A workload model for nurse educators in private higher education: options for improved productivity and job satisfaction

by
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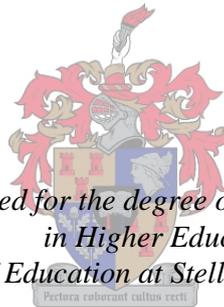
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DECLARATION

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ABSTRACT

Nursing education in South Africa is continuously being influenced by significant changes in all spheres of higher education. There is little doubt that most of these changes have a major impact on the workload of nurse educators in private higher education, possibly even more so in relatively young and developing private higher education institutions. Considering recent contextual changes, this study aimed at investigating the workload position of nurse educators within a typical private higher education institute in South Africa and developing a realistic and suitable workload model that may contribute to raising the efficiency, work satisfaction and productivity benchmark of nurse educators. In this study the researcher employed the systems theory and expectancy theory as theoretical lenses to understand the phenomenon of both the theoretical and clinical components of nurse education and their relation to motivation, productivity and job satisfaction within nursing education. The study centred on private healthcare education at an identified multi-campus private healthcare organisation as the employer. The researcher strived to gauge, describe and possibly improve the productivity and job satisfaction of nurse educators as employees of this organisation. It was argued that the workload of the nurse educator is complex and multifaceted which therefore required a pluralistic research design. A range of research methods employed from within a pragmatic worldview, as the philosophical underpinning, gave the researcher the freedom to select a Framework for an Integrated Methodology (FraIM) to address the research question(s). Data were analysed from workload diaries, individual and group interviews and a Delphi exercise which was used to strive towards consensus. It was concluded that the work situation of nursing educators at one multi-campus private higher education institution is complex and challenging, yet stimulating. The study revealed that nurse educators are under pressure due to increased workloads within a rapidly changing nurse education environment. The study showed a private nurse education sector in South Africa faced with financial challenges and although private institutions acquire skills plan levies for the training of nurses in certain specialties and as listed companies, they do not get any state subsidy for basic nursing education. These institutions are expected to carry the financial burden of training basic nursing students in a highly competitive medical care service provider business world. The main value of the study is its contribution to the development of a practical workload

model that may not only assist in addressing the needs of the host private higher education institution but also add value to the core business needs of the holding company and similar universal nurse education entities. The study contributed to an improved understanding of the various factors contributing to the complex workload of nurse educators. An important outcome of the suggested development of an all-inclusive workload model is the benefit of an effective management tool to determine person-power requirements more accurately during planning and budgeting operations in private nursing education.

OPSOMMING

Verpleegonderwys in Suid-Afrika word beïnvloed deur 'n reeks beduidende veranderinge op alle terreine van hoër onderwys. Daar is min twyfel dat die meeste van hierdie veranderinge 'n beduidende impak het op die werkslading van verpleegopvoeders in privaat hoër onderwys, insluitend relatief jong en ontwikkelende private hoër onderwysinstellings. Met inagneming van onlangse kontekstuele veranderinge, was hierdie studie daarop gemik om die werklas van verpleegopvoeders binne 'n tipiese private hoër onderwysinstelling in Suid-Afrika te ondersoek en om 'n realistiese werksladingmodel te ontwikkel wat moontlik kan bydra tot die doeltreffendheid, werksbevrediging en produktiwiteit van verpleegopvoeders. In hierdie studie is stelselteorie en verwagtingsteorie as teoretiese lense gebruik om die verskynsel van beide die teoretiese en kliniese komponente van verpleegonderwys te verstaan midde hul verhouding tot motivering, werksbevrediging en produktiwiteit binne verpleegonderrig. Dit geld veral vir privaat gesondheidsopvoeders in 'n bepaalde multi-kampus privaatgesondheidsorg instelling as werkgewer om die werkstevredenheid en produktiwiteit van verpleegopvoeders te meet, beskryf en moontlik te verbeter. Daar word geargumenteer dat die werklas van die verpleegopvoeder kompleks en veelsydig is wat 'n multimetodiese navorsingsontwerp vereis. 'n Verskeidenheid navorsingsmetodes is dus in hierdie studie gebruik binne 'n pragmatiese wêreldbeskouing. Hierdie filosofiese onderbou het die navorser die vryheid gegee het om 'n Raamwerk vir 'n Geïntegreerde Metodiek (FraIM) te kies om die navorsingsvraag/vrae aan te spreek. Die FraIM is 'n responsiewe, buigsame en oop metodologiese benadering wat die navorsingsvraag/vrae kon help beantwoord. Die studie het data uit werkslading-dagboeke, onderhoudontleding en 'n Delphi oefening gebruik om konsensus na te streef. Die studie toon dat die werksituasie van verpleegopvoeders by die geïdentifiseerde multi-kampus privaat hoër onderwysinrigting kompleks en uitdagend, maar tog stimulerend is. Daar is min twyfel dat verpleegopvoeders onder druk verkeer weens verhoogde werksladings binne 'n snel veranderende hoër onderwys verplegingsmilieu. Die studie het ook getoon dat die privaat verpleegsektor-onderwyssektor in Suid-Afrika met finansiële uitdagings gekonfronteer word, hoewel privaat instellings vaardigheidsplanheffings vir die opleiding van verpleegkundiges in sekere spesialiteite ontvang. As genoteerde

maatskappye kry hierdie instellings geen staatsubsidie vir basiese verpleegonderwys nie. Daar word van hierdie instellings verwag om die finansiële las van die opleiding van basiese verpleegstudente in 'n hoogs mededingende mediese sorg sakewêreld te dra. Die hoofwaarde van die studie setel in 'n voorgestelde werksladingmodel wat nie net mag help om sekere aspekte van die verpleegonderwysbehoeftes van private hoëronderwysinstellings aan te spreek nie, maar ook waarde toevoeg tot die kernbesigheidsbehoeftes van die verskeie houermaatskappye en soortgelyke verpleegonderwysinstellings. Meerdere insigte en kennis is verkry oor verskillende faktore wat bydra tot die komplekse werkslading van verpleegopvoeders. Een belangrike uitkoms van die ontwikkeling van 'n inklusiewe werksladingmodel is die voordeel van 'n geskikte instrument om mensekragvereistes meer akkuraat te bepaal tydens beplanning en begrotingsaktiwiteite in privaat verpleegonderwys.

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LIST OF ACRONYMS

ACLS	Advance cardiovascular life support
AHA	American Heart Association
BLS	Basic life support for healthcare providers
CF	Conceptual framework
CHE	Council on Higher Education
CPD	Continuous personal development
DoHET	Department of Higher Education and Training
ET	Expectancy theory
FraIM	Frameworks for an Integrated Methodology
HEQC	Higher Education Quality Committee
HEQSF	Higher Education Qualification Sub-Framework
NEI	Nursing Education Institution
NQF	South African National Qualifications Framework
ODA	Operating department assistance
QCTO	Quality Council for Trade and Occupation
SANC	South African Nursing Council
SAQA	South African Qualifications Authority
ST	Systems theory

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The rapid and dramatic changes in the higher education environment of the previous decade have led to higher education functioning in a super complex modern world. The profound shift in society from a knowledge era (circa 1970s – 1990s) to a technologically globalised information era at the beginning of the 21st century also altered the global higher education environment which had to adapt to rapid changes rife with challenges, but also with opportunities. In the healthcare industry, the impact of these broader forces transformed nursing education as the "demand to educate responsive, ethical, and intelligent knowledge-guided nurses" in the 21st century increased (Schmidt Bunkers, 2000: 116).

Since the beginning of the new era higher education institutions (HEIs) and their educators were at the centre of these dramatic changes. Currently, almost two decades later, these institutional dynamics are still continuing to change with educators still expected to conduct research and provide knowledgeable and skilled graduates who can make significant contributions in extremely competitive global markets. Worldwide, these expectations, together with the changing student demographics have led to unhappiness among academics about their work situation which is described as comprising an excessive workload with administrative burdens, low salaries and reduced autonomy. The relationship between higher education institutions, government and society has also changed extensively; hence, international higher education institutions are more performance- and market-driven with consequent profound changes for academics (Liefner, 2003:469; Marginson, 2006:1-3; Sticmac, 2012:23-24).

Much of what happens locally in South Africa (SA) occurs as a result of international trends because the increase in global social relations connects far-off localities in such a way that local events are formed by events that have taken place elsewhere.

In all spheres of South African higher education, including nursing education, substantial changes have also taken shape over the past decade. The most significant of these changes were the control of all higher education by the Minister of Higher Education, the accreditation as a higher education institution (HEI) of all nursing education institutions (NEIs) and the registration of private nursing HEIs with the Department of Education (DoE) (Republic of South Africa, 1997; Republic of South Africa, 2008b; Republic of South Africa, 2016). All learning programmes have to meet the requirements of the Higher Education Qualifications Framework (HEQF) (Republic of South Africa, 2014). Moreover, all programmes offered by the private nursing higher education institutions (NEI's) must be accredited by the Council of Higher Education (CHE), South African Qualifications Authority (SAQA) and the South African Nursing Council (SANC). To obtain a registration certificate from the Department of Higher Education and Training (DoHET) as a higher education institution the process for a nursing education institution (NEI) includes submitting an intention to register with the DoHET as a private higher education institution. Getting approval from the South African Nursing Council (SANC) with a letter of endorsement where after the programme(s) is submitted to the Council of Higher Education (CHE). The SANC provides a provisional letter of endorsement. The Council of Higher Education (CHE) submits the programme(s) to SAQA for inclusion on the South African National Qualifications Framework (NQF) once it has been approved by the Higher Education Quality Committee (HEQC). The NEI and its clinical facilities are required to be accredited with SANC as indicated in regulation R174 (South African Nursing Council, 2013d).

There seemed to be little doubt that the impact of these changes on the workload of nurse educators in private higher education, particularly in relatively young and developing private higher education institutions, had been profound. Considering recent contextual changes, this study aimed at investigating the workload position of nurse educators within a private higher education institute in South Africa. This chapter provides some background information on the issue of nurse educator workload and a description of the research problem. This is followed by the purpose of the study and the ensuing research questions, the significance of the study and the research design and methodology. The rest of the chapter is devoted to

describing how the empirical data were generated and managed, position of the researcher, scope of the research, ethical considerations and the clarification of key terms used in the study. The chapter concludes with the structure of the rest of the study.

1.2 BACKGROUND INFORMATION

The vision of operative healthcare services, renowned for their excellence in providing high quality patient-focused and patient-driven care, is what most private healthcare providers strive for (Econex, 2013:6). In this sense the identified private healthcare provider where the study was conducted is aspiring to be the preferred healthcare service provider locally and to be recognised as a leader in the education of professional nurses in the private South African environment.

During the 1908s the World Health Organization's (WHO) focus on primary healthcare worldwide stimulated the professionalisation of nurses' education. This became a reality in South Africa when, in 1983 and in line with international developments, colleges of nursing became part of the tertiary education system for the first time. In 1986 their association with university nursing departments "became obligatory" (Thompson [1986] cited in Marks, 1994:199). According to Marks, the influx of nurses started to increase dramatically as the demand grew for better trained nurses to "take charge of the new primary health care centres" (Marks, 1994:198).

The number of fully qualified registered nurses, enrolled nurses and enrolled nursing auxiliary nurses rose from 73 500 in 1980 to over 148 000 in 1990 (Searle [1991] cited in Marks, 1994:199). It became evident that the traditional training institutions such as public nursing colleges and universities in the country would be unable to deal with the growing demand for highly qualified registered nurses. Currently, as the extended role of professional nurses continues, the demand for private higher education institutions to educate these nurses also increases. In 2017 there were 100 registered private higher education institutions in South Africa (Department of

Higher Education and Training, 2017) of which 62 train 54% of the nurses in the country (SANC, 2017).

In 1985 the private healthcare company central to this study initiated, developed and implemented a two-year programme leading to a nurse qualification at one of its two nursing education institution (NEI) in Gauteng. Completing this course led to certification as an enrolled nurse. In the following 30 years the training function of the company expanded to seven nursing education institutions in six of the nine provinces in South Africa. At these seven institutions 58 different training programmes and accredited courses are currently offered (Van Zyl, 2015:1-2).

The NEI's of this private healthcare company was accredited as a private higher education institution in 2008. Since accreditation, the nurse educator numbers had been proportionally increased to accommodate the rapidly growing numbers in nursing and operating department assistant nursing students. On the contrary, the increase in nurse educator numbers, however, had up to the time of study offered no particular or suitable adjustment to the extended number of training programmes and courses currently offered.

It has been acknowledged in all spheres of South African higher education, including nurse education, that it is time for particularly higher education institutions to make significant changes. Higher education is in a time of tremendous change with new legislation, further regulations and learning approaches focusing on the international comparability of standards and qualifications. Against this background, nurse educators are expected to facilitate learning in ways that will allow students to enter the profession with high competency levels (Geyer, 2017b:78; Blaauw, Ditlopo, & Rispel, 2014:2; Coetzee & Heyns, 2016:1).

All of these expectations add to the workload demands of nurse educators involved in training at the private healthcare company which formed the focus of this study – a company still in its developmental phase as a higher education institution.

Considering all aforementioned factors, it became clear that current faculty workload models do not seem to fit the profile and needs of this private higher education institution.

1.3 DESCRIPTION OF THE PROBLEM

Relevant literature indicates that internationally higher education institutions are being challenged to do more with the same resources and still improve productivity (Bellamy, Morley & Watty, 2003:14-15; Gumport, 2000:69; Jing, 2012:274; Kenny, Fluck & Jetson, 2012:50; Kenny & Fluck, 2014:585; McDowell, 2004:149-151). These competing demands negatively impact on nursing academics' time and add more work to their already full workload schedules (Langston & Cowling, 1999:28). There is also a considerable variation in academic staff workload across higher education institutions (Mamiseishvili & Rosser, 2011:100).

Internationally, higher education administrators seem to associate increased workloads with an increase in productivity while already overworked academics associate higher workloads with reduced job satisfaction, reduced motivation and lower productivity (Soliman & Soliman, 1997:135). Consequently, researchers have identified a need to investigate the reasons for and implications of higher workload versus the reduced productivity and job satisfaction issue to gain a better understanding of the challenges higher education educators face with regard to the academic workload (Mamiseishvili & Rosser, 2011:101; Soliman & Soliman, 1997:136).

Many researchers have recently focused on the numerous changes educators at private higher education institutions face, but nurse educators in particular are challenged with several changes (Armstrong, Bhengu, Kotzé, Nkonzo-Mtembu, Ricks, Stellenberg, Van Rooyen, Vasuthevan, Geyer & Mngomezulu, 2013:111; Bruce & Klopper, 2016:69; South African Nursing Council, 2013a:20) and the National Strategic plan for nurse education, training and practice (Republic of South Africa, 2013:31). These changes include a more tightly regulated higher education environment, increases in workload diversity and extensive lists of additional work

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tasks to perform. Nurse educators specifically have to cope with escalating volumes of administrative tasks, travelling between clinical facilities and accommodating an increasing level of demands with regard to academic and clinical duties.

According to Mngomezulu and Geyer (2017:21-25), nurse educators have to respond to culturally diverse nursing student groups which, in turn, means more dedicated effort, higher levels of motivation and further demands to remain effective and productive within a competitive business environment. Indeed, Timperley and Robinson's (2000:47) responded at the beginning of the 21st century with an urgent call for radical changes in education to be approached with caution. In agreement, Rothmann, Barkhuizen and Tytherleigh (2008:404-422) warn significant increases in the workload may result in fewer deadlines being met, a decrease in productivity levels and the possibility of less job satisfaction.

Addressing the dynamic changes in the field of nursing education in South Africa, Rothman *et al*. (2008:404) point out such changes could also impact in different ways on the roles and working lives of nurse educators. For example, the recent development involving the change from nursing education institutions to higher education institutions led, among others, to a fragmentation of tasks resulting in an increase in the workload of nurse educators in general and, importantly, the workload of nurse educators employed by the private healthcare company under scrutiny in this study. This fragmentation entails remedial practice of learning support to students who are not prepared for learning at higher education institutions and changes in teaching approaches of the nurse educators to ensure critical thinking.

