extracting general and unique themes from all the interviews and composite summary

A schematic diagram of Hycner's explicitation process, see Figure 3.1 below, demonstrates the steps of Hycner's explicitation process that was used in this study. It depicts a large collection of data from Step 1 to Step 5 and thereby distilling the essence of the phenomena.

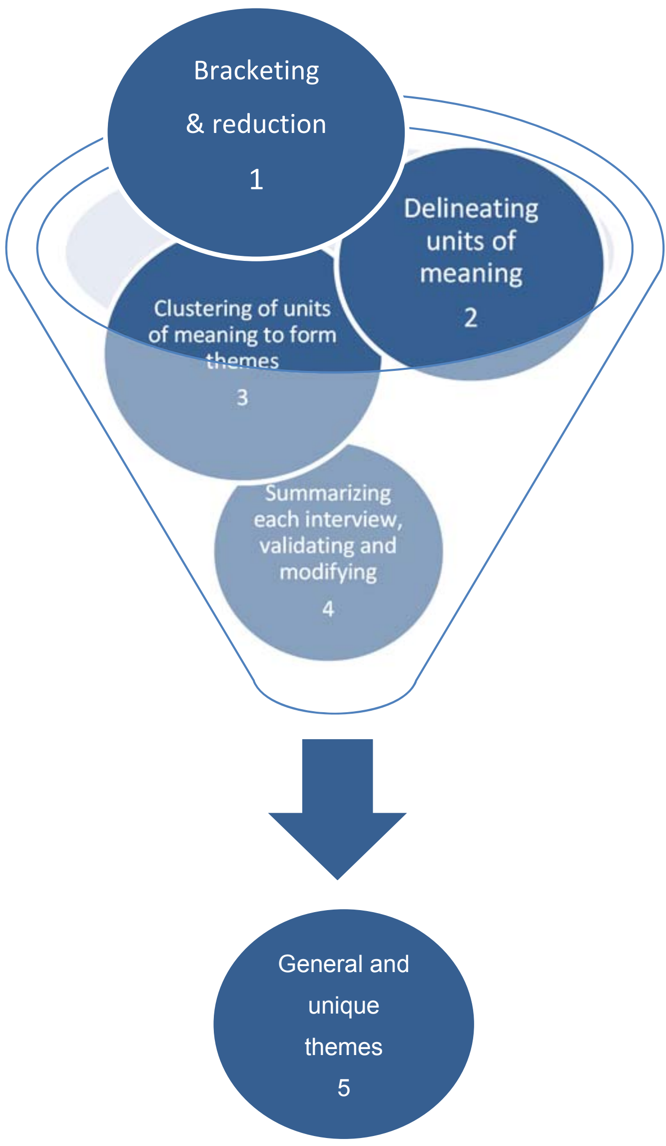

Figure 3.1 Hycner's Explicitation Process, steps 1 to 5

3.9.1.1 Bracketing and reduction

The researcher made a concerted effort to put aside any preconceived beliefs, by listing presuppositions and thus attempted to transcend the everyday understanding of the phenomena of interest, hence being open to whatever emerged. Reductioning thus occurred and enabled the essence of the phenomena to emerge (Hycner, 1985:280; Groenewald, 2004:18). In applying bracketing the researcher's own personal feelings or experiences were put aside so that these perceptions did not "cloud" or enter the unique world of the participant (Groenewald, 2004:18; Hycner, 1985:281).

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The researcher immersed herself in the data through repeatedly listening to the audio recordings and making notes. The researcher familiarised herself with the words, inflictions and tones of the participants. This enabled the researcher to develop a holistic sense, "a gestalt," of the enrolled nurse's experiences of quality care in the general nursing units in the private healthcare setting (Hycner, 1985:281; Groenewald, 2004:18).

3.9.1.2 Delineating units of meaning

Delineating units of meaning entailed a rigorous process of explicitation by examining each transcript (Hycner, 1985:282; Groenewald, 2004:18). Each phrase or sentence was read to ascertain the meaning expressed by the participants. The literal words of the interviewee were used to crystallize the essence of what was being said. This literal data or general units of meaning expressed a unique meaning (Hycner, 1985:282). A list was compiled of the units of meaning for each transcript. These units of meaning were then scrutinised for relevance (Hycner, 1985:282; Groenewald, 2004:19). Where there was ambiguity or uncertainty relating to a unit of meaning, it was initially included and in reviewing the unit could either remain or be deleted (Hycner, 1985:284).

The units of meaning were considered for relevance by examining the literal content of the units, looking at the significance of the number of times the meaning was mentioned and taking into account the voice inflictions from the audio recording (paralinguistic cues). This strategy allows for differentiation between units that initially appear similar but may have very different meanings (Hycner, 1985:282; Groenewald, 2004:19). Table 3.2 demonstrates the methodology followed to extract units of meaning from a participant's interview that was transcribed.

Table 3.2: Excerpt of an example of extrapolated units of meaning from a Participant's interview

<table>
<tr><th>Transcribed section of interview</th><th>Units of meaning</th></tr>
<tr><td colspan="2">Principal [name omitted] Thank you very much for taking the time today to come and speak to me. As you know my study is all about enrolled nurses and their experiences of quality nursing care and I think if we can just like start the conversation, going. If you could possibly let me have your understanding, your personal understanding of what you think quality nursing care is?</td></tr>
<tr><td rowspan="5">Participant 7 Quality nursing care is to look after your patient with dignity first, with respect, with dignity respect and to do your best for the patient as possible, humanly possible and to have the right equipment basically, to look after the patient.
To have the right experience to know what you are doing at the end of the day. That is my idea of quality nursing care.</td><td>1. Quality care look after patient with respect and dignity</td></tr>
<tr><td>2. Best for patient humanly possible</td></tr>
<tr><td>3. Right equipment</td></tr>
<tr><td>4. Right experience to know what doing</td></tr>
<tr><td>5. This is my idea of quality care</td></tr>
</table>

Table 3.3 represents the approach followed in identifying the units of similar meaning. The units of meaning that indicate commonality are indicated in italics. This approach requires the researcher to make a 'judgement call'. For this reason it was important that the researcher be cognisant of her own bias so as not to make inappropriate judgements (Hycner, 1985:284).

The process was replicated for each interview. It involved back and forth examination of the individual transcripts and to re-read the notes made of the non-verbal and paralinguistic cues. Emerging from the data were relevant units of meaning that could be clustered together. Although different clusters emerged it was important to not view them separately but as part of the whole phenomena.

Table 3.3: Discreet units of meaning where commonality in meaning was noted

Transcribed section of interview	Units of meaning
Principal [name omitted] Thank you very much for taking the time today to come and speak to me. As you know my study is all about enrolled nurses and their experiences of quality nursing care and I think if we can just like start the conversation going. If you could possibly let me have your understanding, your personal understanding of what you think quality nursing care is?	
Participant 7 Quality nursing care is to look after your patient with dignity first, with respect, with dignity respect and to do your best for the patient as possible, humanly possible and to have the right equipment basically, to look after the patient. To have the right experience to know what you are doing at the end of the day. That is my idea of quality nursing care.	1. *Quality care look after patient with respect and dignity** 2. *Best for patient humanly possible** 3. Right equipment 4. Right experience to know what doing 5. This is my idea of quality care

* Italics indicates the units of meaning where commonality was noted

3.9.1.3 Clustering of units of meaning to form themes

The lists of units of meaning were rigorously examined to ascertain the essence of the meaning, within the context of each the participant's experience. Where there was commonality or a natural theme occurring in the discrete units of relevant meaning, these units of meaning were clustered together. This enabled the researcher to cluster units of similar meaning together (Groenewald, 2004:19).

Clustered units of meaning were then examined to ascertain the essence of the unit's meaning. This entailed listening to the electronic recording, reading the transcript and comparing the audio and the transcript to elicit the essence, thereby extracting a key word or words that described the meaning. This process was replicated for each of the participants. Key word(s) then became a heading for each clustered unit of meaning. The clustered units of meaning varied amongst the participants. Demonstrated below in Table 3.4 is Participant 7's clustered unit of meaning for Holistic care.

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Table 3.4 Holistic care – labelled heading of units of meaning

Group	Clustered units of meaning
Holistic care	1 – Quality care entails respect and dignity 2 – Best humanly possible 3 – Right equipment 5 – My idea of quality care 7 – Look after patient 29 – It is not just nursing people, but doing so with passion 33 – Nurse with me, prayed for me, held hand 34 – Realized nursing was holistic care 188 – Happy - your patients sense it 189 – One patient said, I'm lying here sick and I hear the nurses laugh and I'm smiling but I don't even know why you are laughing 190 – In a sense it makes your patient happy 191 – It rubs off on them and the healing process is actually quicker 192 – They hear you laugh outside 197 – You are working with people 201 – You working with people's lives

Overlapping clusters of meaning occurred. Through a process of interrogation the unit of meaning was placed with the most suitable cluster. Hycner (1985:290) explained that this was to be expected as it is impossible to totally delineate human phenomena.

Depicted in Table 3.5 below is an example of units of meaning that could not be placed under a heading. They were placed under an unlabelled heading. Once all the units of meaning were

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completed, the units of meaning under the unlabelled heading were re-examined. If relevance was ascertained then the units were moved under a labelled heading. If no relevance was determined these units of meaning were discarded.

Table 3.5 Example of an unlabelled heading for clusters of units of meaning

Group	Clustered units of meaning
Unlabeled	6 – Yes 11 – Where do I see myself?