To illustrate: at the time of study this private healthcare company employed 44 nurse educators who were distributed over seven nursing education sites throughout South Africa. At present, part of the nurse educators' workload is to do clinical accompaniment of students at 37 accredited clinical facilities. In some instances, the nurse educators have to travel long distances from the nursing education institutions to the clinical facilities where the students are placed for clinical accompaniment. In 2011, these clinical facilities' managers decided from that year onward the learning

and development facilitators in the clinical environments would assist less with the clinical accompaniment of the students.

The repercussions of this decision on the workload of nurse educators were considerable. The nurse educators had to somehow budget for more time – a daunting and stressful task considering their already excessively high workload – to accompany the students in the clinical environments. Indeed, taking into consideration the unified stance of Timperley and Robinson (2000:47) and Rothmann *et al.* (2008:404-422), it can be posited that if the identified private healthcare company wants to be an employer of choice, it has to address the potential problem of work overload and ensure the optimal productivity and job satisfaction of nurse educators to provide high quality nursing education (also see Vardi, 2009:500).

Studies found in literature since 1995 report on the interrelationship between academic workload and its relevant components, namely teaching, research, administrative functions and community service (Adams, 1995:307; Houston, Meyer, & Paewai, 2006:17-25; Kenny & Fluck, 2014: 586; Lau, 1996:96; Ruby, 1998:18). Various studies have focused on nurse educators who find it difficult to cope with the teaching and clinical needs of nurses in private higher education institutions (Barret & Barret, 2007:461; Cohen, Hickey & Upchurch, 2009:50; Cowdery & Agho, 2007:73; Kordzadze, 2013:112; Lobo & Liesveld, 2013:2; Rosser & Tabata, 2010:456; Vardi, 2009:499-508).

Researchers have explored the different uses of workload models within higher education nursing contexts (Bitzer, 2007:23; Kenny *et al.*, 2012:50), the improvement of job satisfaction and workload management (Vardi, 2009:499) as well as activity monitoring (Perks, 2014:1; Brady, 2010:3). Workload models appear to be valuable in demonstrating to management how work is distributed in objective ways as well as to identify staff at risk of burnout as a result of excessive workloads (Boyd, 2014:315). Much of the theoretical underpinnings for productivity or performance leading to job satisfaction are grounded in the systems theory (ST) (Sulliven &

Decker, 2005:14; Van der Walt, 2016:70; Yoder-Wise, 2011:122) and the expectancy-based theory (ET) of motivation (Mamiseishvili & Rosser, 2011:101-102; Parijat & Bagga, 2014:4-5).

The principle of one element of a system influencing other system elements is better understood when seen as being merged into a work system which indicates the interactions among people and of people with their environments (Cordon, 2013:21; Germain, 2015:8; Huber, 2013:43; Nel, Werner, Poisat, Sono, Du Plessis & Ngalo, 2011:7; Van der Walt, 2016:690; Yoder-Wise 2011:122). System-based problems can thus not be solved in isolation because of the integration and interrelation of the other parts of the problem (Von Bertalanffy, 1969:91).

The systems theory (ST) thus provides a suitable theoretical lens through which the workload of nurse educators can be studied within its relational context (Caws, 2015: 517; Meadows, Randers & Meadows, 2004:4-5). The systems theory (ST) may also assist to interpret the systemic problem and develop strategies that show the relation of the parts of a system to their environment(s) (Friedman & Allen, 2011:3-8). By making use of the systems theory (ST), the focus in this study was placed on the workload of nurse educators and their relation to other parts of the organisation and the environment as well as their working together to achieve common goals (Cornell & Jude, 2015:1). From a human behaviour perspective, the systems theory (ST) allows for showing the influence of several related behavioural systems and thus the importance to understand the interrelated systems that affect an individual (Caddy & Helou, 2007:319).

Vroom's expectancy theory (ET), based on the premise that employees will be motivated to act when there is an expectancy that their behaviour can result in the achievement of desired outcomes, adds to the theoretical understanding of work contexts (Parijat & Bagga, 2014:3). It is further pointed out by Lunenburg (2011:1) that the expectancy theory (ET) is a cognitive process theory of motivation where people believe there are connections between the effort they put forward at work, the performance they achieve from this effort and the rewards they achieve from their

performed effort. Smit, Botha & Vrba (2016:318) argue that employees have two key beliefs, namely expectancy beliefs (pointing to performance) and instrumental beliefs (pointing to rewards).

This implies that within an educational context, an educator's expectancy will be high when he/she is sure that more students will pass their examinations (performance) if he/she puts in some additional effort to spend more time with students (effort). Thus, the employee's instrumentality will be high if he/she believes that a high pass rate of his/her students will be rewarded with a good performance rating by the end of the year. Such beliefs imply that motivation is driven by an individual's expectancy of preferred outcomes and the power of the attractiveness of those outcomes to the individual employee (Ng'ethe, Iravo & Namusonge, 2012:205; Dugguh, 2014:20).

In fact, literature reveals there may be strong links between workload, motivation and productivity because motivated employees experience job satisfaction when all needs are met; thus, when there is an increase in productivity. Productivity is therefore primarily seen as a function of an employee's satisfaction and motivation (Dugguh, 2014:22; Kim, Wolf-Wendel & Twombly, 2011:724;). It is confirmed by Mamiseishvili and Rosser (2011:101-102) as well as Parijat and Bagga (2014:4-5) that the expectancy theory (ET) has been used by researchers in academic contexts to investigate the workload and productivity of academic staff as well as the relationship between academic productivity and job satisfaction.

In this study the researcher employed the systems theory (ST) and expectancy theory (ET) as theoretical lenses to better understand the phenomenon of both the theoretical and clinical components of nurse education and its relation to motivation, productivity and job satisfaction within nursing education in a private higher education context. The sought understanding pertained specifically to how the phenomenon was observed in the private healthcare education domain in one multi-campus private healthcare organisation.

The attempt with this study was mainly to gauge, describe and possibly improve the productivity and job satisfaction of the nurse educators. The identified knowledge gap also pointed to a need for a better understanding of the issues, contexts, problems and challenges related to private nursing education. In this sense one may well agree with Perks (2014:2) who insists it is "better to have a workload model that fits the activities of an institution than to implement a generic workload model".

The aforementioned issues provided a firm rationale for conducting this study to inquire into the possibilities of a more suitable workload model within private healthcare nurse education.

1.4   RESEARCH AIM AND QUESTIONS

The aim of this study was to inquire into a current existing needs-based workload model for nurse educators within a systems theory and expectancy theory framework. The main research question of this study was thus formulated as:

> *"What constitutes a suitable workload model related to productivity and job satisfaction of nurse educators?"*

The following four subsidiary research questions served as a guide to address the main research question:

1.4.1 How may the concepts 'workload' and 'manageable workload' of nurse educators be better understood in private nursing education contexts?

1.4.2 How do nurse educators at a multi-campus private higher education institution view the influence of their current workload on their productivity and job satisfaction?

1.4.3 What constitutes an expert view of the realistic time spent regarding workload activities of nurse educators at a private higher education institution?

1.4.4 What are the characteristics of a suitable workload model to possibly improve the productivity and job satisfaction of nurse educators within a private higher education context?

These questions were formulated against a background of professional, organisational, policy, national and theoretical concerns (Plowright, 2011:8). These are discussed in more detail in Chapter 3.

1.5 SIGNIFICANCE OF THE STUDY

At present it is apparent that a decisive change in the roles and workload of South African nurse educators due to significant changes in the health and nursing legislation and increases in the academic and clinical duties of such educators is long overdue. The need for investigating the development of more effective workload models, including those for private healthcare environments, is indisputable. It is therefore posited that a research-based, realistic workload model may contribute to the efficiency, productivity and work satisfaction of nurse educators and potentially enhance the quality of nursing education in private higher health education.

At a conceptual level this study aimed to contribute to a more informed understanding of the problems, challenges and coping strategies of nurse educators. This included gaining a better understanding of the complexities concomitant with the issue of nursing education workload – specifically in the South African context – thereby extending the current limited available body of knowledge in this field of inquiry.

1.6 RESEARCH DESIGN AND METHODOLOGY

A mixed methods design with both qualitative and quantitative data was used for this study (Creswell, 2011:3-4). A pragmatic worldview, as a chosen philosophical underpinning, provided the researcher the freedom to choose the best and most suitable methods, techniques and procedures for generating data to address the research problem (Creswell, 2014:11).

The researcher selected the Framework for an Integrated Methodology (FraIM) (Plowright 2011:7-21) to address the main research question as the FraIM promotes a responsive, flexible and open-minded methodological approach to answer research question(s) (Plowright, 2011:7-21). According to Creswell (2014:11), a researcher may use several methods to generate and analyse data to provide the best understanding of the research problem.

Using Plowright's FraIM design (2011:7-21), the empirical part of the study was conducted in three phases:

Phase 1: The workload situation of nurse educators at a multi-campus private higher education institution was determined.

Phase 2: An expert view of the time spent on workload activities of nurse educators at the private higher education institution was determined.

Phase 3: The proposal of a possible improved workload model for nurse educators to improve their productivity and experience increased job satisfaction at the identified private higher education institution.

1.6.1.   Data management

A total of 37 nurse educators from one multi-campus private higher education institution were involved in the research project. These nurse educators were geographically distributed among seven nursing education centres in the following six South African provinces: the Free State, Gauteng, Limpopo, Mpumalanga, the Northern Cape and the Western Cape. The data were generated and managed in three phases as outlined in Table 1.1 below.

Table 1.1: Data management plan for the study

Data collection phases	Information group	Method	Sampling	Data generated
Phase 1	Nurse educators (37)	An analysis of workload diaries.	Participants would select themselves via voluntary participation.	Workload diaries were kept for nine months
Phase 2	Nurse educators (37)	Group and individual interviews with nurse educators.	Participants would select themselves via voluntary participation.	Interviews were conducted over a two months period
Phase 3	Expert panel (33)	A Delphi questionnaire done with selected experts in the field.	Purposive sampling.	Delphi survey was conducted over one and a half months

Data generated during Phases 1 and 2 of the research process were used to determine the current workload of the nurse educators in Phase 1 of the empirical study and to compile the Delphi questionnaire for the panel of experts in Phase 2. In Phase 3 the Delphi survey was conducted. The data generated in Phases 1 and 2 were used to compile a suitable workload model for the nurse educators of the identified private higher education institution to improve their productivity and job satisfaction.

1.6.2.   Participant selection

The population for this study was purposively selected nurse educators based on their exceptional knowledge, skills and experience in private nursing education and their involvement on a daily basis with workload issues. They were engaged in nursing education at the different educational sites (cf. sect. 1.6.1) of the identified private higher education institution and were in the best position to contribute relevant information and rich data (Delbecq, Van de Ven & Gustavson, 1975:23; Polit & Beck, 2012:271).

Plowright (2011:14) suggests that the selection of cases takes place on two levels, namely data source management (first level) and sampling decisions (second level). For the first level of participant selection in this study, the case study data source management strategy was used to collect in-depth data. For the second level, namely the sampling decision, all the participants (37) were invited to participate in stages 1 and 2 of the study due to the relatively small size of the research population (Plowright, 2011:36). The Delphi technique of consensus was implemented during stage 3. Data from this stage contributed to a valid argument for the improvement of nurse educator workload in the context of the identified private higher education institution (Duclos-Miller, 1996:39).

1.6.3.   Data generation

Based on the FraIM, multiple methods of data generation were used as suggested by Plowright (2011:15, 53 & 85). The intention was to use two methods of data collection, namely undertaking artefact analysis (workload diaries) and asking questions. Both methods were characterised by their individual level of mediation and degree of structure (Plowright, 2011:49-50). Artefact analysis had a high level of mediation as the researcher was more distanced from the phenomenon being studied and the asking of questions had a high level of mediation as participants had to answer questions during interviews (Plowright, 2011:49-50). Due to the limited pre-structuring of the data via asking questions, the degree of structure was low as the generated data were only coded after the data collection sessions had transpired (Plowright, 2011:54-56).

Numerical as well as textual (narrative) data were used to gain an in-depth and comprehensive (holistic) understanding of the diverse educational tasks of nurse educators and to assess their own experiences of their current workload versus the characteristics of an ideal workload. Hence, a view of the relationships and processes within their natural surroundings was provided (Polit & Hungler, 2004:262; Creswell, 2009:203; Doyle, Brady & Byrne, 2009:184; Plowright, 2011:85).

In stage 2 of the project a modified Delphi technique questionnaire containing closed-ended questions was used to probe a panel of experts to try and reach consensus regarding the time spent on the different workload activities in the different workload components of a nurse educator's workload. In the Delphi exercise an agreement level of 80% was considered as consensus being reached. This exercise confirmed that input from all the parties involved was obtained in the development towards a credible and suitable nurse educator workload model.

The electronic workload diaries as artefacts were piloted to clarify the instructions, the time it took to complete the activities and to establish whether any activities were omitted. The interview guide was piloted to look at the clarity of the questions, depth of information, time spent on the interview, audibility of the electronic recordings, the quality of transcription and the quality of the transcript for interpretation and data analysis. The purpose of the pilot study of the Delphi questionnaire was to ensure the instructions and questions were clearly worded and appropriate to elicit relevant data. The data and results of all the pilot studies were not included in the data of the main analysis as it was considered not legitimate (Plowright, 2011:89) due to the changes made in the different data collection instruments.

The vital information provided by the pilot runs assisted in making adjustments to instruments and enhanced the quality of the data yielded (Brink, Van der Walt & Van Rensburg, 2012:56; Durand & Chantler, 2014:118; Polit & Beck, 2012:195). It also provided the researcher with the opportunity to check whether the data decisions were sound and corresponded with the nature of the research questions (Plowright, 2011:88).

1.6.4.   Data analysis

The two types of data, namely narrative and numerical were integrated by planning the data procedures as coherent right from the start of the project (Plowright, 2011:119). The narrative (textual) data were generated at the nominal level while the numerical data were generated at an ordinal level as well as a ratio level. Electronically recorded responses of participants to the open-ended questions during

focus group interviews were transcribed and analysed by means of assigning labels and grouping similar codes into themes (Maree, 2007:265). The numerical data from the workload diaries and the Delphi exercise were analysed with mathematical and statistical analyses and the interpretation of the results was presented in tables and distribution graphs (Creswell, 2009:152).

1.6.5. Research sites

The research sites were the seven nursing education sites of the identified private higher education institution as listed.

- Cape Town.

- Bloemfontein.

- Polokwane

- Nelspruit.

- Kimberley.

- Sandton

- Pretoria.

1.7. POSITIONING OF THE RESEARCHER

At the time of study (and currently still) the professional role of the researcher was that of training manager of the seven nursing education sites at the identified private higher education institution. She had held this position for seven years. This was preceded by six years as the learning centre manager at one of the nursing education sites. As mentioned before (cf. sect. 1.3), it was not an increase in workload as such which prompted her to conduct this study, but more the accompanying increases in stress and burnout, the difficulty to meet deadlines and the low job satisfaction experienced by colleague nurse educators which ultimately led to observed productivity challenges.

It was the researcher's primary objective to propose a suitable workload model which may contribute to the improvement in the morale, efficiency and effectiveness of nursing educators in the private healthcare sector. Throughout the enquiry process the researcher constantly endeavoured to remain objective by identifying and consciously setting aside any suspected or bias beliefs and opinions about the phenomenon under investigation. Although bracketing can never be totally achieved (Polit & Beck, 2012:495), the researcher strived to bracket any preconceived values, beliefs, experiences and opinions she may have had in an attempt to consider all viable perspectives and participants' life experiences as well as to manage the data in pure form (Brink *et al.*, 2012:122; Chan, Fung & Chien, 2013:1-2; Polit & Beck, 2012:495; Tufford & Newman, 2010:85). The methods used by the researcher to be as credible and critical as possible during data collection, data analysis and data reporting are explained in Chapter 5 (cf. sect. 5.3.3; 5.5 & 5.6).

1.8.   SCOPE OF THE STUDY

The study was conducted in higher education as the field of inquiry and more specifically in the subfield of nursing education in private higher education. The empirical part of the study was carried out within the context of one multi-campus private higher education institution in South Africa.