The researcher then interrogated all the clusters of meaning, ascertaining the essence of each of the clusters. Through a process of interrogation the central themes emerged from within the groups of clusters of meaning. This process was repeated for each participant.

Once the steps above have been completed, Hycner (1985:291) advises that an interview transcription summary be compiled. The summary provides the sense of the whole and also gives context to the emerging themes.

3.9.1.4 Summarizing each interview, validating and modifying

The participant's individual interviews were summarised, utilising steps 1-4. On completion of the data reduction, themes were elicited. The interview summary compiled after determining the clusters of meaning could then be used to validate the member checking process. Member checking was done one to one with most participants to ascertain if the essence was correctly extracted. This was achieved by providing the participant with a copy of the transcript to read (Hycner, 1985:291; Groenewald, 2004:21).

The participants who had agreed to member checking expressed surprise at the volume of information that they had spoken about. One participant (Participant 6) pointed out that by reading her words she can understand why her colleagues get annoyed with her as she doesn't always finish her train of thought, but jumps around. Two participants added additional information and no additional comments or amendments were made by the other participants.

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3.9.2 Extracting general and unique themes from all the interviews and composite summary

Once member checking had been concluded, the participants were provided with the researcher's compiled interview summary of the transcript, to verify if they were in agreement with the researcher's description of the participant's experience. Together, the interview summary and the transcripts were then examined for emerging themes. The documents were scrutinized for commonality and the frequency of occurrence. The extractions of the themes common to all the participants were then examined. It is at this point that the essences were elicited and thereby acknowledging the existential individual uniqueness (Hycner, 1985:292).

Themes common to most of the interviews were listed as general themes. Themes that were represented by a few or only one of the interviews were represented as subthemes. Hycner (1985:292) warned that this stage is critical as it may be easy to cluster themes capriciously, resulting in the loss of valuable differences. Furthermore, Hycner emphasises that the clustering of themes, does not limit variations within the theme itself.

Depicted below, in Table 3.6 is the emergence of the general theme, Humanism, from the interrogated theme clusters of a participant (Hycner, 1985:290; Groenewald, 2004:20).

Table 3.6: Emergence of general theme of a participant

	Theme clusters	**General theme**
Participant 7	Best care	Humanism
	Equipment available	
	Experience and knowledge	
	Holistic care	

On completion of the general and subthemes the information should be placed into context as this is an essential aspect of understanding the phenomenon. It is placing the phenomenon into context that determines the meaning (Hycner, 1985:293).

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The following common themes were identified from the interviews and are listed as general themes, using Hycner's methodology (Hycner, 1985:291): Humanism, Quality indicators, Leadership, Workforce planning and Cultural diversity.

The following subthemes were identified: Comprehensive care, Safe environment, Norms and value systems, Patient needs is the primary objective, Professional development, Competent staff, Patient and family experience, Documentation, Financial impact, Leadership style of unit manager, Communication and cooperation, Delegation, Organisational climate and culture, Staffing levels, Skills profile, Impact of work inequity, Language diversity, Diversity management and Cultural sensitivity.

3.10 SUMMARY

The research process, data collection and the methodology applied was discussed in depth and corresponds to a descriptive, qualitative approach. Hycner's explicitation process was used for 'analysis' of the data; enabling the essences of the lived experiences of enrolled nurses regarding quality care in the general nursing units in the private healthcare setting, to emerge. Scientific rigour and validity was assured utilising Lincoln and Guba's criteria, as described in De Vos *et al.,* (2009:346). In Chapter 4, the data analysis and interpretation will be presented.

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CHAPTER 4
DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

Chapter 4 describes the data that was affected by the electronic recording, transcribing and then reducing of it into meaningful units of information (Burns & Grove, 2009:695).

The findings are presented in two sections. Section A contains the demographic data of the participants and Section B demonstrates the themes and the sub-themes that emerged from the data.

4.2 SECTION A: DEMOGRAPHIC DATA

Thirteen (n=13) permanently employed enrolled nurses were interviewed, including the exploratory interview participant. Six (n=6) worked in a general medical nursing unit, five (n=5) in a general surgical nursing unit on day duty and two (n=2) worked on night duty in the surgical nursing unit.

4.2.1 Age

The ages of the participants ranged from 23 to 58 years. The age range of the majority of the participants was 23 to 29 years; the youngest participant was 23 years and the oldest 58 years.

4.2.2 Gender

All thirteen of the participants were female. The SANC's geographical distribution report confirms the female dominance in the nursing profession (South African Nursing Council Geographical Distribution, 2013:1). The report reveals that the nursing workforce of enrolled nurses in South Africa comprises 57 928 females and 5 860 males. Specific to the Western Cape, there are 7 927 females and 559 males registered with SANC (South African Nursing Council Geographical Distribution, 2013:1).

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4.2.3 Nursing experience

The participant's years of enrolled nurse experience ranged from one to seventeen years. The median years of experience were 5 years. Seven of the participants had five years or less experience and one participant had more than 15 years.

4.3 Section B: THE EMERGENCE OF THEMES AND SUBTHEMES

Individual participant's interview data revealed units of meaning. The frequency of occurrence of the meanings was then plotted in Microsoft Excel©, clustered under headings of similar meaning. Utilising Hycner's simplified data explicitation process, five major themes emerged (Hycner, 1985:291; Groenewald, 2004:17).

Field note information that was considered when interpreting the electronic recordings was how the participants positioned themselves in seating in relation to the researcher and whether there was anxiety present. This was demonstrated by how visibly relaxed the participant looked, at the beginning, during and end of the interview, by noting the shape of their body or how they changed their position, crossed their legs or folded and unfolded their arms, if they looked away or leaned in towards the researcher. Voice changes, such as pitch and the speed of speaking were also considered. Pauses and periods of silence were noted and the relevance considered.

The five themes that emerged from the interviews are: humanism, quality indicators, leadership, human resources and cultural diversity. Nineteen subthemes emerged from the five major themes and are listed. The themes and subthemes are displayed in Table 4.1. A discussion of the themes follows.

Table 4.1: Emergence of themes and subthemes

Themes	Subthemes
Humanism	• Comprehensive care • Safe environment • Norms and value systems
Quality indicators	• Patient needs is primary objective • Professional development • Competent staff • Documentation • Financial impact
Leadership	• Leadership style of unit manager • Communication and cooperation • Delegation • Organisational climate and culture
Workforce planning	• Staffing levels • Skills profile • Impact of work inequity • Performance appraisal
Cultural diversity	• Language diversity • Diversity management • Cultural sensitivity

4.3.1 Humanism

The theme of Humanism is associated with the welfare of human beings. The participants spoke willingly about their purpose and that through nursing and their devotion to serving others in need, they found meaning in their work and personal accomplishment. The participants expressed a sense of belonging, of being connected to the profession and to the organisation, which gave them confidence. Altruism and selflessness, to serving and supporting those in need, reflects in the participant's expression of their passion for nursing. The participants also described the consequences of not being able to fulfil their purpose which led to moral distress and feelings of guilt.

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4.3.1.1 Sub theme: Comprehensive care

Overall the participants expressed a clear consolidated understanding of what quality care meant to them. The participants spoke spontaneously and were animated in their descriptions of quality care, using the expressions ‘holistic’, ‘comprehensive’ and ‘safe care’. Noticeable was the emphasis placed on the importance of assessing and outlining the individual actions to be taken in providing appropriate care to their patients, which is an out of scope practice. However, the participants revealed that providing care was often impeded by various factors, such as the scarcity of time spent at the bedside. This was ascribed to either the lack of appropriately skilled personnel or to the presence of nursing students. The students are not able to participate in the clinical environment as they are considered not yet competent due to insufficient or inadequate learning opportunities.

The participants expressed that management *per se* did not understand these challenges or have insight into the impact thereof due to their own challenges, lack of experience or managerial skills. Some of the participants felt overwhelmed and frustrated, while others felt guilty as their personal and professional values were disregarded. The lack of managerial support to address the psychosocial needs of the personnel left some of the participants feeling resentful. The participants felt that they were misleading patients as they were not able to provide the standard of care that patients were paying for and expected leaving the participants feeling morally afflicted. They experienced conflict over what they knew should be provided, over the reality:

> **P6:** *“...the thing is with quality nursing we don’t do quality nursing on the patient anymore.”*

4.3.1.2 Sub theme: Safe environment

The participants placed particular emphasis on the importance of attending to the psychological, emotional and physical comfort of patients in enabling the healing process. Despite the circumstances that brought patients to the hospital, the participants expressed that they wanted their patients to be comfortable and happy. Human touch was indicated as having a profound effect on allaying feelings of fear and the unfamiliar. The participants expressed a need to establish a physical connection with patients. Of significance is that the participants indicated

that patients be provided with a consistent standard of care, respect and dignity. It was revealed that due to the lack of professional behaviour amongst some colleagues; the consistency of care was marred, damaging the staff-patient relationship. Some of the participants compensated through being over attentive, whereas others avoided patients, due to feelings of guilt.

Some of the participants reflected upon the value of technology in the patient care setting, noting the interface with nursing routines and work processes that impact on the care experience. Technology affords valuable time-saving measures when working under pressure and time constraints. However, the participants noted the loss of meaningful quality time spent with a patient and the possible impeding of their observational powers of the patient. This is demonstrated by the quote below, with reference to the use of pneumatic stockings:

> **P6**: "...*usually we had to rub the patient's feet and just to keep that circulation going. Now that's in place ... it has saved us time but it's like interacting with the patient is less now ... you could look at the patient's nails if that patient was a diabetic, now the stockings is on and you only take off the stockings tonight when you wash the patient ... so its win and lose."*

Several of the participants reflected on the importance of values and the influence of the family in shaping their sense of self and their worldview. Familial grounding provided an identity and ingress when engaging with patients for the first time. The dichotomy of the assault on personal and professional values and workload affecting personal life and performance was expressed.