This study excluded personnel management but included educational matters involving nursing education that ultimately affected the quality of nursing education. For this reason, the primary focus was on education and training matters and not on the management of personnel. The researcher also restricted her exploration of literature to sources relevant to the context of education and training, but drew on fields such as psychology, industrial psychology and human resources management.

1.9.   ETHICAL CONSIDERATIONS

The study adhered to the ethics requirements of Stellenbosch University as well as those of the identified private higher education institution where the study was conducted. All participants were asked for voluntary consent and the researcher

ensured that participants were not harmed or experienced any discomfort during participation. The researcher further made certain that her position as training manager did not, in any way, influence the decisions of nurse educators in the identified private higher education institution to participate or decline participation in the study.

1.10. CLARIFICATION OF CONCEPTS

1.10.1 Nurse educator

A 'nurse educator' is a registered nurse with a clinical speciality, registered with the South African Nursing Council and who has a formal qualification in nursing education (South African Nursing Council, 2013a:75). In this study the concept 'nurse educator' refers to a registered nurse with a formal qualification in nursing education, appointed by the identified private higher education institution and fulfilling a teaching, clinical practice, administrative and research role.

1.10.2 Workload

Within the nursing education context the concept 'workload' refers to the time-consuming activities directly or indirectly related to the professional activities, duties and responsibilities of the nurse educator as practitioner (Adams, 1995:307; Rosser & Tabata, 2010:456). In this study the concept 'workload' refers to the time spent on all the various activities associated with the teaching, clinical practice, administrative and research workload of a nurse educator.

1.10.3 Teaching workload

The concept 'workload' has been attended to (cf. sect. 1.10.2). Apart from the known type of formal teaching in the classroom, the concept 'teaching' also involves student guidance, counselling of students, the development of programmes and instructional material, committee work, the setting and marking of examinations and maintenance of teaching records (Mellish, Brink & Paton, 2003:74). Thus, in this study the concept 'teaching workload' is regarded as the teaching activities that include the facilitation of contact sessions; teaching preparation; setting of tests and examinations;

formatting tests and examination papers; invigilation of tests and examinations; moderation of tests, examination papers and assignments; marking of tests, examination scripts, assignments and portfolios of evidence (PoE); remediation; counselling of students and the reviewing and development of study material.

1.10.4   Clinical practice workload

As mentioned by Harden and Crosby (2000:337) the clinical workload of a nurse educator is more associated with the preparation of students for practical placement and the placement of students in clinical facilities. The concept 'clinical practice workload' in this study is seen as the clinical accompaniment of students; assessments of the skills of the students; demonstrations and the preparation done for it; practical examinations and the preparation thereof; clinical allocation of students and compiling of monthly planners for clinical accompaniment.

1.10.5   Administrative workload

The process of administration is seen as a collection of activities that enable nursing education. It is a service provided to students and colleagues so that students can be trained and be prepared for professional practice (Mellish *et al.*, 2003:282). In this study, the concept 'administrative workload' is considered as activities that include the management of emails; writing letters; drawing up of the progress, monthly and three-monthly reports of all students; making photocopies; record-keeping; counselling of students; loading marks of students; programme and course completions and learner support.

1.10.6   Research workload

The research role of the nurse educator includes participation in research and the conduction thereof, provision of research consultation to colleagues and the publication and presentation of scholarly papers (Mellish *et al.*, 2003:74). The concept 'research workload' in this study refers to research for own personal development and assistance to postgraduate students doing research projects.

1.10.7   Nursing education site

'Nursing' refers to the actions and care a trained, graduated, registered nurse perform "for the sick or infirm" to whom they give holistic medical "care and attention to" in a healthcare institution such as a hospital, clinic, private practice or in the patient's home (*Concise Oxford English dictionary*, 2006:982). A 'learning site' is an accredited physical location where training and education facilities and resources are available for the delivery of education and training of students (South African Nursing Council, 2013c:3). The concept 'nursing education site' in this study refers to one of the seven accredited nursing education sites of the identified private higher education institution where nurse students are trained to provide healthcare to patients.

1.10.8   Productivity

In education, Meyer (1998:6) singles out workload as the time spent on activities and 'productivity' as the measuring of the product from the time spent on the activity. In this study the concept 'productivity' refers to the improvement of teaching, clinical and administrative productivity.

1.10.9   Job satisfaction

'Job satisfaction' is described by Mustapha and Ghee (2013:11) and Sahin and Sahingoz (2013:10) as a positive or satisfying response from personnel to their perceptions, feelings and expectations regarding their work. The concept 'job satisfaction' in this study refers to the nurse educators' current positive or negative experience of their high workload and the improvement thereof.

1.10.10   Workload model

Perks (2014) believes a workload model is a comprehensive picture of all the different activities of academic staff as well as the time related to these activities. For the purpose of this study a workload model refers to a proposed realistic, achievable, balanced and manageable workload model for nurse educators at the identified private higher education institution.

1.10.11   Clinical facilities

A 'clinical facility' is a medical building such as a healthcare institution or hospital in which a continuum of services is used by educators to teach students to promote health and provide care to individuals and groups (South African Nursing Council, 2013c:2). In this study the concept 'clinical facilities' indicates the SANC accredited hospitals of the identified private healthcare group where the nursing students of the private higher education institution are allocated for the clinical practice component of their studies.

1.10.12   Higher education

According to the Higher Education Act 101 of 1997 means Higher education' all the learning programmes leading to qualifications which meets the requirements of the Higher Education Qualifications Sub-Framework (HEQSF) (Republic of South Africa, 1997b:5).

1.10.13   Private higher education

'Private higher education' is provided by private-owned organisations. Many of these private organisations offer the same qualifications as public providers, with the difference that they are mainly privately funded or sponsored by the private organisations and are generally not subsidised by government (Council on Higher Education, 2003:2).

1.10.14   Private higher education institution

A 'private higher education institution' is any institution providing higher education on a fulltime, part-time or distance basis and which is registered as a private higher education institution under the Higher Education Act 101 of 1997 (Republic of South Africa, 1997b:5).

1.11   STRUCTURE OF THE STUDY

Chapter 1 provided an orientation to the study. Background information was provided as well as a description of the research problem. Further addressed were the purpose and research questions; significance of the study; research design and methodology; data management; positioning of the researcher and scope of the study. The ethical considerations and clarification of concepts were explained.

Chapter 2 explores the key concepts considered to be the fundamental building blocks in setting up the study parameters for the development of a more realistic nurse educator workload model.

In Chapter 3 contextualisation of the study is explored as it formed part of widening the theoretical exploration of this study project. The contextual issues of international and national contexts, private higher education context, professional context, policy context and institutional context are also addressed.

In Chapter 4 the theoretical context of the study is presented and discussed. The focus is on the systems theory and expectancy theory as these were considered appropriate theories to form a theoretical lens for this limited research project. The chapter concludes with a preliminary conceptual framework for the study.

Chapter 5 pays attention to the research design and methodology. The research design; research methods; data management and sampling decisions; methods of data collection; pilot study; data analysis; triangulation of data; warrantability of the study; ethical considerations and analytical lens are thoroughly discussed in this chapter.

In Chapters 6 and 7 the study findings and discussions of the narrative (Chapter 6) and numerical data (Chapter 7) are presented.

In the final chapter (Chapter 8) a number of conclusions are drawn based on the findings of the study and the implications of the research are pointed out. Limitations of the study are also mentioned.

CHAPTER 2

EXPLORATION OF KEY CONCEPTS

2.1   INTRODUCTION

The aim of this study was to investigate and develop a suitable workload model for nurse educators at a multi-campus private higher education institution in South Africa. The main objective was to contribute towards improved productivity and job satisfaction for nurse educators. Supporting evidence indicates that wide-ranging and rapid changes in the global higher education environment accelerate changes in the delivery of educational services to remain competitive in the modern world (Barnet, 2000:440; Coombs, 2018:198).

In nursing higher education institutions educators are expected to conduct research as well as facilitate and train productive graduates equipped with the necessary skills and knowledge to promote safe and quality healthcare (Chaira, Chana, Yua & Taylor-Piliaeb, 2018:150; Crawford, 2010:199; Hargreaves, 2000:175; SANC, 2013a). In addition, the accompanying changes in student demographics (Webster & Mosoetsa, 2001:79-80) mean nurse educators have to respond to cultural diverse nurse student groups. Subsequently, more dedicated effort, higher levels of motivation and the demand on nurse educators to remain effective and productive (Mekwa, 2000:275; Rothman et al., 2008:404) to fulfil these expectations add to the already full workload schedules of nurse educators (Geyer, 2017:91). In many other health care related education situations, for instance in physiotherapy, medicine and occupational therapy, these challenges inevitably lead to unhappiness among the educators about their work situation, low salaries and reduced autonomy (Harden and Crosby, 2000:345; Delanty, 2008:127).

In South Africa, new legislation, regulations and learning approaches increasingly focus on the international comparability of standards and qualifications. One recent development which had a significant impact on nursing education was the transformation of nursing training institutions to higher education institutions which

led, among others, to the heavy fragmentation of tasks which resulted in an increase in the nurse educators' workload (Higher Education Amendment Act, 2016; National Qualification Framework Act, 2009; Rothman et al., 2008:404). The reality is that changes in legislation and healthcare policies have a direct impact on nurse education as well as on productive time management and the roles and work life of nurse educators employed in nursing higher education institutions.

In private nursing education these challenges take place within a competitive and fast-moving health business environment. Thus, for the identified nursing higher education institution to be the employer of choice in the constantly evolving healthcare environment there is no compromise – it has to maintain optimal productivity, achieve continuous efficiency and produce competitively skilled and knowledgeable graduates. The driving force which will ultimately dictate the success – or failure – of this vision is the nurse educator staff. Since most education facilities rely on educators to deliver their service and maintain their competitive edge (Health Advance Institute, s.a.:5), nurse educators at the identified private higher education institution need to be kept professionally alive, growing and productive.

In this regard, it is imperative for this private higher education institution to attract, maintain and retain competent, knowledgeable nurse educators. The main research question formulated was: "What constitutes a suitable workload model related to productivity and job satisfaction of nurse educators?" To partly address this question, this chapter focuses on a better understanding of five key concepts relevant to this study, namely: workload, workload model, productivity, job satisfaction and nurse educator (cf. Figure 2.1). These key concepts were considered the fundamental building blocks in setting the current study parameters and for the exploration of the current workload of the nurse educators of the identified private higher education institution and for the development of a more realistic workload model.

In exploring relevant literature, a number of electronic search engines were used, including Google Scholar, CINAHL, MEDLINE, EBSCOHOST and the library databases of Stellenbosch University. The AND, OR and NOT functions were used to enhance the search level and literature sources found were reviewed for a

discussion of the key concepts. The analytical components of the selected literature on the specific and related context of the research study were considered. These analytical components were judged by deductive and inductive reasoning of the concepts to generate arguments and explanations. The exploration of these concepts assisted in identifying the characteristics, attributes, consequences and the phenomena related to workload as the core problem. In this chapter, as well as in the following two chapters, the theoretical framework developed for this study is explained.
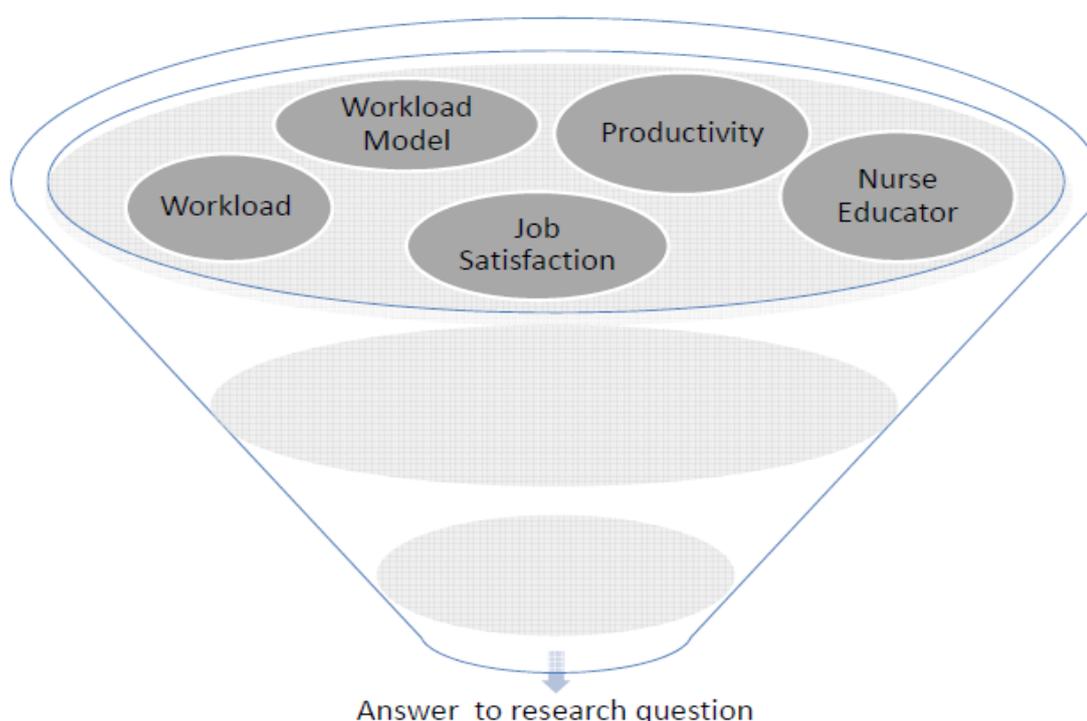
Figure 2.1: Graphic representation of the key concepts as an initial research 'filtering step'

The first step in the development of the theoretical framework was to explore the five key concepts, namely the workload (cf. sect. 2.2) (consisting of teaching [cf. sect. 2.2.1], clinical practice [cf. sect. 2.2.2], service and adminstration [cf. sect. 2.2.3] and research [cf. sect. 2.2.4]); the workload model (cf. sect. 2.3); productivity (cf. sect. 2.4); job satisfaction (cf. sect 2.4) and nurse educator (cf. sect. 2.5).

2.2   WORKLOAD

To reiterate, as the world moved from the knowledge age before 2000 to the information age in the new millennium (Silva, Sorrel & Sorrel, 1995:12), nationally and internationally broader forces have been instrumental in the many changes that have already occurred – and are still occurring – in all spheres of South African higher education, thus including nursing education. Worldwide, thus including South Africa, nurse educators at nursing higher education institutions are faced with an ongoing dilemma – a high standard of quality nursing education must be maintained (or even bettered) and therefore more work needs to be done, but with the same human resources (Langston & Cowling, 1999:28). These constraints have a negative impact on nurse educators' time and add more work to their already full workload schedules. On a personal level overworked nurse educators are less productive, they experience reduced job satisfaction and are less motivated (Soliman & Soliman, 1997:135).

The shortage of well-qualified nursing educators with the necessary professional knowledge and skills is a contributory factor to the high workload of current nurse educators in higher education institutions; it becomes especially troublesome if vacant posts are to be filled (Rispel, 2016). Therefore, it is essential to assure employed nurse educators are satisfied and feel fulfilled in their work environment. According to Vardi (2009:500), the problematic issue of work overload in nursing education needs to be addressed in nursing organisations and educational facilities because the lack thereof influences the provision of high quality education. A significant increase in workload may result in a decrease in productivity levels and the possibility of low job satisfaction (Rothman et al., 2008:404-422; Timperley & Robinson 2000:47).

In an attempt to conceptualise the workload of a nurse educator in higher education, various definitions were explored. In 1987 Kirkpatric, Rose and Thiele (1987:84) already referred to the concept 'workload' within the nursing education context as those time-consuming activities directly or indirectly related to the professional duties and responsibilities of the nurse educator as a practitioner. Rosser and Tabata

(2010:456) state workload is the actual time spent on professional activities or duties assigned to the educator.

Yuker (1984:1-5) refers to 'educator workload' as all educator activities related to the professional duties and responsibilities of higher education practitioners, namely teaching, research, service to the institution, interacting with students, professional development and service to the community. Ruby (1998:18) is of the opinion that educator workload consists of teaching, scholarship, service and professional practice and Lau (1996:96) explains the concept as a quantitative measure of the time spent on teaching, research and service activities.

This author further explains that a high workload could promote educator helplessness which may lead to demoralised educators. At the same time, a too low workload may not assist educators to explore their full potential. Allen (1997:27) sees workload as a forceful phenomenon measured by tradition in the length of a work week or the time allocation of the educator while Seaberg (1998:7) adds the workload is a critical factor dictating effort and the amount of time invested in the working life of a nurse educator. The amount of time it takes to prepare and attend to educator duties therefore seems paramount. The time concept in nursing education is related to the amount of hours spent per day/week on preparing and delivering required tasks (Soliman, 1999:3).

Traditionally, the workload of those working in higher education was described as consisting of teaching, research and service activities within the academic community (Bentley & Kyvik, 2012:529; Colbeck, 2002:43; Pohl, Duderstadt, Tolve-Schoeneberger, Uphold & Hartig, 2002:238; Ellis, 2013:303; Houston *et al.*, 2006:17; Lau, 1996:94; Mancing, 1994:31; O'Shea, 1986:20; Seaberg 1998:7; Zabriskie, Dey & Riegle 2002:4). Much information gained from literature implies teaching and research are the main focus with service delivery taking second place (Houston *et al.*, 2006:17). In terms of weight, the Simpson (2000:69) and Mancing (1994:32) divide the time of the educator into 40 per cent teaching, 40 per cent research and 20 per cent service time as a standard – this is referred to as the 40:40:20 formula.

Within the United Kindgom (UK) context, Tight (2010:207) concludes on average, academic faculty time boils down to 40 per cent teaching, 31 per cent research and 18 per cent administration.

Surveys on nurse educators' typical working hours per week vary. Seaberg (1998:7) at the Virginia Commonwealth University found educators were satisfied with working an average of 50 hours per week while in the NLN/Carnegie National Survey Kaufman (2007:296) report they worked more than 50 hours per week. Jordan (1994:16) mentions a working time of 52 – 57 hours per week for nurse faculty members – 56% was spent on teaching, 16% on research and 28% on administration and other activities. Mayes (1998:148) at the University of Kentucky cites a 48-hour work week with 75% teaching time and Gerolamo and Roemer (2011:260) report a 53- to 56-hour work week during students' block time with a 24-hour work week during breaks. Furthermore, Williams-Utz (2009:63) indicates a 56- to 58-hour work week; Griscti, Jacono and Jacono (2005:87) a 40-hour work week and Forgasz and Leder (2006:14) indicate a 49- to 55-hour work week. Academic responsibilities and educator expectations were found by several authors to be affected by the demands of nurse educators' respective departments as well as by disciplinary and individual priorities (Colbeck, 2002:45-47; Collins, 2006:24; Fairweather, 2002a:98-104; Paulsen, 2002:5-6; Simpson, 2000:69).

Kyvik (2013:10) draws attention to the fact that academic staff works much more additional hours than their normal working time. In South Africa, the Basic Conditions of Employment Act 11 of 2002 (Republic of South Africa, 2002) stipulates normal working time as 45 hours weekly. If the employee works a five-day week it will be nine hours per day (excluding a lunch break) and if the employee works more than five days per week it totals eight hours per day (excluding a lunch break). The allocation of working week hours of a nurse educator as an academic is considerably different from other professionals (Dennison 2012:301). A number of surveys indicate an average working week of more than 40 hours. For instance, a study by Kuntz (2012:777) found that many nurse educators do their work outside the usual

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40-hour work week which Ellis (2013:304) perceives is the way in which the nurse educator attempts to achieve all his/her role expectations.

In all areas of nursing education, pressure and performance expectations have increased the workload of nurse educators significantly; therefore, if educator workload exceeds 40 hours per week, the moral of a nurse educator seems to be affected by her/his heavy workload (Voignier, Hermann & Brouse, 1998:35). A survey done by Bentley and Kyvik (2012:535) across 13 countries indicated that a typical working educator week consisted of 50.5 hours in the period 1969 – 1970; 45 hours in 1992; 54.8 hours in 1994; 49.9 hours from 1998 to 1999 and 47.2 hours in the period 2007 – 2008. In this study educator time was divided into 15.6 hours teaching, 18.5 hours of research and 6.9 hours of administration.

The calculation of workload is usually based on a 40-hour work week and the estimate hours spent on teaching, service and research activities per week are calculated accordingly (Candela, Gutierrez & Keating 2015:580). A nursing education institution needs to strive for a balanced workload distribution between practical and academic responsibilities (Sawyer, Alexander, Gordon, Juszczak & Gilliss, 2000:513) which means each education institution needs its own criteria for a balanced workload (Lobo & Liesveld, 2013:277).

When Colbeck (2002) describes educator workload in terms of teaching, research and service, the author foresees two problems. Firstly, the processes of participating in teaching, research and service activities are confused with their products or with the institutional goals to which these activities and products contribute. Secondly, teaching, research and service as exclusive activities are often difficult to categorise for its singularity (Colbeck 2002:43-44). In addition, Harden and Crosby (2000:334) identified twelve roles for the changing role of the medical teacher, similar to the roles of the educators of nursing, physiotherapist and occupational therapist. Lobo and Liesveld (2013:276) expanded on this with a variety of other factors that can contribute to the increases in the workload of nurse educators and which may lead to

educator burnout. These include challenges associated with overloaded course content, the supervision of clinical students and the impact of changing technologies.

Academic and scientific work is dependent on international higher education as indicated in a study by Bentley and Kyvik (2012:529). The realities of globalisation thus also impact on the changes and developments in South African higher education institutions (Du Toit, 2000:275). This position may also be true for nurse educators as higher education practitioners in South Africa. As pointed out by Soliman (1999:2), standards and principles that have an influence on workload need to be revised regularly, must be transparent, equitable, reasonable, fair and consistent as well as recognise the demands of teaching, research and service. It thus seems necessary to implement more formal approaches to workload management due to its complexity and the increase in demands for staff equity and fairness (Barrett & Barrett, 2010:183).

Of concern to Paewai, Meyer and Houston (2007:385) is the workload challenges in higher education that are related to complex sets of interacting issues such as diverse student populations, research environments that become more competitive and escalating administrative tasks. These authors explain that, in order to understand the challenges of effective workload management, it is important to recognise the wider education environment in which educational institutions as complex organisations operate. It is evident to them that a systems concept, a systemic perspective and systemic analyses can assist with the wide array of workload challenges. They also note the reprioritisation of tasks or simply refusing additional tasks where resources are already stretched rather than attempting to solve workload problems.

Other authors mention a range of activities related to the excessive workload of nurse educators. These include teaching, supervising clinical practice, maintaining own clinical expertise, serving on committees, being active in professional associations, taking part in continuing education programmes for other nurses and research (Harden & Crosby, 2000: 334; Kordzadze, 2013:112). The incorporation of

such activities into the traditional nurse educator functions of teaching, research and service activities makes the workload of the nurse educator increasingly complicated (Cohen *et al.*, 2009:50; Ellis, 2013:303). On top of this, nurse educators also need time for their own professional development (Kordzadze, 2013:112). Ellis (2013:303), for one, draws the conclusion that it must be exhausting for nurse educators to be effectively involved in all their roles. To study a nurse educator's workload is thus complex and challenging because of dynamic factors such as organisational structure and the distribution of organisational resources. It also seems of utmost importance to base workload in nursing education on the mission of the nursing education institution and adapt it according to institutional strategies (Ellis, 2013:303).

Harden and Crosby (2000:334) and Ruth (2001:196) are in agreement that education institutions have to categorise the workload activities of educators. This is needed to ease the weight assigned to each workload activity, specifically in terms of the exact weight each category should be given of the total workload. The findings of Ruth (2001:206) and Kordzadze (2013:113) indicate differences in the distribution of the number of workload categories, their weight and time between institutions are consequences of the differences in the mission, functions, clinical priorities and research priorities of each institution.

It seems clear that concerns about nurse educators' workload are neither new nor unique (Voignier *et al.*, 1998:35), but the concept thereof is a complex issue that can be measured in a number of ways (Seaberg, 1998:8). Moreover, it is a long-standing problem of which little is known; similarly, not much is known about its management in nursing education institutions (Lobo & Liesveld, 2013:276). A study by Langford (2010:42) indicates that the measuring of workload of a nurse educator is one of the worst measured practices. Vardi (2009:505) affirms the growing dissatisfaction of educators with regard to the equitable distribution of workload and the lack of ensuring realistic work limits. On the whole, education in health care is rapidly changing (Simpson, Marcdante, Souza, Anderson & Holmboe, 2018:243) and many educators might not be effectively protected against work overload.

From the literature reviewed it seemed important to have a clear understanding of the different components and the time involved in each component of a nurse educator's workload (Soliman, 1999:3). It further emerged that it was essential to define an institution's expectations, educator roles and educator productivity in the teaching, research and service components as such divisions pose a continuing problems in higher education (Collins 2006:20). A study by Wilborn, Timpe, Wu-Pong, Manolakis, Karboski, Clark and Altiere (2013:9) confirmed expanded educator roles due to budgetary constraints, increased expectations of legislators and the administrators of a university are factors related to workload increases. From the aforementioned authors' views and findings it can therefore be concluded that more formal methods of workload measuring may assist to improve workload equity of nurse educators. Voignier *et al.* (1998:38) add that a teaching workload formula may result in a more equitable and manageable workload that will decrease job pressure and increase job satisfaction.

The perception that the equity of nurse educators' workload is associated with their job satisfaction seems solid and therefore it is paramount to find open-minded and truthful ways to investigate such workloads (Cohen *et al.*, 2009:51). Apparently, nurse educator workload and workload allocation have to be based on a clear understanding of the complex and multidimensional theoretical and clinical components of nursing education (Langmead & Kenway, 1998:29; Soliman & Soliman 1997:138; Southon & Braithwaite, 1998:24).

In the private higher education institution under scrutiny the teaching, clinical practice and service components of academic workload carried a higher weighting than the research component. This was to be expected given the business aim of the institution. In the next sections the key issues regarding teaching, clinical practice and service within the context of private nursing education are explored.

2.2.1. Teaching

This section contains an overview of the teaching component of the workload of a nurse educator as well as the challenges experienced and the factors that play a part

in the unique teaching role of a nurse educator. Teaching is a demanding, complex and time intensive activity in education (Harden & Crosby, 2000:334) and, in particular, in nursing education in private higher education. This is so because nursing teaching draws on extensive professional skills and practices as well as high levels of disciplinary expertise. Assuring the quality of such teaching means to meet the particular requirements of the nursing context and having an understanding of what it means to be an effective nurse educator. Such an understanding is critically important for the individual nurse educator, teaching support staff, the management of the institution as well as the larger nursing higher education environment (Devlina & Samarawickremab, 2010:111 & 118).

As a complex process, teaching – also teaching in nursing education – is both an art and a science which involves special skills and knowledge; nurse educators thus need to prepare themselves for their teaching role and responsibilities in nursing education (Cangelosi, Crocker & Sorrell, 2009:369). Nine teaching roles of the nurse educator are identified by Hall (1996:110), namely self-manager, subject expert, evaluator, course manager and designer, communicator, motivator, academic advisor, research supervisor and assessor. It is a challenging task for a nurse educator to teach nursing students in a class composed of students of different ages, genders, cultures, races, languages, religious beliefs and learning styles (Billings & Halstead, 2016:1).

As an integral part of the academic life of a nurse educator, apart from for classroom teaching, teaching also involves preparation, student advice, student guidance, the counselling of students, development of new curricula, developing and implementing programmes and instructional material, committee work, the setting, grading and marking of examinations as well as the maintenance of teaching records (Colbeck, 2002:43; Collins, 2006:20; Dennison, 2012:301; Mellish, *et al.*, 2003:74). This list of tasks is supplemented by Billings and Halstead's (2016:1) and Bruce and Klopper's (2016:109) contributions that nurse academics furthermore are responsible for the learning needs of students; the planning of teaching in such a way that nurse students achieve the outcomes they must achieve; the presentation of information in

structured and organised ways, various facilitation strategies as well as assessing learning and evaluating students' performances. Kauffman and Mann (2014: 12) point out that the educator often models the required attitudes, behaviour, knowledge by interacting with students, colleagues, patients and other health professionals.

The Lancet report (see Frenk, Chen, Bhutta, Cohen, Crisp, Evans, Fineberg, Garcia, Ke, Kelly, Kistnasamy, Meleis, Naylor, Pablos-Mendez, Reddy, Scrimshaw, Sepulveda, Serwadda, & Zurayk, 2010:1924) indicated that the education of professionals in the 21st century must be systems based in order to strengthen the health systems worldwide. The report further recommended informative learning for the production of experts, formative learning for the production of professional and transformative learning for the production of enlightened change agents. Transformative learning and interdependence in education was proposed in this report to achieve high quality comprehensive services in an independent world (Frenk *et.al.,* 2010:1924). The Global Health Workforce report (Global Health Workforce and World Health Organisation, 2013:28) also emphasises that health depends largely on competent health workers who can meet and deliver quality health services across the world. Similalrly, the WHO Bulletin (Campbell, 2013:887) highlighs the importance of a strategic plan for the production of a sustainable health workforce that will be fit for purpose and fit for practice towards effective universal health coverage by 2030.

Kaufman (2007:296) sees teaching as the utmost time intensive activity performed by an educator whereas in the opinions of Collins (2006:20), Dennison (2012:301) and Harden and Crosby (2000:336) teaching is more than time in the classroom. There is much truth in the latter three authors' view because a nurse educator has to stay abreast of discipline developments and keep themselves current with their discipline in order to share the latest material and information with their students. It is expected from nurse educators to have in-depth knowledge and demonstrate specific educational skills such as the development and implementation of curricula, student assessment and course evaluation (McDonald, 2010:127). Nurse educators

certainly seem to require more skills than merely the teaching of diseases and how to care for patients. They also have to understand how to create a curriculum, setting tests and assignments, how to assess and evaluate students and how to cater for different learning styles and meet the needs of students (Siler & Kleiner, 2001:398).

Since the emphasis of learning has largely shifted from teacher-centered learning to student-centered learning, the nurse educator is seen as the facilitator of student learning rather than the transmitter of information (Bruce & Klopper, 2016:194; Harden & Crosby, 2000:339). As facilitator the nurse educator uses teaching and learning approaches and strategies in which students actively participate to achieve their learning outcomes (Mellish, Brink & Paton, 2003:75; Meyer & van Niekerk, 2013:111). The role of the nurse educator (Kauffmann & Mann, 2014:19) is that of a facilitator and content expert assisting the student to reach expected learning outcomes. Another study (Albanese and Dast, 2014:65) at the University of Winconsin indicated that better learning outcomes are achieved if the educator has content expertise. The educator as facilitator thus also has to develop his/her content expertise.

Within the national context, it is not only a requirement of the South African Nursing Council for nurse educators to acquire a diploma in nursing education (South African Nursing Council, 2013a:75), but it is also considered important (Dattilo, Brewer & Streit, 2009:368) to determine whether nurse educators have the necessary skills to provide high quality nursing education. Nurse educators in private nursing higher education institutions are challenged by the impact of factors such as specific skill expectations of graduates by employers and the accreditation requirements of professional bodies for nursing students. Currently, nursing students experience new challenges in the healthcare environment due to new technologies, extreme changes in the delivery of healthcare and decreases in the length of stay of the patient in acute care settings (Skiba, Connors & Jeffries, 2008: 226-227). Nurse educators are thus required to come up with innovative high quality educational methods and activities to prepare nursing students who are competent to function and execute tasks successfully in a labile health environment.

What seems clear is that teaching in private nursing education is not only the effective transfer of knowledge and skills, but that learner-centeredness requires professional dedication from the nurse educator in the planning, implementation, facilitation and evaluation of the performance of nursing students (Harden & Crosby, 2000:339). Because the skills of critical thinking are carried by the content of a subject (Billings & Halstead, 2016:1; Meyer & Van Niekerk, 2013:81), nurse educators must respond to a variety of student needs, use various mediums of stimulating teaching technologies, be creative in the application of different learning strategies and teaching methods for the integration of theory and practice as well as to improve the personal and professional development of a nursing student.