4.3.1.3 Sub theme: Norms and value systems

Norms, values and beliefs that the participants were exposed to during their childhood, together with social influences, shaped their behaviour and understanding. The participants commented that their motivation to choose nursing as a career was inspired by their devotion and desire to care for others. Some of the participants acknowledged appreciating the uniqueness of their patients and how their patient's different perspectives and values enlightened their own personal and professional understanding. This positively influenced the patient care that they provided as they were more effective in understanding the individual needs of their patients as they expressed that they wanted to provide their best for their patients. Thus the participants revealed a common humanity shared between them and their patients.

The participants revealed that working with team members who shared the same values was both beneficial to the patients and the nursing team. The participants recognised shared values through the thoroughness, competence and friendly disposition displayed when engaging with patients, which positively influenced the quality of care. Efficiency of teamwork is demonstrated, where the work environment is conducive to learning, respect and trust. This is illuminated in the quote below:

> **P7**: *"Most of the people that I work with share the same views. It is important that we share the same views, how are we going to look after the patient at the end of the day if the one, if you do this and the one is pulling the other way and you don't give that same nursing care at the end of the day, it is not going to be appropriate."*

Noted by some of the participants was the impact of the lack of different values, which created tension and resentment, negatively influencing team cohesion.

4.3.2 Quality indicators

The theme Quality Indicators extends from the previous theme of Humanism, which highlighted the ENs understanding of the definition of quality care. In reflecting their understanding, the participant's perceptions of their positive and negative experiences of quality care were revealed.

The participants described the quality indicators that they used to distinguish 'good' from 'poor' care, noting that the patient should always come first, professional development and competent staff were essential and the impact of documentation and the financial influences on care provision.

4.3.2.1 Sub theme: Patient needs is the primary objective

Several of the participants expressed the commitment to the nursing profession was based on patient-centred care. The patient's self-determination is supported through the establishment of a rapport and engagement with the nurse, the patient and their family:

> **P7**: *"Quality care is to look after your patient with dignity first, with respect, with dignity respect and to do your best for the patient as possible, humanly possible and to have the right equipment – basically to look after the patient."*

The challenge revealed by the participants, bringing both frustration and disappointment, is the lack of professional behaviour displayed by some colleagues, negatively impacting work efficacy. The lack of professionalism negatively affects the team dynamic and work performance, which indirectly influences the patient experience of care provided.

Added to their disappointment was the lack of supervision and control by unit and some senior management to address the poor work behaviour. Poor supervision and ineffective interpersonal skills resulted in a breakdown in the support processes necessary for efficient and effective performance. This had given rise to deviations in practice, notably where patient needs were being ignored. Some of the participants expressed feeling powerless as there was no visible consequence to staff members displaying counter productive work behaviour. This behaviour showed total disregard for the patient and their rights, but also negatively impacted on the respect for their colleagues and the loyalty to the organisation. The behaviours referred to were often innocuous in nature and at other times overt.

One participant experienced the work environment very negatively, shaking her head often and tut-tutting, expressing her disapproval of the lack of respect displayed by some colleagues towards their patients:

> **P1**: *"... What makes me really angry is when staff just go to tea or lunch; their work isn't finished or they just leave the medication trolley because it is now their tea time."*

Another participant described the time constraint and its impact on the quality of time spent with at the patient's bedside:

P10: *"Yes because everything is like in a rush because we are so busy, you see* (clears throat) *pardon me, my throat is becoming very dry. Because of the busy ward that we are working in, I would like to spend more time with my patients but unfortunately there's only so much you can really spend with all of them."*

The above quotes reflecting the dichotomy in the values and behaviour, leading to moral distress.

4.3.2.2 Sub theme: Professional development

The participants emphasized the need for continuous professional development. Personal development and self-actualisation provide a sense of belonging to the body of nursing within the hospital and the greater nursing profession. Most of the participants revealed that they felt valued and respected by their peers and that their behaviour displayed their ethical underpinning. The findings above suggest that a strong intrinsic motivation is required to encourage professional development, albeit together with an appropriate support network, to assist personnel, especially those inexperienced to transition into the realities of clinical practice. The participants emphasized that one must not be afraid to ask questions.

Incidents were revealed where some colleagues were reluctant or unwilling to provide support and guidance to less experienced personnel and students. It was noted that some registered professional nurses absolved themselves from their clinical supervisory responsibilities; hence the support and nurturing of less experienced colleagues and students, were thrust onto enrolled nurses who are incapable of meeting the students learning needs.

Some of the participants revealed the unrealistic management expectations of newly qualified enrolled nurses, who lacked sufficient experience or competence to deal with the responsibilities associated with the position. This was due to insufficient preparation or exposure to the qualified role, during training. One participant described the overwhelming feelings of being thrust into a position of responsibility without the necessary support and experience:

P8: *"It wasn't easy because they expect from you, once you come from college you have to know it all and then the top forgot I have also been there. You know I also, I have been a child, I also crawled, I also what, but they expect from you just to, you must know it all."*

Some of the participants highlighted the support of the training department. However, it was revealed that some colleagues used the training sessions to escape the workload pressures, hence did not benefit from the intended developmental opportunity. Training needs were perceived to not always align to the operational needs.

4.3.2.3. Sub theme: Competent staff

The participants revealed the lack of competence and proficiency, not limited to one nursing category, which left them feeling frustrated. Concern was expressed about the recruitment of personnel and students and the standard of education provided which impacted on the ability of the workforce to perform effectively:

> **P8:** *"...you get frustrated; really you get frustrated because we all had our training. It is maybe not the same but the basics is the same ... things must be the same, you must know how and if you don't even know ... how did you get to pass."*

4.3.2.4 Sub theme: Documentation

Several of the participants expressed their dissatisfaction with nursing documentation as it took them away from direct patient care. A few of the participants conveyed there resentment of completing non-clinical documents, for other departments, that were not directly related to patient care. Excessive time wasted on completing duplicate information and cumbersome documentation processes resulted in frustration and job dissatisfaction. Some of the participants emphasized it was not always possible to complete the documentation accurately and comprehensively, adversely affecting the quality and safety of patient care provided.

The participants voiced notable concern on the unethical behaviour of some nurses who were not truthful in the recording of care. The integrity of personnel is questioned as indicated below, with patient safety ramifications:

> **P1**: *"We do a lot of audits in the wards for the sisters… then you see that the documents are only completed half or not at all. So in the end it's the patients that suffers because the staff doesn't fill it in, is important to* complete *the forms. If you look at the observation*

chart the respiration rate is eighteen. It has become a joke as no one counts the respirations and it is actually very important."

As indicated above, documentation forms an essential part of the nurse's day reflecting the type and quality of care provided. Registered professional nurses audit patient records to monitor the standards of care, ascertaining if appropriate care is provided according to the patient's needs. If not, then action plans are implemented, monitored and measured to ensure improvement and patient safety. Described above is that enrolled nurses are performing a function expected of the registered professional nurses. Enrolled nurse training does not enable enrolled nurses to critically evaluate and interpret. Hence, the participants observed documentation that is incomplete, noting vital signs that do not reflect reality. Of concern was that the consequences of this unprofessional and unethical behaviour were not translated into the impact on patient safety, or the incidence of adverse events, patient complaints and litigation.

4.3.2.5 Sub theme: Financial impact of quality of care

The participants commented that the private sector was a business, with a focus on providing a patient service with astute management of costs. As health care cost increased, there was a greater focus on operational efficiency, which had influenced the nursing skill mix. The decrease in the availability of registered professional nurses and the utilisation of enrolled nurses to fulfil the gap created had altered the staffing patterns, and the ability of personnel to manage the increased workload:

P9: *"…what I have noticed in the private sector, ... they always talk about, it is always about money. They can't because it is so much for the ward and, like they go according to a budget, but in the meantime the staff is struggling."*

P10: *"I don't know whether it's all about the money or what, I don't know but nursing is just not the same anymore because some people do nursing but not with, how do you call it now … the heart, they're doing it for the money and I think there is where the problem starts..."*

The participants asserted that the current financial remuneration did not compensate the workload and challenges experienced by enrolled nurses:

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> **P13**: "…*they do almost the same work as the registered professional nurses ... and they don't get the same amount of money for that ... definitely financial, the whole package, financially and recognition in the ward, I think definitely that would motivate staff nurses a lot more. Because a person gives more of yourself if you feel like you're being valued."*

4.3.3 Leadership

The participants expressed various feelings in describing their positive and negative experiences of leadership.

4.3.3.1 Sub theme: Leadership style of the unit manager

They reflected on their experiences with different leadership styles and how this influenced the culture in the nursing unit. Each expressed how the actions and the behaviours observed in their leadership influenced team cohesion and performance. Some of the participants described positive role models, whose qualities resonated with their own values, creating a positive working environment. Other participants described role models who did not reflect the same ethos as their own. This resulted in tension and conflict as there was a lack of consistency in addressing personnel issues, with no consequences for unprofessional behaviour or unsafe practices. Some of the participants expressed job dissatisfaction. The perceived lack of managerial skills and experience was seen as a contributory factor, amongst some unit managers, in being incapable of managing the challenges of a dynamic nursing unit. The participants understood the managerial challenges of operational efficiency and impact on cost containment; however, it was distressing to experience the ramifications of these measures as it translated to patient care.