Student- and practice-based teaching is seen as a call for nurse students to be afforded learning opportunities involving learning experiences from real life. Such learning experiences need to motivated and assisted by applicable thinking strategies, supported by thinking tools while misperceptions should be corrected by providing immediate, continuous and positive feedback (Booyse & Du Plessis, 2008:31). What seems to be expected is for nurse educators to use a range of teaching methods and technologies complemented by new ways of communication with the different groups of nursing students (Benson & Samarawickrema, 2009:119).

However, in the learning environment of today it is not possible to teach all the content of a nursing programme to nursing students; therefore, the nursing educator guides (facilitate) and manages the teaching-learning situation. This requires a fundamental shift from teacher-centred learning to student-centred learning (Harden & Crosby, 200:339). The available contact time in class is not always enough to teach the student nurses everything they need to know. For this reason the students are led by the nurse educator to gain the necessary knowledge independently through, for example, theory practice integration and-problem solving in the workplace. Within nursing higher education the nursing student requires more than the traditional theoretical classroom teaching. Hence, the nurse educator is

challenged to remain credible within both theory and practice (Gillespie & McFetridge, 2006:639).

Compared with research and service, Ellis (2013:303) and Candela *et al.* (2015:586) consider teaching as the largest component of the assigned workload of the nurse educator. The findings of studies by Keys and Devine (2006:236), Paulsen (2002:6) and Seaberg (1998:9) prove teaching is the most important component of the workload, yet it constantly has to compete with other educator work in the allocation of educator time. In the opinion of Du Plessis (2005:1379), teaching is often times regarded as an additional source of income to support research as a business rather than giving recognition to teaching as a valuable and high-status career in its own right.

The vast difference of 63% to 73% in the teaching time of different types of education institutions is a huge obstacle in the measuring and calculation of teaching load (Collins 2006:20). Collins's (2006) findings resulted in several institutions measuring teaching workload in terms of either student contact hours or the conventional credit hours. The Merriam-Webster Dictionary (2018:Page?) defines a credit hour as "the unit of measuring educational credit usually based on the number of classroom hours per week throughout a term". Most often credit hours are used as a general measure for comparing activities and to inspire education institutions to greater efficiency. This approach, in the opinion of Wellman and Ehrlich (2003:1-4), may not be an accurate indicator of educator time.

The findings of Roberts and Turnbull's (2004:283) and Zibrowski, Weston & Goldszmidt, (2008:874) studies evidence scholarly productivity is limited with a high teaching load while Durham, Merrit and Sorrel (2007:184) found high teaching workloads are associated with increased responsibilities such as course coordination. Furthermore, a survey done by Ntshoe, Higgs,Higgs and Wolhuter (2008:398) indicates undergraduate teaching demands more planning, marking and administrative duties from a nurse educator. These authors further state it is expected of a nurse educator as an academic to undertake the role of an

administrator, a manager and support staff which propels the nurse educator's teaching role into a more demanding and diversified role with a much higher workload.

Governments and institutions are nowadays willing to recognise the important role of quality education in higher education as well as the impact thereof on student preparation for their future contribution to society and the economic performance of a country (Armstrong, 2017:135). Nursing students must be able to process and evaluate large amounts of information as this enables and empowers them to make informed clinical decisions for safe patient care. Preparing nursing students for the complex healthcare environment of today requires the nurse educator to guide the former in high order learning and thinking skills. Nursing students need to be equipped with these two particular skills not only for the private healthcare environment, but also for public healthcare environments.

In summary, it seems although teaching is one of the most important components of the nurse educator's workload, it is also a complex process in nursing education. It appears to be a time-intensive activity; teaching draws on extensive professional skills and practices as well as high levels of disciplinary expertise. As nursing higher education students currently require more than traditional theoretical classroom teaching, nurse educators are challenged to facilitate student-centered learning and be more creative in the application of learning strategies for the integration of theory and practice to promote critical thinking. Of utmost importance in this process is student support, continuous positive feedback, teaching in real-life situations and the correction of the misperceptions of students via feedback. These expectations contribute significantly to the workload of a nurse educator.

In this section the complexity of the teaching component of the workload of a nurse educator was outlined.

2.2.2.   Clinical practice

Nursing as a practice-based profession with academic and clinical dimensions requires theoretical and clinical education that is especially important for the identified private higher education company to provide quality healthcare to its patients. The majority of research conducted to date focused on the teaching, research and service component of the nurse educator's workload and did not include the clinical component of nursing education. Literature has pointed out that the clinical practice discipline, as part of the workload of nurse educators, had not been investigated because the clinical workload is associated more with the transmission of clinical practice information in preparation of students for practical placement in the nursing units where the students are placed on a regular basis (Harden and Crosby, 2000:334-338).

In private nursing education and specifically in the private higher healthcare environment, the clinical practice component of the workload of a nurse educator is a time-intensive activity due to the challenges of mentoring programmes in the clinical practice environment of the identified private healthcare company. In the South African Nursing Council's training and education regulations regarding the new nursing programmes, clinical practice is a requirement. The SANC keeps the nursing education sites responsible for the clinical accompaniment and clinical supervision of nursing students in the clinical practice environment (SANC, 2013a:103-106). In higher education, with the paradigm shift from teacher-centered learning to student-centered learning, nurse educators are challenged to facilitate learning and create an learning environment which is essential for the achievement of the learning outcomes of nursing students in the classroom as well as in the clinical practice environment (Bruce & Klopper, 2016:194; Harden & Crosby, 2000:339).

Ruby (1998:20) views clinical practice as a professional practice and refers to it as 'the forth domain'. The consulted literature showed the terminology related to the clinical practice environment varied considerably. The term 'faculty practice' is used by Premji, Lalani, Ajani, Lakhani, Moez and Dias (2011:880). Identifying professional practice as 'clinical teaching', Schuster, Fitzgerald, McCarthy and McDougal (1997:154) assert it is an important component of nursing education which takes

place in the hospital as well as in the community environment. The nurse educator is expected to be a teacher and a clinical expert as confirmed by the aforementioned authors. However, clinical teaching in itself is perceived as a demanding job. Saxe, Burgel, Stringari-Murray, Collins-Bride, Dennehy, Janson, Humpreys, Martin and Roberts (2004:166) see clinical practice as a formal contractual arrangement between the private higher education institution and the clinical facility. These authors are of the opinion that compliance with this arrangement addresses the needs of the patients in the clinical facility as well as the teaching, practice, administrative and research needs of a private higher education institution.

In the traditional sense, a nurse educator is responsible for teaching and the nursing supervision of nursing students' patient care in a nursing unit (Elliot & Wall 2008:580-581; Rudy, Anderson, Dudjak, Kober & Miller, 1995:78). These authors acknowledge the move from nursing colleges to the tertiary education system (cf. Chpt.1 sect. 1.2) was necessary due to the extended development and growth of nursing education within the hospital setting. Educator practice is regarded by Becker, Dang, Jordan, Kub, Welch, Smith and White (2007:51) as the direct or indirect provision of nursing care with the aim of integrating teaching, professional practice, scholarship and service. It is also viewed by the American Association of Colleges of Nursing (AACN) (2005:20), Premji *et al*. (2010:880-881) and Williams and Taylor (2008:900) as an important part of the educator workload and for this reason the AACN and mentioned authors allocate up to 20% of a nurse educator's work time to educator practice. They strongly feel educator practice must be part of a nursing education institution's mission, goals and strategy. In addition to the normal educator workload, the AACN (2005:25) also expects from their members at a nursing education facility to stay updated in their clinical expertise and to do student accompaniment in the clinical practice as part of the educator work.

The South African Nursing Council (SANC, 1992:7) emphasises the crucial importance of adequate clinical accompaniment of student nurses in the clinical practice environment. According to the SANC (1992:7), such clinical accompaniment promotes theory and practice integration and also helps with the development of a

student nurse from a dependant to a competent independent practitioner. The practice of the educator of a nursing education facility can also be used to build relationships between the academic and clinical sectors, integrate theoretical and clinical systems, close the theory/practice gap and create an opportunity for change in the attitudes, beliefs and values with regard to direct patient care (Premji *et al.*, 2010:876).

For Becker, Dang, Jordan, Kub, Welch, Smith and White (2007:45) the clinical practice environment provides educational opportunities to the students and practice sites for the nurse educator, it enhances the clinical competence of the nurse educator and makes provision for research opportunities for students and the nurse educator as academics. The authors emphasise it is important to consider clinical practice responsibilities concomitant with the amount of time spent on clinical practice which they argue must be negotiated so that it can be accurately included in a educator workload formula.

With the move of nursing education into higher education it created not only new priorities for the nursing faculties but also resulted in nursing departments of nursing emerging as one of the biggest growing areas in higher education. The aim of colleges and universities is to combine forces by working together through teaching, conducting research and enhancing services to make the clinical practice and the maintenance of clinical competence a more valued activity (Rudy *et al.*, 1995:78). To be effective teachers, institutional education in clinical courses necessitates educators to keep abreast of all clinical changes (Harden and Crosby, 2000:338). Although Cohen *et al.* (2009:51) support the view of various authors that nurse educators have to practise to maintain their clinical competence they identify it as a concern in the balancing of nurse educators' workload.

Nursing education institutions have a choice between including clinical practice as part of the teaching load or to have it in addition to the teaching load (Collins, 2006:30). At the time of study, the particular private higher education institution included clinical practice activities as a component of the workload of the nurse

educator in order to comply with legislation. As a practical profession, nursing needs the clinical environment as the primary place where the nurse educator develops knowledgeable and skilled nurse practitioners. However, it is an enormous challenge for nurse educators to meet academic expectations as well as to maintain their clinical skills (Schuster *et al.*, 1997:154; Rudy *et al.*, 1995:78).

The majority of nurse educators' lack of practical experience is the result of nurse educators who do not practise (Barger, Nugent & Bridges, 1992:263). This situation worsened with the move of the nursing education from hospital-based education to higher education because the teaching practice model had to make room for a teaching scholarship model that also affected the nurse educator in terms of maintaining clinical competence (Speziale, 2001:84). From this author's argument it may be deduced that if the nurse educator as an academic remains active in the clinical practice environment, he\she will be capable of sharing current nursing practices better in the classroom as well as in clinical practice. Subsequently, it will result in a better informed student and healthcare workforce.

In a study done by Steele (1991:15) on the attitudes about educator practice and the perceptions of nurse educators' role and role strain, it was found the practicing educator believed the active involvement of nurse educators in the clinical environment increases teaching effectiveness and they experience more confidence in their other educator roles. The findings of Steele's (1991:20 & 21) study further indicated some nursing education institutions consider clinical practice as a form of services rendered and not as a role of the educator. The quality of nursing education is determined by the educational skills of an educator, theoretical understanding of the educator, application of the theoretical understandings in the practice environment and the educator being current in clinical practice (Shuttleworth, Rudd, Smith, Combs & Wain, 2008:703).

It can be posited that the nursing education educator workload is unique. To demonstrate, nurse educators are required to constantly update their clinical skills because it is vital for their teaching- and clinical-related programmes. Therefore, it is

pivotal for the education institution to support them in completing the required clinical hours and to include these hours in their workload calculations (Laustsen, Martyn, Melander, Ridenour & Savrin, 2015). Clinical teaching is usually not within the framework of reference of nursing education faculties, yet it must be done at the same time as the theoretical component under the supervision of the nurse educator and the mentor in the clinical practice (Republic of South Africa, 2008a:22; South African Nursing Council, 2013a:22). For these reasons, it is emphasised that clinical contact hours should be taken into account when calculating workload because it is part of the workload of the nurse educator.

The importance of the clinical practice discipline, the extensive student instructional time clinical education requires and the programme workload that does not always provide for the assessment time in credit hours are emphasised by O'Shea (1986:21-22). The clinical discipline of educator workload varies from the academic discipline as indicated by quite a number of educator publications (Adams, 1995:310-311; Harden & Crosby, 2000:337; Ruby, 1998:18). Workload is identified as a major challenge to clinical practice because in nursing, educator practice turns out to be valued and recognised as an integral component of the educator's role expectations (Rudy *et al.*, 1995:78; Sawyer *et al.*, 2000:513; Speziale, 2001:87).

Although the university sector admits the clinical practice role of the nurse educator as vital, this sector seems to be more concerned with the academic and research profile of the personnel and the profession. Harden and Crosby (2000:337-338), on the other hand, recognise the important role of the educator in the transmission of information which is directly relevant to the clinical practice teaching of the students in the nursing unit. Moreover, Budgen and Gamroth (2008:273) state the fundamental task in a practice-based profession is to ensure students have adequate academic as well as real-life training because it will assist them in the development of specific knowledge and skills so that they can manage the work in the practice environment (Budgen & Gamroth 2008:273).

Clinical mastery and credibility in the area of practice is crucial to nurse educators as indicated in the nursing education and training standards of the SANC (2013a:20). The advantages of the clinical involvement of nurse educators in the clinical environment are outlined by Elliot and Wall (2008:584) who lists the benefits as staying in touch, bridging the theory/practice gap, ensuring the maintenance of clinical skills and improving relationships with trained staff. The stance of this author is very clear – more clinical involvement will have to be created by nurse educators in a culture which values and protects clinical time. The importance of allocating adequate time in the development of clinical skills that will meet the ever-increasing expectations of a very demanding healthcare environment is further confirmed by Elliot and Wall (2008:584).

In addition, Crotty (1993:460-462) claims clinical practice is one of the key aspects of a nurse educator's role and functions. Crotty's (1993:460) study findings imply nurse educators spend only half-a-day per week in the clinical environment to support clinical staff and visiting students. Griscti *et al.* (2005:85) and Shuttleworth *et al.* (2008:704) both identify the lack of time as the primary barrier preventing nurse educators from fulfilling their clinical role in practice. Clifford's (1995:14) observation is that a nurse educator spends too much time on administration and management at the expense of clinical contact.

In this section the uniqueness and complexity of the clinical component of the workload of a nurse educator in nursing education was outlined. Clinical practice activities must be included in the workload of the nurse educator. Similar to teaching, clinical practice is an important but also time-intensive component of the nurse educator's workload. The clinical practice environment is essential for theoretical practice integration during the clinical guidance of nursing students and their development to practice as independent practitioners. From the literature consulted, universities seemed to admit the clinical practice role of nurse educators is vital. Their concern with teaching and the research profiles of the personnel and the profession was apparent. Literature confirms clinical practice must be part of a nurse

educator's workload. Although a challenging task, the nurse educator has the responsibility to stay current in her/his field of clinical expertise.

2.2.3   Service and administration

Service and administration is part of the work life of a nurse educator at the identified private higher education institution. The administrative responsibilities seem to carry more weight than the service responsibilities. Administrative responsibilities include all student affairs (such as record-keeping activities and the maintenance of student records) while service obligations relate to the institutional, professional and private hospitals of the private healthcare company. The nurse educators of this private higher education institution undertake the service and administration roles to carry out the academic work of each of the seven nursing education sites (between two to 15 nurse educators per nursing education site).

Nursing education institution services and administration, introduced in higher education to assist the growing economy in the nineties, became more important and essential as the current century moved through its first and second decades. Towards the middle of this second decade, as service activities increased over time, educators had to cope with the reality that changes due to growing service and administrative demands were becoming more and more inevitable (Mamiseishvili & Miller, 2015:281). The literature search revealed that of the three most notable functions in higher education institutions, namely teaching, research and service, the teaching and research functions generated wider interest among researchers and academics than the service and administrative function. This was specifically apparent in health sciences (Brazeau, 2003:1; Lawrence, Ott & Bell, 2012:326; Neumann & Terosky, 2007:283).

In Brazeau's (2003:1) opinion, although different definitions of 'service' are portrayed in literature, no one definition covers service and administrative activities from education institution governance to public outreach satisfactorily. The author feels service includes a broad spectrum of activities such as advising students, participation in governance bodies and student affairs to name a few. Brazeau

(2003:3) and Ward (2003:3-11) agree that the service and administrative roles of the educator in higher education are not clearly defined and that academics attach different meanings to the service and administrative function of educational institutions when they discuss or talk about it. Neumann and Terosky (2007:282) regard service as an ill-defined concept playing an insignificant role in promotional processes and the reward structures of institutions whereas Blackburn and Lawrence (2002:222) define service as a general concept used for everything that is neither research nor teaching. The Webster's new World College Dictionary (2014) define administrative duties as the tasks and activities done by a nurse educator as part of the daily operations of the nursing education institution of which the most of the administrative duties is clerical like filing and photo copies.

Due to the unclear definition and understanding, the service role is often considered as less meaningful and important than the teaching and research roles of a nurse educator. According to Ward (2003:12), the type of institution determines the internal and external service functions that may, depending on the time and place, have different meanings and interpretations. For example, it can inter alia refer to service to the profession, service to discipline, service to the institution or service to the students. Bensimon, Ward and Saunders (2000:36) argue that service and administration is difficult to quantify and they feel educators often receive little departmental guidance when their service and administrative workload and the development of their service portfolios are considered.

Importantly, in South Africa effective academic administration and general management within nursing programmes are requirements for nursing students registered with the South African Nursing Council (SANC, 2013a:80). In other words, nurse educators' administrative workloads are just as important as teaching and research to render quality teaching and learning (Zibrowski, Weston & Goldszmidt, 2008:874). These authors further found that there is a relationship between reduced administrative workloads and scholarly productivity. The process of administration is seen as a collection of activities that augment nursing education; it is a service provided to students and colleagues so that students can be trained and prepared

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for professional practice (Mellish *et al.,* 2003:282). The administrative responsibilities of a nurse educator include counselling of students with problems, preparation for class facilitation, being creative in teaching presentations, keeping lecture records, reporting on student progress and setting and marking tests and examinations to name a few (Mellish *et al.,* 2003:282).

The administration component of the educator workload can further be separated into institutional and public activities. The institutional activities are seen as departmental like committee work, liaising with student organisations, organising seminars and administration duties of the educator (Collins, 2006:23; Harden & Crosby, 2000:334) while the public activities is seen as canvassing of prospective students and cooperating with clients and professional bodies (Collins, 2006:24; Gordon, 1997:68;).

The service and administrative role of the educator is regarded by Williams-Utz (2009:63) as less important than the teaching and research roles of the educator; therefore, the majority of educator spend more time on research and teaching than on service and administration (Pfeifer, 2016:238). This mismatch between the service and administrative demands and the value associated with services and administration in the institutional reward structures may lead to dissatisfaction among educators (Jaeger & Thornton, 2006:346). According to Brazeau's (2003:2) interpretation, this mismatch occurred because the time spent on service and administrative activities gradually and quite unnoticeably increased as the student numbers grew until fortuitously it became a tangibly challenging issue. Therefore, it is time to rethink and get a better understanding of the nature and implications of service and administrative activities and how nurse educators can effectively document these activities (Brazeau, 2003:2).

Many service activities are in the form of ad hoc projects. It is a challenge for nurse educators to record the impact and value of the service due to insufficient guidelines on how to document ad hoc projects (Pfeifer, 2016:250). Nonetheless, the service activities of the nurse educators influence their workload and have to be calculated

as such in workload formulas (Williams-Utz, 2009:63). The administrative responsibilities of nurse educators are substantial and increase their workload with two hours per week and an additional seven to 10 hours per week if the educator has to maintain clinical skills (Ellis 2013:305). It is evident from research done by Tight (2010:211) that a considerable amount of academic workload pressure is caused by the increasing impact of administrative demands.

From the above, it seems obvious that over time legislation has had a vast influence on the increase of administration and service duties of a nurse educator; therefore, it currently constitutes a major component of the workload of nurse educators. Administration and service are not clearly defined within academe and its role in higher education and therefore it differs between specific institutions. The type of business usually determines the internal and external administrative and service functions. There is a vast difference in the service and administration responsibilities between public and private higher education institutions. Public universities, for instance have a separate department dealing with administrative matters such as student registration and the faculty deals with the service activities such as in educational and research projects. From a business point of view, it is considered more effective if the nurse educators at the nursing education sites of this private higher education institution perform most administrative and service tasks with the assistance of an administrative assistant to manage the minor day to day clerical duties like venue bookings.

2.2.4   Research

The research role is one of the many important roles a nurse educator must fulfil. In South Africa, this is not much practised in nursing higher education and even less in private nursing higher education. As an accredited private higher education institution making provision for research in institutional policies, it is not just legislative pressure that results in research, but it is also one of the nursing education and training standards of the South African Nursing Council that a nurse educator has to engage in research to the benefit of the nursing education institution and the students (SANC, 2013a:80).

This role includes participation in research and the conduction thereof, the provision of research consultation to colleagues and publication and presentation of scholarly papers (Mellish *et al.*, 2003:74). These authors assert the basis of a scientific body of new knowledge is research and no profession can be evaluated or improve its control without it. Therefore, the importance of research as a scientific activity in nursing education cannot be disputed. Of course international-based research is of value, but it cannot always be applied in the South African context, due to the transformation of education and training and health care reform in South Africa (Geyer, 2017a:64-89). Hence, it is necessary and urgent to provide evidence-based practice for the growth and promotion of the nursing discipline in South Africa (Bruce & Klopper, 2016:113).

Edgerton (1993:11), who re-examined faculty priorities in the early nineties, concludes many higher education groups (Academics) believe the teaching workloads in research universities decline because of the pressure by the faculty reward systems to conduct research even if it has no value to society. A study by Steinert, Nasmith, McLeod and Conochie (2016:142-149) found heavy administrative and clinical workloads as major challenges to educator research programmes. Naidoo and Mthembu (2016:216) explored and identified the high teaching and clinical workload roles of the nurse educator as stumbling blocks in the available time for doing research. Time was also indicated as a barrier for research and the development of scholars in research by Zibrowski *et al.* (2008; 872). However, an increased interest in the development of knowledge through research became an important element in higher education in the late nineties and beginning of the 21st century. Consequently, the important comprehensive role of research also became a key component of the workload of universities (Brazeau, 2003:2). The contribution of research to the production of knowledge and high skilled graduates in South Africa, as well as the contribution to the worldwide knowledge economy, was confirmed by another study (see Naidoo and Mthembu, 2015:216).

According to (Brazeau, 2003:2), the responsibility of universities is not only to generate new knowledge, but also to analyse and apply this knowledge to all sectors of society. This emphasis on research calls for a shift away from faculty work and the aspects of faculty roles and local concerns of teaching toward research to build a more unique and global knowledge base (Ward, 2003:54) from which nurse educators, academics and nurses can draw upon to advance the service of humankind (Schmidt Bunkers, 2000:116).

Nurse educators have to incorporate research findings in their lectures and make it part of their professional role. Collins (2006:22) found some research institutions decrease the teaching workload to accommodate the required time for research. However, faculties find it difficult at times to balance teaching and research activities when considering an average of 15% to 27% of their workload is spent on research activities (conducting research and preparing articles) (Collins, 2006:21). Bazely (1994:122) who argues that conducting research is as complex as teaching, states in the older universities more time is spent on teaching than on research.

Mancing (1994:31) divides research into scientific research, humanistic scholarship and artistic creativity. The author sees research as a product for publications and not as a process per se. Varghese (2006:68) agrees that research is highly important and adds the importance of research cannot be overlooked because it is central to the work of a university and the production of knowledge. If research is as important as studies imply and it is a faculty responsibility, Simpson (2000:72) suggests the only way to generate an interest and promote research, is to reduce the faculty workload.

The Hanover research report lists socialisation, content knowledge, basic and advanced research skills, simultaneous projects, orientation, autonomy and commitment, work habits and motivation as individual characteristics facilitating research productivity (Hanover Research, 2014:9). Obviously then, it is important for enough time to be made available – and allocated according to the guidelines and principles of the institution – for nurse educators to spend on research (Bentley &

Kyvik, 2013:329). Stating the duration of time made available is usually insufficient and the allocation of this time for research is very rare, Bentley and Kyvik (2013:346) affirm their statement by mentioning a study they conducted across13 different countries. The results of their study indicated a substantial variation in the number of hours (an average of 12.2 – 22.5 hours per week) devoted to research within and between these 13 countries. Their results further revealed due to lesser engagement in research, considerably less time was spent on research in medical science.

Ostlie (2010:1) believes it is critically important for a faculty to stay active scholars in their specific disciplines as they model the fundamental importance of exploration and research for the undergraduate student. The evaluation of scholarship of performance is not an easy task, thus the traditional methods of assessing scholarship depend on the number of publications and the status of the publication source (Braxton & Del Favero, 2002:20). Four domains of scholarship assessment are highlighted by Boyer (1990:60), namely scholarship of discovery, scholarship of application, scholarship of integration and scholarship of teaching.

On the other hand, Fairweather (2002a:99) supports the non-traditional value approaches of evaluating teaching and research activities of a faculty. In the opinion of the author, these methods contribute to an increase in the faculty workload and the time spent on these evaluations negatively impacts on the teaching and research time of a faculty. Candela *et al.* (2015:587) comment the demand to conduct research, which is time-consuming, should be considered with the calculation of the workload of educators. These authors therefore feel that organisational support is vitally important in research if it is expected from the nurse educators to generate new knowledge, promote the future of the nursing profession and healthcare as well as the organisation's mission.

The role of research in nursing and nursing education cannot be diminished because it plays an important role in expanding the knowledge base of the nursing profession and guides nursing practice. It is not only necessary for nurse educators as academics to conduct high quality research, but also to renew their motivation to be

devoted to the teaching and the preparation of nurses for the present and the future. An environment must be created to give credit to both teaching and research so that both can flourish (Kelly, 2002:28). According to Varghese (2006:68), evidence shows that little research is done in private higher education institutions due to the costs involved. The writer points out it are important for private higher education institutions to maintain a balance between research and education so that they can remain viable partners in the academic community.

A nurse educator who conducts research regularly introduces research-based material to the students in the classroom (Tierney, 1999:58). Therefore, it is an essential need to set time aside for research. Research is critically needed in nursing education to prepare the nurse of the future to provide highly skilled quality care to patients (Candela et al., 2015:587; Dennison, 2012:301).

To conclude, worldwide the time spent on research varies between institutions as well as between the different world countries. Regardless of these differences, research remains a very important aspect of workload for generating new knowledge and to ensure the survival and development of a science. In the nursing profession, research is not only important as a scientific activity in the development of the nursing profession, but also in nursing education, especially in nursing private higher education. Hence, nursing education institutions have to make provision for research time in the workload of nurse educators.

2.3.   WORKLOAD MODEL

Nurse educators have to facilitate learning in a way that students become professional nurses who are "empowered and emboldened to become future leaders in the profession" (Coetzee & Heyns 2016:1). Hence, the nurse educator's main purpose is to facilitate learning in each of the programmes offered at the private higher education institutions by planning and implementing actions "to refine programmes so as to enhance the knowledge, skills and academic outcomes of students" (Coetzee & Heyns 2016:1). However, for nurse educators at the identified private nursing higher education institution to be successful instruments of change

and achieve this goal they need a tool to guide them, namely a workable workload model. Workload models are guides utilised by nurse educators to meet the demand of educating "responsive, ethical, and intelligent knowledge-guided nurses" (Schmidt-Bunkers 2000:116). According to this author, "nursing theory-based education, practice and regulation models" are "prototypes for nursing, providing a blueprint for creating nursing theory-guided practice, education, research and regulation" (Schmidt-Bunkers 2000:116).

Through observations and preliminary studies done on current workload models it became evident that none of these existing models fitted the unique profile and needs of nursing educators employed by the identified private higher education institution. This was a definitive finding which resulted in the current inquiry to determine which existing needs-based workload model for nurse educators within a systems theory and expectancy theory framework would be a suitable workload model to revise for the nurse educators in private higher education to improve productivity and job satisfaction.

For the nurse educators employed at the identified private higher education institution the teaching-learning transitions and changes collectively led to almost insurmountable challenges in their work and professional life simply because no current faculty workload models could be found that fitted the unique educator work profile in private higher education institutions. Consequently, the workload of nurse educators at the nursing private education institution kept on escalating while their productivity and job satisfaction as professionals and their quality of life as human beings plummeted. This intolerable situation obviously necessitated the development of a suitable workload model that could contribute to improved productivity, job satisfaction and a healthier overall lifestyle.

It was of the utmost importance to clearly identify and include all aspects and vital components within the framework of a workload model for nurse educators (Barrett & Barrett, 2008:4; Waldrop & Chase, 2014:97). Following is a discussion of workload models that were investigated and evaluated but found unsuitable for the unique

needs of nurse educators in the nursing private higher education institutions. The discussion starts with a brief overview of what constitutes the concept 'model' in a professional educational practice.

A model is perceived by Bruce and Klopper (2016:43) as one of the types of conceptual frameworks representing concepts and statements in a logic way to describe a phenomenon. Walker and Avant (2011:126) describe a model as a symbolic representation of practical experience while Brink et al. (2012:26), Polit and Beck (2012:128) and Pilot and Hungler (2004:108) are in agreement that a model is a symbolic visual illustration or framework of reality providing a schematic representation of the interrelationship among concepts by using boxes, arrows, other symbols and/or diagrams to represent an idea. In the opinion of all these authors a model assists with the structure and the way a phenomenon is viewed.

The building blocks used in a model comprise concepts with minimal words (Brink *et.al.*, 2012:27) to figuratively represent the reality in order to make the phenomenon of interest more understandable and visual (Polit, Beck & Hungler, 2001:31; Polit & Hungler, 2004:108). In their book, Knowledge development in nursing: theory and process, Chinn and Kramer (2015:159) define a model as "a symbolic representation of an empiric experience in the form of words, pictorial or graphic diagrams, mathematic notations or physical material". A conceptual model thus graphically presents key concepts and statements as well as the relationship between the key concepts and the statements (Polit & Beck, 2012:722).

According to Vardi (2009:505), the contact hours workload-based model, actual hours workload-based model and points workload-based model proved to be useful in equitable workload distribution, but these models do not protect an educator from an extensive overload of work. The results of a survey done by Dennison (2012:301) indicate that the workload of a nurse educator should be distributed fairly and equitably according to the requirements of the discipline and the assignment. Appropriate time ratios should also be allocated and considered. In Australia workload models form part of negotiated requirements within employment

agreements (Boyd, 2014:316). From notes on evaluating workload models it became clear workload models containing workload calculated in units, objectives, targets or outputs as a measure could not be used because these models offer no safeguard against work overload and they do not provide realistic measures of time.

Voignier *et al*. (1998:35) investigated research studies on nursing education focusing on the way nurse educators spend their time as academics, the manner in which faculty time was distributed and the development of faculty workload formulas during the seventies and eighties. Subsequently, these authors developed a formula which focused on a full time 100% teaching workload. A workload formula with realistic weighting to clinical teaching and classroom teaching was developed by Crawford *et al*. (1983:285) that acknowledge the differences in the two types of teaching as well as allowing two different preparation time periods for each of these types of teaching: firstly, two hours of preparation for each hour of lecturing (2:1) and secondly, one hour of preparation for each three hours of clinical teaching (1:3). This formula of Crawford *et al.* (1983:285) contains factors which account for the number of hours per weekly lecturing as well as seminar, lecturing and seminar preparation time; the number of hours spent weekly in clinical and laboratory time; the average weekly teaching load and preparation time for the whole university; the number of weeks in a term and the number of units for the teaching load.

The formula developed by Kirkpatric *et al.* (1987:85) used units per clock hour per week to allocate time for teaching, research, service and other activities. These authors found it difficult to determine the appropriate number of hours worked per week to be used in their formula; therefore, the units per clock hour was used which did not make provision for variation in teaching methods, scholarly activities and preparation time. The problems of faculty overload, dissatisfaction, lack of learning or student perception of faculty disinterest were not addressed by workload formulas according to Grams and Christ (1992:99). Therefore, these authors argue faculty workload formulas contribute only to the hierarchical structure of the institution and do not address the interests of individual faculty members.

The inappropriateness of these workload formulas for use by nurse educators in nursing private education institutions is noted. Firstly, the individual uniqueness of faculty members is not recognised due to a false assumption that they all have equal opportunity to achieve academic goals according to standard guidelines and the same amount of time. Secondly, the changing clinical teaching environment is not accounted for in these workload formulas.