The lack of supervision and appropriately skilled personnel exacerbated the negative working climate. Registered professional nurses, if present, assisted the doctors on rounds, hence their clinical, supervisory responsibilities were neglected. The participants felt disillusioned and angry.

> **P9**: *"I feel angry and I feel there is nothing is done about it. Although some of the nurses are complaining about they said, they said they did but nothing is done."*

Some institutional practices negatively influence the perception of the patient's and the family. Registered professional nurse's accompanied the doctors on patient rounds, affording them an overview of all patients in the ward. Other categories of nurses did not necessarily have this opportunity. Due to the lack of exposure to the doctors' rounds, staff felt ill-prepared to respond when receiving queries, which professionally reflected on them poorly.

4.3.3.2 Sub theme: Communication and cooperation

The participants highlighted the correlation between leadership and communication. Some of the participants described positive working environments, where the culture of the nursing unit supported effective communication thus enabling team cohesion and performance. There was a clear understanding of responsibilities and sharing of the workload. Other participants described work environments where conflict and tension was experienced, due to a breakdown in communication. Poor communication was also perceived, in some instances, as an element of 'power' or 'control':

> **P9**: *"They don't want to work with each other. They are complaining about each other. They don't approach the problem directly, it is always vice versa."*

4.3.3.3 Sub theme: Delegation

The participants commented on the incidence of out of scope practices. Two participants viewed out of scope practices positively, despite knowing that an unsafe and illegal practice. The perception of the participants is that they are able to confidently fulfill the task requirements expected of a registered professional nurse as the boundaries between the different nursing category practices overlap. They did not express any concern for potential litigation or violation of Regulation R.2598 (South African Nursing Council, SANC, 1984:1). Instead the unsafe practice was regarded as a form of appreciation and reward. Their ability to be 'deployed' in the position of a shift leader was perceived as management condoning and sanctioning the practice. This is of grave concern for patient safety and not only exposes the risk to the personnel, but to the reputation of the organization. With nursing skill shortages a reality it is perhaps opportune to review and clarify the roles of the nursing categories and optimize their efficiency to meet the patient care demands safely. The introduction of the new nursing diploma in nursing should address the current limitations.

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Other participants felt uncomfortable and described feeling coerced, or made to feel guilty if indirectly asked to disregard their scope of practice. These participants refused to compromise their professional and personal values. However, this left them feeling insecure about job security and future work opportunities. A number of the participants felt that they were being exploited and resented the increased workload and responsibilities without financial recognition or compensation.

> **P13:** *"...we can just make all the staff nurses' registered professional nurses then everyone is happy."*

Some of the participants revealed that they worked via an agency, at different hospitals, some within the same group and others not. Locum working resulted in confusion and conflict amongst personnel members when work was allocated, as different practices existed from ward-to-ward and hospital-to-hospital. There was no continuity in nursing practice.

The participants also spoke out about the important role played by the enrolled nurse auxiliaries and care workers, who in their absence were able to observe patients and then report on any abnormalities or irregularities observed. This again highlights the blurring of nursing tasks, where the lack of an appropriately skilled workforce has to provide a service.

One participant also indicated a disconnection between one's work profile and the scope of practice.

4.3.3.4 Sub theme: Organizational climate and culture

The participants confirmed that their work environment is influenced by many interrelated factors: leadership, communication and shared values. They described a lack of leadership consistency across the various departments in the hospital, indicating a lack of alignment with the organizational values and mission. The participants expressed witnessing unprofessional behaviour. Some of the participants themselves engaged in, unsafe practices. Dishonesty was also experienced. This created issues of mistrust and loss of respect in some nursing units. It influenced operational efficiency and the work performance in the nursing unit, which impacted on patient care and patient satisfaction. There was evidence of low morale and fatigue due to the challenges in the working environment.

The participants elaborated on ‘professional jealousy’ amongst some colleagues, in which developmental opportunities provided to younger colleagues, left some senior personnel feeling unfairly treated. The participants also commented on the non-alignment of verbal and non-verbal behaviour, illustrated by examples of negative working environments that do not foster good working relationships or team cohesion.

Differences between the day and the night shifts influenced the ward climate. The participants spoke out that permanent night personnel appeared short tempered and fatigued. Some of the participants revealed that this behaviour was condoned due to insufficient staff numbers to rotate through the shifts and due to poor personnel management:

> **P10**: *“...they’re working like seven nights in a row or five nights then they’re too tired, they can’t see what I see, you see, because I’m well rested when I come on duty.”*

The participants noted the negative regression of nursing. People’s negative attitudes have added to the staffs frustrations.

> **P1**: *“Yes, now six years, if I look back six years that I have been nursing and see how things have deteriorated; it really makes me heart sore. You know people do not think much of nurses as it is ... it really upsets me that people come to work and they don’t want to work...*”

> **P10**: *“They don’t have the feeling, you know, the old people used to say you are born to be a nurse but some of them you can see ... they’re just here for the sake of the money.”*

The participants said that victimization, dishonesty and unprofessional behaviour in the working environment was demoralizing, resulting in a lack of job satisfaction. This required urgent intervention due to the social impact on their personal wellbeing:

> **P8**: *“It gets up to oh Lord when you sleep at night, twelve/one o’clock you are awake and the day is playing a role. Oh God I didn’t do that, oh okay first thing when coming in tomorrow ...”*

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Some of the participants recounted having debriefing sessions with colleagues to alleviate the anxiety and stress that overwhelmed them. In addition, this provided an opportunity for reflection.

The participants recognised the complexities of the practice environment, demonstrating the frustrations and challenge that enrolled nurse experience.

4.3.4 Workforce planning

This theme is an extension of the previous theme denoting intensity in the negativity experienced by the various participants. The participants conveyed their disquiet with the lack of appropriately skilled staff and budgetary constraints that hindered the acceptable functioning of the unit.

4.3.4.1 Sub theme: Staffing levels

The participants commented on the lack of adequately skilled personnel and on the quality of nurses recruited. They expressed concern over the loss of experienced personnel to retirement, noting the introduction of inexperienced personnel entering the workplace. The participants remarked on the importance of selecting the right person for nursing. This was essential for the acquisition of skill and knowledge to provide quality, safe patient care. The right person also needed to share and align with the same values as the organisation as this would enhance efficiency, team cohesion and work performance.

Supplementing the workforce with agency personnel, some of the participants spoke out about the inadvertent negative experiences encountered by agency personnel. It was intimated that ward turnover, lack of orientation, lack of knowledge of documentation and lack of understanding of doctor's protocols were contributory factors. Agency personnel also lacked the continuity associated with being employed by a hospital.

The expectation on agency personnel to fulfil the role expected of them is challenging. One participant empathised with the agency nurses due to the precarious position of not being wanted, but needed.

4.3.4.2 Sub theme: Skills profile

The participants expressed the value of appropriate supervision, especially where personnel shortages are experienced. Support for decision making and prioritization of care was sometimes lacking, resulting in anger and frustration amongst the participants. They looked to the registered professional nurse for guidance but none were forthcoming. It was suggested by some of the participants that registered professional nurses neglected their supervisory responsibility, due to their perceived lack of experience and competence. Communication was generally one-sided, with the enrolled nurses receiving instruction. The consequences were that the participants resented the burden of the workload as very few registered professional nurses were clinically ‘hands on’. The lack of supervisory support and working with an inappropriate skills mix, resulted in some enrolled nurses having to be responsible for the supervision of other staff members.

The perceived blurring of nurses roles had evolved out of necessity due to the nursing shortage, despite awareness that personnel were violating their scope of practice.

4.3.4.3 Sub theme: Impact of work inequity

The participants asserted that the scarcity of appropriate nursing skills was burdensome and negatively influenced their ability to function optimally. The lack of optimum staffing levels increased their workload in the absence of registered professional nurses. The participants expressed their anguish about the lack of job satisfaction, in some instances resulting in absenteeism due to the associated stress. Concerns were also expressed about the ramifications should an adverse event occur:

> **P3**: *“...if anything happen, they can chase me out.”*

> **P5**: *“I’m very scared because anything can go wrong…”*

The reality noted from the participants is that registered professional nurses, when available, are predominately used in a supervisory capacity to assist the doctors and are not hands on. Some of the participants expressed experiencing the positive influence of having a dedicated shift leader and dedicated qualified staff, which motivated them and enhanced job satisfaction:

> **P7**: *I'm happy where I am today, I'm happy I'm still working here."*
>
> **P11***: "I love nursing, I love nursing that I know."*

The participants commented on the challenges of utilizing staff from other departments, who were not necessarily familiar with the routine or the patient volume. Furthermore, despite enrolled nurses having the same rank, their different experience levels set them apart, which posed challenges when one enrolled nurse delegated and supervised the work of another.

Other participants reflected on the negative impact of working under pressure, where insufficient qualified staff or guidance is provided, leaving them angry and frustrated.

4.3.4.4 Sub theme: Performance appraisal

Some of the participants expressed that appreciation and recognition positively reinforced their motivation and their job satisfaction. It was revealed that some unit managers encouraged further development and proposed a plan of achieving it. Others revealed that performance management was not applied consistently, leaving them feeling disillusioned and dissatisfied as there was no development planned:

> **P1**: *"Because the people are so tired and drained and then they just feel but why am I bothering to do this; nobody checks the work done, no one recognises what I have done ... they* [the senior staff] *just decided they could no longer endure the situation, there was nothing motivating them to stay so they resigned."*

The findings of the participants highlighted their fears and concerns regarding the workplace within which they work. Many felt overwhelmed and frustrated.