Collins (2006:27) states a workload formula is the best approach for establishing a nursing faculty workload policy. A clinical practice workload formula was calculated by Speziale (2001:87) at a rate of three credits for every four hours of practice. Schuster, Fitzgerald, McCarthy and McDougal (1997:155) mention in their survey the huge difference in clinical contact from one to three clinical hours for each credit. They therefore suggest a ratio of eight to 10 students per clinical practice contact session their view being that a larger student group will influence the quality of clinical education per student. Rudy, Anderson, Dudjak, Kober and Miller (1995:78) allocated four hours per week as an appropriate amount of clinical practice time for nurse educators to spend in practice.

When an educator supervises a group of students in one or more nursing units, a nurse educator to student ratio of 1:6 to 1:10 is suggested by Budgen and Gamroth (2008:274), Lobo and Liesveld (2013:276) and Schuster *et al.* (1997:156). The educational guidelines of the Texas Board of Nursing (2013) suggest a nurse educator ratio of no more than 1:10 students per clinical group and if the nurse educator is supported by an assistant 2:15 student per clinical group. Schuster *et al. (*1997:154) feel the nurse educator to student ratio which can be safely managed by a nurse educator in the clinical environment may be the faculty's decision or it can be a standard indicated by the legislative bodies.

The results of a study conducted by Cowdery and Agho (2007:73) reveal credit hours are used as metrics in the majority (87%) of health education programmes to measure the workload of educators. Ellis (2013:304), Keys and Devine (2006:236) and Kordzadze (2013:117) are of the opinion that credit hours are used to measure

student learning and development when measuring the teaching workload of the educator. Credit hours can therefore also be used to measure clinical workload. One workload credit hour is provided by Ellis (2013:305) for two to three hours of clinical teaching.

Ehrlich (2003:46) comments credit hours may work well in the measuring of lectures, but the application thereof is rigid and therefore it is not appropriate to measure research and service. The study of Kordzadze (2013:117) shows credit hours to be more accurate. It reflects transparency and also calculates as countable units all the work activities and components of the workload of a nurse educator as an academic. This author's conclusive opinion is that workload by credit hours is logical and therefore its implementation is easy to understand. O'Shea (1986:20), on the other hand, points out that faculty workload indicated in credit hours do not reflect the contact hours of a programme which also has a clinical practical component. In support, Collins (2006:26) comments that student contact hours provide the best assessment of the teaching activity.

Traditionally, the nurse educator's workload has always been regarded as the time spent by the nurse educator as an academic with the student based on contact hours (Burgess, 1996:66). Boyd (2014:316) feels academic workload is generally calculated in hours or units. Simpson (2000:70) recommends nine hours per week as effective instruction time for graduate programmes, 12 hours per week for undergraduate programmes with no more than six separate programme preparations annually – but this excludes research, counselling or unconventional ways of teaching.

Cohen *et al.* (2009:52) suggest preparation time of two to three hours for each hour of instruction which must be added to the workload of the nurse educator. However, this suggestion does not include the clinical practice of nursing education. Barret and Barret (2007:471) seem to be certain if hours are used as a measuring unit, educators will work according to the prescribed hours and not outside of it. For Burgess (1996:69), time-based hours do not truthfully reflect the actual workload

hours. Lyons and Ingersoll (2010:144) are also uncertain about the effectiveness of a time-based approach. Their stance is that enforcement of a time-based approach may be a challenge to management.

Vardi (2009:506) sees time-based workload models as the comprehensive coverage of academic work which is directly linked to human resourcing and costing of units. In a study done by Soliman (1999:4) the general feeling was that a time-based model in the form of a detailed workload chart of the components of the workload will assist with the analysis and planning of individual workloads as well as the development of academic workload profiles. This information mentioned by the author may be useful in effective time management and the measuring of productivity. Studies conducted by Mahoney (1996:35) as well as Soliman and Soliman (1997:136) show a link exists between an increase in the workload of a nurse educator as an academic and a decrease in job satisfaction and productivity of him/her as a nurse educator. An effective, credible and transparent workload model will require the input of all faculty members (nurse educators). Therefore, it is important to consult all nurse educators in the faculty with the designing, development, implementation and evaluation of a workload model (Houston *et al.*, 2006:21; Kenny & Fluck, 2014:585-600; Kenny *et al.*, 2012:51; Ruby 1998:20; Vardi 2009:506).

From the literature consulted on workload models it is clear that workload formulas, credit hour models and the workload models formulated by various researchers did not incorporate all the activities of a typical nurse educator as an academic at the identified private higher education institution. Although none of the discussed workload models suited the specific needs of nurse educators at the identified private higher education environment, Perks's (2014) statement that a workload model is a comprehensive picture of all the different activities of academic staff as well as the time related to these activities was insightful. Perks (2014) emphasises the importance of having an effective workload model specifically designed for each institution in conjunction with its academic staff and taking into consideration the way in which such an institution operates.

In this study the workload model refers to a proposed realistic, achievable, balanced and manageable workload model for the nurse educators of the identified private higher education institution which will assist in the fair, transparent, consistent, safe, healthy and equitable distribution of the workload of the nurse educators.

2.4. PRODUCTIVITY

When thinking about productivity or talking about it, even in an essential service like higher education, it always refers to inputs and outputs (Massy & Wilger, 1995:10). Productivity should not only be seen as a costing account, but also as the improvement of productivity which requires innovation of a more fundamental nature (Hayzen & Reeve, 2000:36-39). In the identified private higher education institution productivity requires, in addition to good outputs, the identification and invention of better teaching, clinical and administrative practices that will provide an increase in the teaching, clinical practice and administrative productivity of the institution to the benefit of both the private higher education institution and the private healthcare organisation.

To economists, productivity is simply a matter of output relative to inputs (Garret & Poole, 2006:5) But, this simplistic explanation does not encompass management strategies aimed at increasing productivity and therefore Garret and Poole (2006:6) view their definition of productivity as more effective because they divide productivity into two parts, effectiveness and efficiency. Darra (2006:102) confirms in education the measuring of productivity must include both effectiveness and efficiency even if this means measuring effectiveness is made more difficult. Productivity is defined by Massy and Wilger (1995:10) as the ratio of output to inputs. Meyer (1998:6) singles out workload as the time spent on activities and productivity as the measuring of the product derived from the time spent on the activity. The effectiveness and efficiency of a faculty member is expressed in units of time that serve as a measure of productivity during the transformation of a faculty member's input into the expected outputs of teaching, clinical guidance, research and service delivery (Allen, 1997:27). Therefore, according to this author, economic measures of quantities traditionally used are indeed not suitable to measure productivity.

In academic institutions productivity is primarily measured by the number of scientific articles produced and published (Dunn & Antonio Chiocca, 2015:328; Fairweather 2002b:26; Townsend & Rosser 2007:8). Although Garret and Poole (2006:7) and Akl, Meerpohl, Raad, Piaggio, Mattioni, Paggi, Gurtner, Mattarocci, Tahir, Muti and Schunemann (2012:611) do not agree or disagree with the aforementioned statement, these authors' interpretation of how to measure productivity best is simply that there is no 'best way' to clearly measure productivity. Massy, Sullivan and Mackie (2013:19) reaffirm Garret and Poole's (2006:7) standpoint that it is complicated to measure productivity in higher education institutions. Townsend and Rosser (2007:8) emphasise the importance of clarifying the meaning of faculty productivity and its measurement. In fact, it is vital to keep in mind that productivity does not take place in an organisational vacuum, but it is seen together with workload as a function in the organisational context influenced by cultural factors, interpersonal relationships and relations with authority (Allen, 1997:25).

Ruby (1998:19) measures productivity based on the value expectations of the education institution with emphasis on teaching and student learning, the number and type of programmes being taught and the class entries generated by those programmes. Allen (1996:25) measures workload by the time spent on teaching, doing research, delivering service and doing administration; thus, the effectiveness and efficiency of the nurse educator as an academic to achieve the expected standards is seen as faculty productivity. Akl *et al.* (2012:602), Fairweather (2002b:27) and Tierney (1999:20) measure the productivity of a nurse educator as the output related to the teaching activities, clinical accompaniment and research as well as administration activities.

Relevant literature indicated teaching productivity, also known as instructional productivity, can be confirmed by credit hours, contact hours, the number of courses and students taught, number of hours spent advising students, method of instruction, a summary of student score ratings of instruction and descriptions of new courses and programmes developed (Colbeck, 2002:45; Cowdery & Agho, 2007:74).

Teaching workload is considered as instructional productivity and the pass rate and job placement of graduates are seen as more relevant to measure faculty productivity (Townsend & Rosser, 2007:8).

Middaugh's (2001:233) finds the pass rate in certification examinations and job placement of graduates to be a more suitable measure of productivity while a basic observation of faculty productivity is the number of hours spent in the classroom, according to Duderstadt (2000:278). The authors Fairweather (2002b:32) and Tierney (1999:61) suggest policymakers often confuse teaching productivity, quality and effectiveness and policymakers interpret the hours spent on teaching (input) as student learning outcomes. Thus, these authors support Townsend and Rosser's (2007:8) advice to select the appropriate productivity output measures of a nurse educator in order to identify the nurse educators who are highly productive in teaching, clinical practice, research and administration. Contact hours spent with a student in the classroom is an accurate productivity measure for instructional productivity as indicated by Fairweather (2002b:34).

On the other hand, Allen (1996:25) feels faculty productivity is incorrectly measured if using times allocated to nurse educators for teaching, the number of classes presented and the number of contact hours with the students as a yardstick. The author argues in this situation it measures priorities and not productivity while further stating inter-institutional mobility, intrinsic motivation, institutional incentives and external stimuli have a huge influence on workload and productivity.

The regular evaluation of faculty members leads to a progress in productivity throughout all components of faculty work and certain departmental collective responsibilities will possibly better be resolved by other staff members rather than to change the assessment procedures or to rearrange faculty work (Fairweather, 2002b:98). Productivity is about achieving the goals with minimum effort and resources; therefore, effective evaluation of faculty workload becomes increasingly important as workload increases for various reasons (Lau, 1996:97).

Faculty productivity should not be evaluated individually, but departmentally because each faculty member cannot be productive in all domains of teaching, research, service and clinical practice (Melland 1996:37-38). Fairweather (2002b:29) disagrees with Melland (1996) by stating a faculty member can be productive in all faculty work domains. Presenting a paper at the annual meeting of the American Educational Research Association Faculty regarding perception of elements influencing teaching and professional development, Gottlieb and Yakir (1994:1-2) made it clear that a preference of one domain over others does, in fact, a remarkable influence on overall productivity and job satisfaction.

The responses of individual nurse educators to workload differ. There is a possibility that workload pressure may be a positive experience for some nurse educators; however, as posited by Shah, Jaffari, Aziz, Ejaz, Ul-Haq and Raza (2011:257) the positive experience may become negative as the pressure becomes excessive. Consequently, it is important to ensure the consistent allocation of a reasonable workload to a nurse educator as an academic. To avoid counterproductive behaviour, Jenkins (2004) maintains it is important to define and manage the relationship between research, teaching and the broader work expectations on institutional as well as individual levels.

Finally, it is clear that productivity as a dimension of the workload of a nurse educator employed at a private higher education institution is much more than the quality of output related to the inputs because productivity is also influenced by the cultural and interpersonal relationships of the organisation. It was further evidenced in literature that the measuring of productivity in nursing higher education is complex due to the different activity hours of the workload a nurse educator spends on the production of a competent nurse who is ready for the labour market on completion of a programme.

2.5. JOB SATISFACTION

Nurse educators spend a great deal of their professional lives at work – and even after working hours, much time is spent on job-related tasks which makes it

extremely important for them to experience job satisfaction to the fullest. A lack of job satisfaction may impact on the performance of the nurse educator and the achievement of the goals of the identified private higher education institution which may result in low productivity.

Job satisfaction, also known as work satisfaction, as a multidimensional concept is used in a quantity of studies of workers in the industry, business and education environment (Gui, Barriball & White, 2009:470). It is described by Mustapha and Ghee (2013:11) and Sahin and Sahingoz (2013:10) as a positive or satisfying response from personnel to their perceptions, feelings and expectations regarding their work. For Mullins and Christy (2010:661) job satisfaction is more of an emotion, an attitude, a feeling and a matter of perception which involves the likes, dislikes, intrinsic and extrinsic needs of an employee. Job satisfaction in the opinion of Mumford (1991:11-19) is a match between the requirements of the organisation, the employee's quest and what the employee receives.

High job satisfaction is an important factor in improving the productivity and performance of an organisation (Mustapha, 2013:121). Job satisfaction should therefore never be overlooked as it improves the teaching, clinical, service and research productivity of a higher education institution (Syptak, Marsland & Ulmer, 1999:27). High job satisfaction contributes to quality teaching, job commitment and the production of competent nurses (Mustapha, 2013:120) and is, in fact, one of the most effective resources to increase the productivity of educators. Influencing factors that impact on job satisfaction include personal characteristics, education, value judgement and work experience (Akinci, 2002:4). Depending on the work environment, Bakan and Buyukbese (2004:7), Bozeman and Gaughan (2011:156), Johnsrud and Rosser (1999:122) and Mustapha (2013:121) add factors such as the difficulty of the work, compensation, working conditions, job security, promotion opportunities, employee involvement in decision making and the workload of personnel influence an employee's sense of job satisfaction.

A high workload was identified as one of six factors that reduce job satisfaction in the studies conducted by Hammen (2006:1065) and Altaf and Awan (2011:93). These studies revealed an increase in the workload resulted in employees experiencing dissatisfaction with their job situation. Roelen, Koopmans and Groothoff (2008:435) associate and measure job satisfaction based on the working factors such as workload, job content, job pass, independence, growth, financial rewards, job differences, working conditions, promotion, supervision, communication, working time, salary, colleagues and work demand.

In an academic environment a high level of job satisfaction is the result of positive interaction, support from the institution's management, employee independence in job creation, minimum supervision, intellectual challenges, professional growth, structured work, value of teaching and its intrinsic satisfaction and, finally, the contribution to student development (Gappa, Austin & Trice, 2007:105). These authors support the view that in the higher education environment of today it is the priority of a nurse educator to have a career that is meaningful, satisfying and centralised around personal needs and values.

In the opinion of Candela, Gutierrez and Keating (2012:855) job satisfaction is influenced by the positive factors such as the involvement of leadership in a programme in the faculty, educators being recognised and appreciated, being treated with respect and complimented when necessary, working independently and student achievement to name a few. Studies conducted by Evans and Meyer (2003:154-155) and Zabriskie *et al.* (2002:6) on academic role satisfaction and motivational theories mention intrinsic motivators, external academic motivators and teacher-student relationships as important factors for educators to experience job satisfaction.

Worldwide an interest in research on employee satisfaction in higher education institutions has been observed (Chinomona, 2014:363; Dorasamy & Letooane, 2015: 258; Hanaysha, 2016:130; Maharjan, 2012:46; Sohail, Safdar, Saleem, Ansar & Aseem, 2014:41-42). Many authors ascribe the attention this phenomenon is

receiving to the fact that the labour intensiveness of educators at these institutions has finally been recognised. Historically though, most studies have focused mainly on the profit-making industry and service organisations (Hanaysha, 2016:130-140). Since higher education institutions depend mainly on the effectiveness of their educators (as the instruments of change) it is essential for a higher education institution to be satisfied with the educator corps. Sufficient wise and knowledgeable educators have to be employed for educating institutions to reach their goals and expectations in the offering of quality educational programmes (Amstrong *et al.*, 2008:88).

The workload is viewed as an important component of the work life and job satisfaction of a nurse educator (Cohen *et al.*, 2009:51). In their study on the job satisfaction of nurse educators Gui *et al.* (2008:469) highlight faculty workload as an important component of the job satisfaction of nurse educators. With the integration of nursing education into higher education, the increase in the workload of nursing educators led to a decrease in job satisfaction because of the accompanying excessive workload. For the individual nurse educator, his/her perception of whether he/she achieves success in his/her job depends greatly on how productive the work environment is while his/her extent of achieving job satisfaction depends on the extent to which his/her expectations and needs are fulfilled (Kusku, 2003:347). If nurse educators experience a high level of job satisfaction, the higher education institution will benefit by being seen as a beacon of development; the nurse educators will contribute by becoming motivated agents of change releasing their creativity, take responsibility for empowering nursing students and be accountable for the promotion of their own productivity as well as that of the higher education institution (Kusku, 2003:354; Moharjan, 2012:45).