They agreed that the unit manager played an important role in determining the climate and set the standard. However, many of the participants experienced the workplace negatively with the unit manager having little regard for their psychological and emotional wellbeing or empathy for the situation. In some instances the unit managers were newly appointed and the senior staff used this to their advantage, by taking advantage of inexperienced personnel or new appointments and humiliating them.

4.3.5 Cultural diversity

Cultural diversity reflects various factors that influence the enrolled nurse's experience of quality care. Culture not only refers to race, gender and social circumstances; it also includes the 'culture' of an environment**.**

4.3.5.1 Sub theme: Language diversity

Some of the participants drew attention to the insensitivity around language differences. Some personnel are poorly informed of other languages, which makes them appear insensitive.

> **P1**: *"Here, here we are very Afrikaans speaking, then the agency personnel who come an assist are a different culture. You know what is right for your culture is not the same in another so it is possible that we do not understand each other correctly. You know what I think is 100% maybe 50% for them. You know not really understanding or wanting to understand is difficult; it is difficult for some people to get over that barrier."*

One participant experienced some patients that used the language barrier as a form of racial prejudice:

> **P13**: *"You know I hate, that's also very counterproductive because then you have to leave your patients and go and do admission on the other side just because that man is now pretending not to understanding English but he actually understands English very well, he just wants a white girl to do his admission, that's very irritating."*

4.3.5.2 Sub theme: Diversity management

The participants expressed that educating personnel on workplace diversity was essential due to the changing workforce demographic. It was acknowledged that people from different cultures and generations contribute a wide pool of diverse skills and work styles. Some of the participants suggested that it provides an opportunity for employees to learn and share in a multigenerational work climate. It was revealed that in some instances it was not addressed that the cultural differences or even backgrounds could result in conflict, affecting professional networks and relationships. As illustrated below:

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P5: *"Peoples ways of working, attitudes, their behaviours, body languages, it's different and you just need to, what I do myself, I just need to make peace with you ... your ways, the way you speak, the way you are."*

4.3.5.3 Sub theme: Cultural sensitivity

The participants noted that they had many similarities, despite the many generational differences that they are exposed to in the work environment. It was conceded that each generation, baby boomers, Generation X, Generation Y and Millennials had unique characteristics that contributed to the workplace, however these same attributes could bring conflict.

Some of the participants commented on the importance of being cultural sensitive both in meeting the needs of the patient and their colleagues. Being culturally aware enhances positive team cohesion.

4.4 SUMMARY

The thirteen participants described a myriad of perspectives on their lived experiences of quality nursing care as ENs in the private healthcare setting. The data was collected, using Hycner's (1985:280) explicitation process and was reduced through a repetitive process, crystallising and condensing units of meaning into groups and then into themes. Five general themes and 19 subthemes emerged.

The five general themes and subthemes, with clusters of meaning, are described as follows:

4.4.1 Theme I: The importance of values, beliefs and norms as essential elements underpinning the personal and professional foundation of 'being' was demonstrated by providing comprehensive care, in a safe environment.

4.4.2 Theme II: Recognising patient-centred care was described. Positive experiences of professional development were provided and the importance of mentoring and coaching by ENs. The important role of patient education and the family influence on the provision of care were highlighted. Negative experiences of personnel placing their needs before their patients were

reported. The negative impact of documentation on the provision of care was identified. Of concern was the perceived absolution of the teaching and mentoring role of the registered professional nurse and the lack of competence and critical thinking skills. Noted was the lack of consequence for out of scope practices, adverse events and the impact on the provision of quality care. This was not translated into the potential for litigation and the ramifications to the patient and personnel safety and wellbeing.

4.4.3 Theme III: Positive experiences were described with ENs organising and prioritising their work activities, with good communication and teamwork playing a positive role. Negative experiences of unit management indifference and the impact on the work environment were reported. Insidious behaviour and "bullying" were described. This was emphasized by the lack of supervision and the lack of a positive organisational work climate, which influences delegation, accountability and out of scope practices.

4.4.4 Theme IV: Concerns were expressed over the selection and recruitment to the profession and the role of agency personnel with personnel shortages. The challenges of the inconsistent practices in providing the appropriate skills mix in respect of patient acuity were described. The lack of translation into the consequences of this behaviour was demonstrated. The impact of workload inequity and personnel shortages was reported. Performance management inconsistencies were described.

4.4.5 Theme V: Cultural sensitivity and tolerance were described. Negative experiences were reported from the patients towards nurses.

4.5 CONCLUSION

In this chapter the results of the study were discussed according to the study objectives. The aim of the study was to explore the experiences of enrolled nurses regarding quality care in general nursing units in the private healthcare setting. The private health sector functions differently to the public sector in that they are profit driven. The investigation of the experience of enrolled nurses suggests that quality is perceived to be hampered by the profit incentive.

It can be concluded that the role enrolled nurses play in the private healthcare setting far exceeds the legislated regulatory practice for their level of training. This poses a risk for patient

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safety and could exacerbate attrition levels of this important cadre of nursing. Moral distress and the consequences thereof are revealed, notably the registered professional nurses lack of supervisory responsibility and a lack of adherence to the legal requirements in terms of the scope of practice. Of concern is the lack of translation of the inconsistencies in behaviour and unsafe and unethical practices on patient and personnel safety and wellbeing.

The key findings will be discussed in chapter 5 to demonstrate how the objectives for this study were reached. The study limitations will be outlined and future recommendations will be provided.

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CHAPTER 5
DISCUSSION, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter the study findings are guided by published literature. Thereafter the study objectives are addressed. The limitations of the study are described. The implications for quality patient care are followed by the recommendations.

5.2 DISCUSSION OF FINDINGS

It appears that this is the first study to explore and describe the experiences of enrolled nurses as they experience quality nursing care in the private healthcare setting.

Literature reviewed described the private healthcare setting within which the enrolled nurses work and the mandatory legislative and regulatory framework of the Constitution of South Africa (Act 108, 1996:1247). Nursing care practices in South Africa are accredited by the South African Nursing Council (SANC). As in the public sector, the private sector experiences challenges with personnel shortages (Chitty & Black, 2011:347). As a result of the demand for nursing personnel, pressure on salary costs is a reality.

The findings of this study have highlighted positive and negative experiences.

5.3 ADDRESSING THE OBJECTIVES

The aim of this study was to explore the experiences of enrolled nurses regarding quality care in general nursing units in the private healthcare settings. A brief discussion of the findings of the study as it relates to the study objectives follows.

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5.3.1 Objective: Enrolled nurses understanding of quality care

The participants understanding of quality care was described as providing ‘holistic care’ and a ‘comprehensive care’ in a safe environment. Where not specifically mentioned, the participants referred to ensuring that all the patient’s needs were met and much emphasis was placed on addressing the emotional and psychological aspects of care.

Underpinning the participants understanding of quality care was the influence that their own upbringing had had upon their professional lives. Reference was made to the familial influences on their values and beliefs and the power this had had in the approach to patients and colleagues.

From the participants descriptions it appears that they have a very clear understanding of what quality nursing care is. However, it was noted that despite understanding all that quality entails it was not always possible to provide the level of care that they would like. This is substantiated by a study by Flynn *et al*., (2009:763) in which the challenges of nursing workload and insufficient staffing levels can affect the delivery of care. A further study indicates that the care provided is influenced by the category of nursing personnel who is providing the care (Welton *et al*., 2006:417).

If the care provided is not supervised or directed this results in poor practices and personnel deviating from acceptable practices leading to unethical behaviour. The participants confirmed the blurring of nursing category responsibilities and out of scope practices. In addition, concern was raised for the inaccurate recording of vital signs. The comprehension and implications of this behaviour having not been understood as compromising the health and safety of patients through performing these unsafe practices.

Studies do corroborate the descriptions provided by the participants of the impact of documentation volume and duplication that negatively impacts their ability to perform their work (Blair & Smith, 2012:164; Cheevakasemsook *et al.,* 20006:366; Keenan *et al.,* 2008:1). Conversely, the importance of why documentation is required is understood.

Despite the best intentions of the participants, it is clear from their descriptions that a quality strategy for the delivery of comprehensive patient care is not possible in the current situation.

The fundamental aspect that is lacking is leadership (WHO, 2006:21). The lack of commitment and supervision by the registered professional nurses and some unit managers means that the desired quality outcomes will be difficult to achieve.

The objective to ascertain the enrolled nurses understanding of quality care was achieved.

5.3.2 Objective: Enrolled nurse's understanding of their value and contribution to quality care

Each participant expressed a clear understanding of their personal contributions towards the quality care they provide. Some of the participants referred to their contribution as providing 'holistic care,' while others emphasised the provision of emotional and psychological support and educating their patients.

Some of the participants also emphasized that they contributed to the professional development of students through the sharing of knowledge, providing support and mentoring. Most of the participants reflected on their own personal professional development as an essential aspect to providing quality care to enhance the patients' experience. Studies corroborate the importance of professional development and empowering others (Coetzee *et al.,* 2012:163; Kirwan *et al.,* 2012:254).

Despite the participants revealing the valuable contributions that they personally and professionally contribute, it highlights the deficiency in the supervisory and clinical role of the registered professional nurse in the working environment. Activity slip and the blurring of responsibilities by lower categories of nurses, due to the lack of supervision, by registered professional nurses as shift leaders and unit managers, was expressed. This is corroborated by Dorse (2008:16).

Twigg *et al.,* (2012:144) corroborate the use of a predominantly registered professional nurse workforce being associated with a greater quality of care. Providing adequate, skilled personnel is an organisation requirement, legislated by the Basic Conditions Employment Act (Act 75, 1997:10). From the participants descriptions the availability of competent, skilled personnel is problematic. Studies corroborate the challenges of high attrition rates and vacancy rates (Mokoka *et al.,* 2010:6; Brunetto *et al.,* 2013:2; Breier et al., 2009:18). Contributing factors

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perceived by the participants is the cost of appointing appropriately skilled personnel to meet the patient care needs. As employed by a profit driven business, they perceive that using lower categories of personnel to deliver care is less expensive (Welton, 2011:310; Welton, 2006:417; Stimpfel & Aiken, 2013:122).

Notwithstanding the enrolled nurses contributions in the challenging circumstances described, studies do corroborate that lower categories of nurses having difficulty in meeting the patients' needs. Their inability to meet patient's needs was described by some of the participants. They attributed their inability to meet patient demands to personnel shortages and poor skills mix. However, in addition to these challenges studies do confirm that this inability is also attributed to lower levels of education (Twigg *et al.,* 2012:2712; Aiken *et al.,* 2012:144; Winslow, 2001:13). The lack of critical and analytical thinking skills, affect the ability of the lower categories of nurses to adequately integrate theory and practice (Lubbe & Roets, 2013:59).

The objective to understand the enrolled nurses understanding of their value and contribution to quality care was thus achieved; however, it highlighted the deficiencies in the responsibilities of registered professional nurses.

5.3.3 Objective: Enrolled nurse's experiences (positive and negative) of quality nursing care in private health care settings

The participants described having experienced both positive and negative experiences in their daily work environment. One participant specifically experienced her work environment negatively due to the lack of cultural sensitivity, poor leadership role modelling and the lack of teamwork. There was a disregard for using English as the language of choice and she expressed frustration that the unit manager was sensitive to the patient's needs, but not to that of the personnel.

The importance of language sensitivity and being culturally aware is substantiated by Ghyoot (2000:125) and Allan (2010:315). Training inconsistencies would need to be addressed.

Favouritism and differing acceptable behaviours, such as registered professional nurses drinking tea, whilst the enrolled nurses had to start work, was also highlighted.

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This behaviour of different standards and behaviours that are tolerated may be indicative of 'power' and insidious intimidation. The studies of Zimmermann and Amori, (2011:5), corroborate this. Van Bogaert *et al.,* (2009:2176) and Zangaro and Soeken (2007:446) substantiate the negative correlation between job satisfaction and work frustration. It also reflects on the lack of leadership and supervision by senior personnel and the unit manager to ensure consistency in behaviour amongst personnel members and to foster a positive working environment. Two participants described their unit managers as being good role models. However, the other described their unit mangers as being focussed on cost containment and being absent from the nursing unit to attend meetings. Some are perceived as uncaring and one participant feared that they may lose their job if not doing as they are told, even though what was expected of them was out of their scope of practice.

A few of the participants embraced the role as shift leader, aware that they were working out of their scope of practice. However, in their opinion if it were with their management's consent and support, they did not perceive it to be a legal liability. Furthermore, they attributed their years of experience, good interpersonal skills and leading a well-integrated team as an indication of their competence. They expressed that they were well respected and acknowledged that they could only do their work due to the sum effort of the team as a whole. The perceived lack of responsibility on the organisations part to condone this illegal practise is of concern.

Some of the participants were overwhelmed with their daily tasks due to the inexperience of the personnel assigned with them and their own inexperience.

The objective to understand the ENs experiences (positive and negative) of quality nursing care in private health care settings was achieved.

5.4 RECOMMENDATIONS

The recommendations based on the scientific evidence obtained in this study are:

5.4.1 Prepare the registered professional nurse for her professional role:

- Educating and developing as future nurse leaders needs to be developed during formal training.

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- Organisations need to provide learning opportunities within a safe environment where the registered professional nurse can be exposed to professional responsibilities, whilst being mentored and coached. This will empower them in their clinical supervisory role.
- Registered professional nurses need to be equipped with the necessary skills to enable efficient and effective functioning as a team member. This will ensure that they do not work in isolation and can apply what they have been taught.
- The importance and benefit of fostering a learning environment needs to be understood and supported.
- A formal standardised programme that can direct and support learning in a meaningful way is required to nurture students, e.g. PDSA cycle.
- They need to ensure adherence of enrolled and enrolled nursing auxiliaries to legislative and organisational requirements.

5.4.2 Prepare the enrolled nursing students for culturally-sensitive health care:

- Enrolled nurses need to understand the different cultural value systems that shape human behaviour to address the needs of the patients and their colleagues.
- Educate and clarify the Bill of Rights, contained within the Constitution of South Africa (Act 108, 1996:1247) that endorses the democratic values of human dignity, equality and freedom.
- Create value awareness that will assist in identifying insidious workplace behaviour and how to address.

5.4.3 Provide structured, standardised orientation and in-service training:

Enrolled nurses have a truncated formal training programme in which the theoretical knowledge component does not sufficiently prepare the enrolled nurse to perform tasks unsupervised (Lubbe & Roets, 2013:58). Enrolled nurses should practice in accordance with the scope of practice and the hospital and organisation specific policies.

- The provision of standardised orientation programmes needs to be facilitated to ensure consistency of care.
- Organisations need to adhere to the scope of practice and ensure that nursing categories are educated about their compliance to the scope of practice. This will prevent abuse.

5.4.4 Attitudes and behaviour of senior personnel need to be addressed:

Personnel shortages are a reality and therefore all employees should strive to build and maintain their human resource pool. Some private health care institutions are accredited training institutions and their permanent employees should be sensitised to the training role expected of them. There is a perception of some personnel of not wanting to relinquish the 'power' of knowledge, instead 'setting one up for failure'.

- Registered professional nurses and senior personnel need to be made to understand that the old adage of 'sink or swim' is not beneficial to learning and development and does not provide a receptive environment for students.
- A portfolio of evidence, of areas for improvement should be made available.
- Appropriate support, supervision and guidance of students by registered professional nurses must be provided in order to limit the potential for litigation.
- Nursing processes that are the responsibilities of registered professional nurses should not be delegated. It is the registered nurses responsibility to identify problems and implement a plan of action. Accountability cannot be delegated, e.g. audit of patient folders to identify learning opportunities should be positively encouraged and supported by management.
- Registered nurses should actively adopt action plans and take responsibility for monitoring as part of performance management.

5.4.5 Employers investment in providing a nurturing work environment:

- Provide the appropriate skill mix.
- Where not able to provide the appropriate skill mix, provide alternatives that will not further compromise personnel and patient safety.
- Ensure sufficient staff available not to compromise safety.
- Management must provide the appropriated supportive mechanisms to assist personnel in these situations.
- Unit managers are pivotal in the effective functioning of the unit and should therefore have the necessary clinical and managerial skills and experience.
- Compulsory refresher courses should be made available to appropriately equip the unit manager and nursing management sufficiently for the dynamic work environment.

- Appoint administrators to manage the nursing units as business units. Many unit managers time is consumed by non-nursing tasks, instead they should utilise their clinical expertise at the bedside in supervising personnel and being 'hands on.'
- Promote a just or learning culture wherein the personnel are taught to identify, define and support the eradication of an insidious workplace culture.

5.4.6 Enhancing the patient experience through providing details of the organisational work environment:

- Provide detail on the organisation work flow process and role players to improve the patient experience.
- Promote a learning culture that will enable personnel to function cooperatively through education, coaching and mentoring to achieve the desired standards.
- Develop a patient safety culture that supports personnel who identify or express concerns regarding system barriers.

5.4.7 Development and enhancement of the nursing profession in practice:

- In-service training to clarify roles and responsibilities of nursing categories.
- Adapt the business model to accommodate nurse category supply to enhance patient safety and 'do no harm'.
- Provide programmes that influence practice behaviours, demonstrating the nursing professions foundation elements – ethos, caring, performance.

5.4.8 Address disengagement and burnout

- Engage with unit manager's on-to-one that will identify areas of concern from their perspective, thereby enabling HR to prepare for nursing unit workforce engagement.
- Identification of issues on management and workforce level will determine strategy.
- Develop a wellness programme that will assist in the support and maintenance of a healthy work environment.

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- Incorporate skills development workshops that are aligned, both in the training of enrolled nurse students and in in-service training sessions in the hospital environment to support team engagement in the nursing units.
- Include communication programmes that will develop and enable effective communication and the identification and management of conflict.
- Provide and support debriefing opportunities, to promote understanding and team building.
- All employees of the hospital and the organisation must demonstrate the desired values through their behaviour and interaction with others.
- Be transparent and keep personnel informed of hospital and organisational developments.

5.5 FUTURE RESEARCH

The recommendations for further research are:

- Research in the public South African hospitals to attest to this study's findings. As the public sector is not profit driven, replication in this environment may reveal new insights.

5.6 LIMITATIONS

This study was conducted in the private healthcare setting of the Western Cape and the public healthcare institutions were excluded. Enrolled nurses in the public sector may have different views to those expressed by their colleagues in the private sector.

5.7 CONCLUSION

Chapter five discussed the study findings and addressed the study objectives.

The implications of the findings are that some enrolled nurses are being deployed as shift leaders as a result of the nursing shortages. The ramifications are that unsafe practices are condoned that may have severe legal consequences, as both patients and personnel are at risk. A lack of leadership has exacerbated unsafe and unethical practices. The consequences of

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these ‘practices’ are demonstrated by the negative attitudes and behaviours, poor working environments and feelings of being overwhelmed as described by the participants. There is also a perceived lack of consideration for the impact on patient safety, that unsafe practices and unethical behaviour can lead to legal liability, as well as there being a reputational risk to the organisation, further tarnishing the image of nursing as a noble profession.

The relinquishing of the clinical supervision responsibilities by registered professional nurses needs to be urgently addressed as these are the role models and support structures required to mentor, support and coach students.

The research question “What are the experiences of enrolled nurses regarding quality nursing care in general nursing units in the private health care setting?” has been answered.

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7. Annexures

Annexure A: Permission from the University of Stellenbosch to conduct research

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approved with Stipulations
New Application

20-Nov-2013
Haakestad, Andrea N

Ethics Reference #: S13/10/193
Title: The experiences of enrolled nurses regarding quality nursing care in the private health care setting

DearMs Andrea Haakestad,

The **New Application** received on **30-Oct-2013**, was reviewed by members of **Health Research Ethics Committee 2** via Minimal Risk Review procedures on **18-Nov-2013**.

Please note the following information about your approved research protocol:

Protocol Approval Period: **19-Nov-2013 -19-Nov-2014**

The Stipulations of your ethics approval are as follows:
1. We are unsure why there are 2 sets of Information consent forms (ICF's). The "alternative" forms are incomplete and I would like to suggest that the researchers only the standard ICF form.

2. Please write in the first person throughout. Currently it is a mix of different forms.
3. Indicate the duration of the interview on the ICF.
4. Change the word "medical records" to study records or something similar.
5. Declaration by interpreter - will an interpreter be used? If not, delete this section.

Please remember to use your **protocol number** (S13/10/193) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389207.

Included Documents:
CV - Stellenberg

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Health General Checklist
Protocol Synopsis
Protocol
CV - Furst
Consent Forms General
Application Form
CV - Haakestad
Consent Forms - Alternative
All Declarations

Sincerely,

Mertrude Davids
HREC Coordinator
Health Research Ethics Committee 2

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Annexure B: Permission to conduct research at hospital

MEDICLINIC OFFICES
STRAND ROAD
STELLENBOSCH
7600

PO BOX 456
STELLENBOSCH
7599

T +27 21 809 6500
F +27 21 809 6756
ETHICS LINE 0800 005 316

www.mediclinic.co.za

18 December 2013

Ms A Haakestad
9 Afsaal
Sparrowhawk Crescent
D'URBANVALE
7550

Dear Andrea

PERMISSION TO CONDUCT RESEARCH AT MEDICLINIC PANORAMA

Your research proposal entitled "*The experiences of enrolled nurses regarding quality nursing care in the private health care setting*" refers.

It is in order for you to conduct your research at Mediclinic Panorama, and I wish you success with this project.

Yours sincerely

ESTELLE JORDAAN
Nursing Executive

MEDICLINIC (PTY) LTD
REG. NO. 1969/009218/07

Stellenbosch University http://scholar.sun.ac.za

Annexure C: Permission from hospital to conduct research

31 January 2014

Mrs A Haakestad
Mediclinic (Pty) Ltd.
P O Box 3948
TYGER VALLEY
7536

Dear Mrs Haakestad,

PERMISSION TO CONDUCT RESEARCH: MEDICLINIC PANORAMA

It gives me great pleasure to grant you approval for the research that you would like to conduct at our hospital.

Please contact Mrs K Barry to make the necessary arrangements.

If you have any questions, please do not hesitate to contact me.

I wish you every success with your studies.

Kind regards,

ANNMARIE SIEBRITS
NURSING MANAGER

Stellenbosch University http://scholar.sun.ac.za

Annexure D: Permission to conduct research at hospital

Netcare Management (Pty) Limited

Tel +27 (0)11 301 0000
Fax: Corporate +27 (0)11 301 0499
76 Maude Street, Corner West Street, Sandton, South Africa
Private Bag X34, Benmore, 2010, South Africa

RESEARCH OPERATIONAL COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2014-0007

Ms AN Haakkestad

E mail: Andrea.Haakestad@Mediclinic.co.za

Dear Ms Haakkestad

RE: TO EXPLORE THE EXPERIENCE OF ENROLLED NURSES REGARDING QUALITY NURSING CARE IN THE PRIVATE HEALTH SETTING

The above-mentioned research was reviewed by the Research Operational Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Netcare N1City Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Sustainability Committee of Netcare (Research Operational Committee).

ii) All information with regards to Netcare will be treated as confidential.

iii) Netcare's name will not be mentioned without written consent from the Sustainability Committee of Netcare (Research Operational Committee).

iv) All legal requirements with regards to patient rights and confidentiality will be complied with.

v) Insurance will be provided and maintained for the duration of the research. This cover provided to the researcher must also protect both the staff and the hospital facility from potential liability

vi) In accordance with MCC approval, that medicine will be administered by or under direction of the authorised Trialist

vii) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2000)

viii) Netcare must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from Sustainability Committee of Netcare (Research Operational Committee) as well as a

Directors: M S F da Costa, J du Plessis, K N Gibson R H Friedland, K Naicker, M B Nkosi, C Pallman, N Phillipson, P Warrener, D van der Bergh

Company Secretary: L Bagwandeen Reg. No. 1996/012714/07

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FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

ix) A copy of the research report will be provided to Netcare (Research Operational Committee) once it is finally approved by the tertiary institution, or once complete.

x) Netcare has the right to implement any Best Practice recommendations from the research.

xi) Netcare reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/Netcare or should the researcher not comply with the conditions of approval.

xii) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER.

We wish you success in your research.

Yours faithfully

Prof Dion du Plessis
Full member: Research Operational Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Shannon Nell
Chairperson: Research Operational Committee
Network Healthcare Holdings Limited (Netcare)
Date: 18/2/2019

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Annexure E: Permission from hospital to conduct research

Netcare N1 City Hospital

Louwtjie Rothman Street, Goodwood, 7460
P O Box 12581, Goodwood, 7463
Tel: +27 (0) 21 590 4444
Fax: +27 (0) 21 595 2304
www.netcare.co.za

30 December 2013

Ms Andrea N Haakestad
9 Afsaal
Sparrowhawk Crescent
D'Urbanvale
7550

Dear Ms Haakestad

PERMISSION TO CONDUCT RESEARCH

We acknowledge receipt of your letter dated 12 December 2013.

Kindly contact the Research department to obtain the necessary forms to complete your application. Their contact details are as follows:

Dr CW Fölscher
Project Manager: Bursaries & Research
76 Maude Street
Sandton
2196

Telephone number: 011 301 0000
Email address: research@netcare.co.za

Yours sincerely

LETTIE BLOM
NURSING SERVICE MANAGER

Netcare Hospitals (Pty) Ltd T/A Netcare N1 City Hospital
Directors:
J Du Plessis, R H Friedland, K N Gibson
Company Secretary: L Bagwandeen **Reg. No.** 1996/006591/07

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Annexure F: Permission to conduct research at hospital

Life Healthcare Head Office
Oxford Manor, 21 Chaplin Road, Illovo 2196
Private Bag X13, Northlands 2116, South Africa
Telephone +27 11 219 9000
Telefax +27 11 219 9001
www.lifehealthcare.co.za

Life Healthcare Group (Pty) LTD is registered as a Private Higher Education College with the DHET
Registration number 2008/HE07/003

27 February 2014

ATTENTION: ANDREA HAAKESTAD

APPROVAL FOR RESEARCH STUDY

TITLE: The experience of enrolled nurses regarding quality nursing care in the private healthcare setting.

Our previous correspondence refers.

The Research Committee of Life Healthcare has granted permission for your study to be conducted within the company's facilities.

We look forward to seeing the results of your research once it is completed.

Yours sincerely

Anne Roodt
Education Specialist

Life College of Learning

Life Healthcare Group (Proprietary) Limited
Reg. no. 2003/024367/07 Registered address Oxford Manor, 21 Chaplin Road, Illovo 2196, Private Bag X13, Northlands 2116
Directors: CMD Flemming (Chief Executive Officer), CLW Bekker, D Scheublé, PP van der Westhuizen

Stellenbosch University http://scholar.sun.ac.za

Annexure G: Permission from hospital to conduct research

Life Vincent Pallotti Hospital
Alexandra Road, Pinelands, Cape Town 7405
PO Box 103, Howard Place 7450
Telephone: +27 21 506 5111
Telefax: +27 21 531 0116
www.vincentpallottihospital.co.za

17 December 2013

Andrea Noleen Haakestad
9 Afsaal
Sparrowhawk Crescent
Durbanville
7550

Dear Andrea

RE: Request for Permission to Conduct Research:

Thank you for submitting your request for Permission, to Conduct Research at the hospital. Your exploration of the role of the Enrolled nurse and Quality is a very relevant topic.

We hereby grant you permission and wish you all success for your research.

Yours sincerely,

Alta Dorse
Nurse Manager

A division of Life Healthcare Group (Proprietary) Limited
Reg. no. 2003/024367/07 Registered address Oxford Manor, 21 Chaplin Road, Illovo 2196, Private Bag X13, Northlands 2116
Directors: CMD Flemming (Chief Executive Officer), CLW Bekker, D Scheublé, PP van der Westhuizen

Stellenbosch University http://scholar.sun.ac.za

Annexure H: Participant information leaflet

PARTICIPANT INFORMATION LEAFLET

TITLE OF THE RESEARCH PROJECT: *The experiences of enrolled nurses regarding quality nursing care in the private health care setting*

REFERENCE NUMBER: S13/10/193

PRINCIPAL INVESTIGATOR: Mrs Andrea Noleen Haakestad

ADDRESS: 9 Afsaal, Sparrowhawk Crescent, D'Urbanvale, 7551

CONTACT NUMBER: +27 21 943 6227

Dear Colleague

My name is Andrea Haakestad and I am Stellenbosch University Masters Nursing student. I would like to invite you to participate in a research project that aims to explore the experiences of enrolled nurses regarding quality nursing care in the private health care setting.

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to accepted and applicable National and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

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Very few studies are available pertaining to the experiences of enrolled nurses in the South African context of quality nursing care in the private hospital sector.

This study is aimed at exploring the experiences of enrolled nurses who have a minimum of 6 months experience working in an adult general surgical/medical nursing units relating to quality nursing care in the private hospital setting. Three different private hospitals groups will be used to explore how enrolled nurses feel and what they understand about quality nursing care.
Four enrolled nurses from each participating private hospital group will be invited for an interview. In total of 12 (or more) enrolled nurses will be interviewed individually and in sequential order until data saturation occurs.

Your participantion has been randomised by your respective unit manager. An appointment date will be scheduled with all interested participants to conduct a one-to-one interview at a venue of the participants' choice. Interviews will be audio-recorded and transcribed. During interviews, a research assistant will take notes and assist the interviewer to enhance the accuracy of the data. All participants will be given a pseudonym to enhance protection of identity and confidentiality, and thus ensure anonymity.

Read this leaflet, think about and reflect honestly on your understanding of quality nursing care and your experiences of quality nursing care in the private hospital group setting. Complete and sign this consent form in duplicate. Keep one form for yourself and give the other to the researcher.

As an enrolled nurse the opportunity to express what you feel may be enlightening and empowering. You have experience of the quality nursing care that is provided in the private hospital group setting and could contribute valuable insight into the service delivery of quality nursing care. The researcher will gain an understating of the enrolled nurses experiences of quality nursing care. Nurses in general may directly benefit from the findings in understanding the enrolled nurses' perceptions of quality nursing care. Patients will benefit indirectly due to the awareness created, which can positively influence nursing outcomes.

There are no risks involved in this study. You may withdraw your consent at any time and discontinue participation without penalty. All data will be locked up in a safe for a period of five

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years and will only be made available to the supervisor, co-supervisor and research ethics committee upon request. Please note that you will not be paid to take part in the study.

Yours sincerely

Andrea Haakestad

Principal Investigator

Stellenbosch University http://scholar.sun.ac.za

Annexure I: Participant information and consent form

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:
The experiences of enrolled nurses regarding quality nursing care in the private health care setting

REFERENCE NUMBER: S13/10/193

PRINCIPAL INVESTIGATOR: Mrs Andrea Noleen Haakestad

ADDRESS: 9 Afsaal
Sparrowhawk Crescent
D' Urbanvale
7551

CONTACT NUMBER:	**CELL:**	**079 1096588**
	HOME:	**021 9790775**
	OFFICE:	**021 9436227**
	E-mail:	**andrea.haakestad@mediclinic.co.za**

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the research investigator any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the

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international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

Very few studies are available pertaining to the experiences of enrolled nurses in the South African context of quality nursing care in the private hospital sector.

This study is aimed at exploring the experiences of enrolled nurses who have a minimum of 6 months experience working in an adult general surgical/medical nursing units relating to quality nursing care in the private hospital setting. Three different private hospitals groups will be used to explore how enrolled nurses feel and what they understand about quality nursing care.

Four enrolled nurses from each participating private hospital group will be invited for an interview. In total 12 (or more) enrolled nurses will be interviewed individually and in sequential order until data saturation occurs.

Interview procedure:

- Your participantion has been randomised by your respective unit manager.
- An appointment date will be scheduled with all interested participants to conduct a one-to-one interview at a venue of the participants' choice; of about 30-45 minutes in duration.
- Interviews will be audio-recorded and transcribed.
- During interviews, a research assistant will take notes and assist the interviewer to enhance the accuracy of the data.
- All participants will be given a pseudonym to enhance protection of identity and confidentiality, and thus ensure anonymity.
- Participation is voluntary and may be terminated at any time.

Why have you been invited to participate?

You have experience of the quality nursing care that is provided in the private hospital group setting and could contribute valuable insight into the service delivery of quality nursing care

What will your responsibilities be?

- Read this leaflet.

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- Think about and reflect honestly on your understanding of quality nursing care and your experiences of quality nursing care in the private hospital group setting.
- Complete and sign this consent form in duplicate. Keep one form for yourself and give the other to the researcher.

Will you benefit from taking part in this research?

As an enrolled nurse the opportunity to express what you feel may be enlightening and empowering. The researcher will gain an understating of the enrolled nurses experiences of quality nursing care. Nurses in general may directly benefit from the findings in understanding the enrolled nurses' perceptions of quality nursing care. Patients will benefit indirectly due to the awareness created, which can positively influence nursing outcomes.

Are there risks involved in your taking part in this research?

There are no risks involved in this study.

If you do not agree to take part, what alternatives do you have?

There are no alternatives – either you participate or not. You may withdraw your consent at any time and discontinue participation without penalty. Participation is voluntary.

Who will have access to your participant records?

All information collected during interviews will be treated as confidential. The identity of the participant will remain anonymous at all times, including in any publication or thesis resulting from the study. All data will be locked up in a safe for a period of five years and will only be made available to the supervisor, co-supervisor and research ethics committee upon request.

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

No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

You can contact the **Human Research Ethics Committee of the Faculty of Medicine and Health Sciences at 021-938 9207** if you have any concerns or complaints that have not been adequately addressed by the interviewer.

- If you have questions regarding your rights as a research participant, contact Ms Laetitia Fürst [lfurst@sun.ac.za; 021 938 9822] at the Division of Nursing, Stellenbosch University.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I …………………………………..…………. agree to take part in a research study entitled "The experiences of enrolled nurses regarding quality nursing care in the private health care setting."

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…........…………….. on (*date*) …………..……….. 2014.

....	....
Signature of participant	**Signature of witness**

Declaration by investigator

I *(name)* ……Andrea Haakestad……..……… declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.

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- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did not use an interpreter.

Signed at (*place*) ....…........……………….. on (*date*) …………...……….. 2014.

....

Signature of investigator

....	....
Signature of witness	**Date**
....	....
Signature of research assistant	**Date**
....	....
Signature of research assistant	**Date**

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Annexure J: Semi structured interview guide

TITLE: The experiences of enrolled nurses regarding quality nursing care in the private health care setting

The interview will be guided by probing questions to explore the experiences of enrolled nurses, should they not volunteer information:

- To explore the enrolled nurse's understanding of quality care
- To explore the enrolled nurse's understanding of her value and contribution to quality care
- To explore the enrolled nurse's experiences (positive and negative) of quality nursing care

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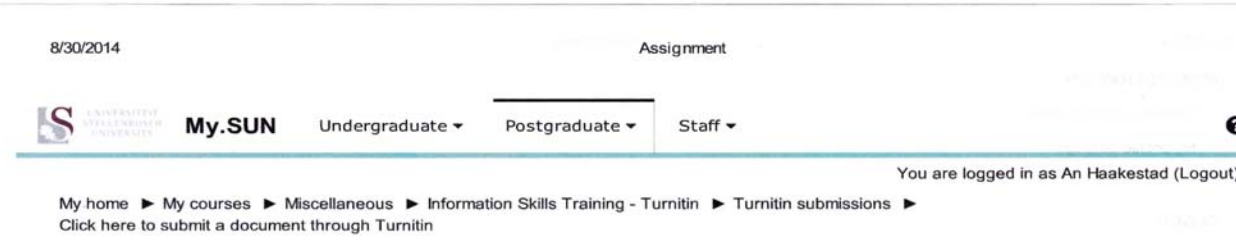
Annexure K: Plagiarism report



Click here to submit a document through Turnitin

Submission status

Submission status	Submitted for grading
Grading status	Not graded
Due date	Thursday, 31 December 2020, 11:55 PM
Time remaining	6 years 125 days
Last modified	Saturday, 30 August 2014, 11:00 AM
File submissions	Thesis.docx 12% Export to portfolio

Edit submission

Make changes to your submission

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Annexure L: Language editing certificate

Mary A. Cohen
Language Practitioner

Copy editing for academics

4 Swan Lane
Bergvliet
7945
Phone 021 7130397
swanlake@mweb.co.za

29 August 2014

Ms AN Haakestad
Student Number: 14974541
9 Afsaal,
Sparrowhawk Crescent,
D'Urbanvale,
7551

The above-named student' thesis titled

"Exploring the experiences of enrolled nurses regarding quality nursing care in general nursing units in the private healthcare setting"

was edited for grammar, spelling, syntax, Harvard referencing technique and it was formatted according to the requirements of Stellenbosch University.

Annexure M: Transcription certificate

C: 083 227 5966
F: 086 647 8813
P: PO Box 7627, Centurion, 0046
E: juliamb1@mweb.co.za

05 August 2014

To Whom it May Concern,

LETTER OF DECLARATION ANDREA NOLEEN HAAKESTAD

STELLENBOSCH UNIVERSITY STUDENT 14974541

I confirm that professional audio transcribing services were recently provided to my client, Andrea Noleen Haakestad, a Stellenbosch University Student. Student Number 14974541.

I assure confidentiality of the information received in transcribing the audio recordings.

Sincerely,

Julia M. Martinelli

Transcriber

T: 083 227 5966

E: juliamb1@mweb.co.za