Consequently, it is important to bear in mind that the nurse educators' perception of the distribution of workload influences her/his job satisfaction (Lobo & Liesveld, 2013:276); the higher the workload, the lower her/his job satisfaction (Mustapha & Ghee, 2013:15). Educational organisations must therefore monitor the volume of the workload of their educators as a reasonable workload will determine the educators' job satisfaction – an educator with a high level of job satisfaction will obviously be

more loyal and more supportive to the organisation. Competent educators with high job satisfaction are the cornerstone of any education system; hence, the growth in overall productivity and heightened quality performance of an organisation may be the testifier to highly satisfied employees (Mustapha & Ghee, 2013:12). As Murray (2008:107-109) writes, educators perform better and experience high levels of job satisfaction if their work expectations are in line with the reality of the workload.

An increase in workload reduces job satisfaction. Consequently signs of nervousness, tension and fatigue may be reflected in the nurse educator's performance through less effective work, lower concentration and an increase in errors. The workload of educators and their job satisfaction also has a direct impact on students, colleagues and clients in the workplace, in the case of this study the identified private higher education institution. Therefore, it is essential to encourage a positive attitude towards their work in nurse educators (Sahin & Sahingoz, 2013:11-14). A survey done by Kaufman (2007:297) on how nurses spend their work time indicated 50% of nurse educators were extremely dissatisfied with their increasing workload. Job satisfaction of the nurse educator is essential because it contributes to the quality of student education and it increases the production of competent nurses (Mustapha & Ghee, 2013: 11). There is concern about the job satisfaction of the nurse educator for it is influenced by the increase in extended work requirements due to compliance with organisational and legal requirements, the increase in administrative duties and the increase in teaching requirement due to the use of technology (Houston *et al.*, 2006:19 & 20).

To conclude, productivity and performance of a nurse educator depend on the nurse educator's experience of job satisfaction. The efficiency and effectiveness of the identified private higher education institution depends on their nurse educators in the production of competent nurses. Thus, management should not overlook the importance of satisfied nurse educators but monitor the volume of their workload as a reasonable workload will determine the nurse educators' job satisfaction. It is not only the nurse educators who benefit from job satisfaction, but also the private higher education institution because a satisfied nurse educator will work harder and stay

with the organisation which will reduce the labour costs of the healthcare organisation in the long run. In today's higher education environment it is the priority of a nurse educator to have a meaningful, satisfying career centralised around his/her personal needs.

2.6.   NURSE EDUCATOR

As in other professions such as physiotherapy, medicine and occupational therapy, the nurse educator as a professional fulfils many roles in the nursing education context. Nurse educators operate and play a critical role in the process of developing a nursing student's knowledge, critical thinking and problem solving skills and ability to make independent and critical judgements. As a professional, the nurse educator in the private healthcare environment is a role model who provides the needed leadership in strengthening the nursing workforce.

The World Health Organization (WHO, 2016:5) considers the nurse educator as a competent person with the necessary knowledge and skills to adapt to new approaches and who can plan, organise, implement and evaluate nursing education programmes to assist in providing skilled, effective and efficient nurses to address and manage the needs of the population in the 21st century. The South African Nursing Council (2014b:1) define a nurse educator as a professional nurse with nursing education as an additional qualification and who is registered at this legislative body as a nurse educator. Scholarship of teaching and learning, academic and student management, curriculum development, management and leadership, personal development, research and knowledge creation is seen by SANC as the competencies of a nurse educator. In *Mosby's online medical dictionary* (2009) a nurse educator is described as "a registered nurse at university level with at least a master's degree in nursing science who provides nursing students with theoretical and practical training in order to prepare them for their duties as professional nurses." A survey conducted in 2011 by the Forum of University Nursing Deans in South Africa (Fundisa) indicated a lack in the mentoring of young nurse educators and pointed out that a high number of nurse educators to retire within nine years of

the study being conducted (Mulaudzi, Daniels, Direko & Uys, 2012). This will result in nursing education institutions with inexperienced nurse educators.

Internationally, most professional bodies of nursing education nowadays consider a master's degree in nursing as the minimum acceptable level of preparation for a nursing educator. However, the American Association of Critical Care Nurses regard a doctorate as the most desirable and appropriate qualification for a nurse educator (Kelly, 2002:26). Addressing the duration and type of nursing education in terms of the differences among countries, Geyer (2017b:78) suggest resolving this by means of establishing a 'global standard' for university-based nursing education for future professionals nurses and midwives. This could assist nurse educators with decision-making processes and consideration of global frameworks as their educator tasks shift (Bruce & Klopper, 2016:57).

Since the 21st century is acknowledged as a turning point in nursing education, it is important to look at the current situation regarding the education and training of professional nurse educators who are at the forefront to provide competent nurse graduates as the goal of higher education is to provide comprehensive knowledge, academic development and education to students (Mustapha & Ghee 2013:11). According to Kusku (2003:348), nursing higher education institutions are labour intensive and for this reason they are dependent on their nurse educators to be effective.

Health challenges and needs in healthcare have shifted dramatically and became more complex (Simpson *et al.,* 2018:243). The education of nurses has had to change to accommodate these challenges while 'quality' became the buzz word in all healthcare sectors to meet the demands of the evolving healthcare system. As far as nurse educators are concerned, they now have to fulfil expanding roles, develop new educational models and master the burgeoning new technology and information management systems – while all the time keeping 'quality' in mind (Gappa *et al.*, 2007:13; Gui *et al.*, 2009:469; Skiba *et al.*, 2008:225-227). These authors are all in agreement that a nurse educator must make use of the power of technology to

prepare the next generation of nurses. In fact, the same authors state nurse educators have to engage in continuous professional learning and development (lifelong learning) to grow in their own teaching, clinical, services and research skills and competencies. Due to the changes in medical education and the health care landscape the educator of 2025 will need specialised training for their new roles as indicated by another study (Simpson *et.al.,* 2018:244).

The educational and technological changes in the academic higher education environment have altered the workload of the nurse educator in an unexpected way; mostly, it has affected the academic role of the nurse educator. (Hendel & Horn, 2008:62; Tight 2010:214-215). Nurse educators of today are expected to facilitate learning in ways that will allow students to enter the profession on completion of their programme at a high competency level. Therefore, nurse educators cannot only be equipped academically; they must also be knowledgeable in the clinical areas of the relevant nursing programme(s) as well as staying informed about the realignment of the curricula of nursing programme(s) to comply with the requirements of the new categories of nurses (Bruce & Klopper, 2016:108; Republic of South Africa, 2008a; Nursing Education Stakeholders Group (NES), 2012:1-12). According to Little and Milliken (2007:2), nursing educators are expected to fulfill the dual roles of academics and clinical practitioners which brings about two separate sets of competencies to fulfill.

Moreover, Waldrop and Chase (2014:96) claim the growing shortage of nurse educators, increase in courses and programmes and the pressure to produce more nurses at all levels are major factors that impact on the academic role of the nurse educator. Hence, as an experienced nurse educator, they are expected to fulfill the role of a specialist professional nurse in other disciplines (clinical and research) apart from their professional role as educators. Also, at present, the increasing need for skilled registered nurses who can provide high quality healthcare takes place at a time of high consumer awareness; therefore, nurse educators need to be better equipped to prepare nurses for the clinical environment practice in the ever-changing and demanding healthcare environment of today – and the future (Kelly, 2002:28). In

fact, not only are consumers more enlightened, but the nursing workforce itself is a highly trained and well-prepared cadre of professionals. This adds additional pressure on the nurse educators as academics to remain informed and up to date with changes in the clinical field (Candela *et al.*, 2013:854).

Inevitably, professional nurses trained as nurse educators find it difficult and strenuous to maintain their professional competency as educators as well as to competently fulfil their clinical, service and scholarship role as academics. With the integration of nursing education into higher education, the workload of nurse educators in higher education institutions became multifaceted, fragmented, demanding and complicated (Candela *et al.*, 2013:853; Council of Higher Education [CHE], 2016:15; Gao, Chen & Cheng, 2011:1430). This major shift in their workload has had a serious impact on their work and personal worlds which nurse educators still struggle with today.

In their work, they are expected to meet various expectations, for example, increasing graduate production and conducting more scholarship activities. Although healthcare providers are in favour of the integration of nursing education into higher education, they are concerned about the clinical component of programmes because it requires nurse educators to maintain a significant clinical role. Obviously, a nurse educator must also remain clinically competent thus Shuttleworth *et al.* (2008:703-704) wonder whose responsibility is the clinical competence of the nurse educator and whether or not time should be allocated within the nurse educators' total workload to accommodate his/her clinical competence.

Gui *et al.* (2009:469) assert this integration into higher education *de facto* brought about some daunting challenges for nurse educators regarding their assistance to students who are in the process of making the transitional change from school education to higher education. Negative consequences of the integration into higher education and concomitant higher workload include insufficient time for tasks to be properly or timeously completed; nurse educators thus have to work longer hours in an attempt to manage the increasing workload. Their already loaded academic

workload is even more affected by the varying demands and expectations of the widespread and diverse student groups. Gappa *et al.* (2007:11) and Mangold (2007:22) affirm nurse educators are under a great deal of pressure to manage student groups with respect to the differences in age, ethnicity, gender, values and previous learning experiences. It requires additional time from the educator to consider innovative teaching strategies and find different ways to communicate with a diversity of students.

In the context of the current study, nurse educators make sure the nursing education sites of the identified private higher education institution provide competent qualified nurses who will be able to provide high quality nursing care. These sites are located in different provinces which mean nurse educators spend time – a commodity they can ill afford to lose – travelling. Nurse educators assist not only the nursing students, but also the nurses who practise in the private healthcare services of the private healthcare company. They identify these nurses' learning needs, their strengths and limitations so that the former can select learning opportunities for the relevant practising nurses to build on their strengths and overcome possible limitations.

As further pointed out by Bullock and de Jong (2014:149), Skiba *et al.* (2008:225) and Vardi (2009:506), the pressure on educators to implement new and advanced teaching methodologies such as e-learning is another fiasco complicating their workload. Before implementing it, they have to master it themselves which takes time and energy. In this regard, Lobo and Liesveld (2013:276) agree the constantly evolving technological changes place much pressure on the nurse educator who has to adjust his/her teaching and learning strategies of all nursing programmes. In addition, getting to understand and implement new communication technologies (for example, online teaching) in higher education are profound challenges for nurse educators to master and use in their teaching activities (Kyvik, 2013:2; Skiba *et al.*, 2008:225).

Gappa *et al.* (2007:32) draw attention to the fact that technological advances increase students' accessibility to a nurse educator. This means the much needed boundaries between personal time and work time of nurse educators disappeared – the general feeling is that nowadays nurse educators are expected to be available at all times. Kinman and Jones (2008:42) view the loss of personal time as a critical issue within the nurse educators' personal world because it affects the balance between academic work and the nurse educators' family life as so aptly reflected in the first words of the title of their study, *A life beyond work?* In the view of Kordzadze (2013:112), a fair and equitable distribution of the workload of educators in higher education institutions will make it possible for nurse educators as academics to effectively carry out their duties, fulfill their obligations regarding research and administration as well as student responsibilities while still having time for a personal life.

Clearly, nursing education as a profession has tangibly changed forever. Growth and success are measured by the levels of skills and competencies nurse educators possess, transfer to nurse students and promote productivity in the identified nursing higher education institution. The nurse educator plays a critical role in the development process of nursing students and practising nurses in the private healthcare services of the identified private healthcare company. The delivery of high quality care to meet the demands of the evolving healthcare system necessitates the nurse educator to facilitate teaching of students in such a way that the produced graduates can successfully enter the profession with a high level of proficiency on completion of a programme. Nurse educators fulfill the dual role of academics and clinical practitioners leading to two sets of skills they must meet. With the integration of nursing education into higher education, it is required from the nurse educator to engage in continuous professional learning and development as well as to perform an increased selection of varying tasks. This results in an imbalance between the increase of the already loaded academic workload and the family life of the nurse educator.

2.7.   SYNTHESIS

In this chapter the key concepts explored were 'workload', 'workload model', 'productivity', 'job satisfaction' and 'nurse educator'. The consulted literature showed the workload of the nurse educator comprises a very wide range of teaching, clinical practice, research and service workload activities. The job satisfaction and productivity of the nurse educator were viewed within the nurse educators' assessable or measurable outputs of their teaching, clinical practice, research and service activities.

Nursing as a practice-based profession involves both academic and clinical practice education. The consulted literature showed noticeable differences in the distribution of the number of workload categories, their weight and the time patterns among countries and higher education institutions which is mainly due to the differences among higher education institutions' missions, functions and strategic priorities. A clear understanding of the teaching, clinical practice, research and service workload components of the nurse educator and the time involved in each workload activity is of utmost importance when one considers a workload analysis.

The relevant literature indicated teaching in nursing education to be a complex process; it was identified as one of the most important components of the workload of a nurse educator. The importance of quality education and its impact on the preparation of nursing students is recognised by governments and institutions. Teaching as a time intensive activity requires extensive professional skills and a high level of disciplinary expertise. For the nursing student in the current higher education environment to be prepared for the complex healthcare environment, they need to process and evaluate a large volume of information to make informed clinical decisions for safe patient care. For this reason the traditional theoretical classroom teaching is no longer sufficient. The nurse educator therefore has to be more creative in the application of learning strategies and methods to be able to lead nursing students to high order learning and thinking skills during the integration of theory and practice. During the teaching process it is of utmost importance to support students, provide continuous positive feedback, use real-life situations and

correct student misperceptions. All these teaching expectations contribute to an increase in the workload of the nurse educator.

In addition to teaching, clinical practice is also an important although time intensive component of the workload of a nurse educator. It is described in literature as 'unique' and 'complex'. During clinical accompaniment of the nursing student, the clinical practice environment plays an important role in theoretical practice integration and the development of the nursing student to become an independent practitioner. The consulted literature showed although universities confirm the clinical practice role of nurse educators as essential, they are more concerned about the teaching and research profiles of the staff and the profession thereof. It was also evident from the consulted literature that clinical practice should be part of the workload of nurse educators whose responsibility it is to keep up to date with their clinical expertise.

The service and administration workload components of the nurse educator were traditionally considered less important in relation to the teaching and research workload components. Changes in legislation over time contributed considerably to the increase of the administration and service duties of the nurse educator which constitute one of the major components of the workload of the nurse educators. It increases the workload with two to ten hours per week. Usually the internal and external administrative and service functions are determined by the type of business. There is a fundamental difference in the service and administration responsibilities of universities and that of the private higher education industry. Typically, a university has a department dealing only with administrative matters whereas the faculty deals with the core business which is education.

Research is time consuming and the time spent on research varies between institutions in countries worldwide. Regardless of these differences, research remains a very important aspect of workload as it generates new ideas, extends the knowledge base, promotes the future of the nursing profession and healthcare and ensures the survival and development of a science. In the nursing profession,

research is not only important as a scientific activity in the development of the nursing profession, but also in nursing education. The researcher's belief that higher nursing education institutions must allocate adequate research time to nurse educators despite the high workload was supported by relevant literature.

The review of various researchers' formulated workload formulae, credit hour models or workload models which covered the same field indicated none addressed all the relevant workload activities within the roles and responsibilities of nurse educators in the modern day higher education fraternity. Most of the workload models investigated in the literature overview proved to be useful in equitable workload distribution, but did not provide realistic measures of time which is crucial to prevent the nurse educator being overloaded. As confirmed by Perks (2014) it is important to specifically design an effective workload model for an institution in conjunction with its academic staff while taking into consideration the way in which such an institution operates. For the purposes of this study the workload model refers to a proposed realistic, achievable, balanced and manageable workload model which will assist in fair, transparent, consistent, safe, healthy and equitable distribution of the workload of nurse educators.

Productivity of a nurse educator is much more than the quality of output related to the inputs because it is also influenced by the cultural and interpersonal relationships of the organisation. The measurement of productivity in nursing higher education is complex due to the different working hours of the workload of a nurse educator spent on the production of a competent nurse who is ready for the labour market on completion of a programme. The productivity and performance of a nurse educator are influenced by her/his experience of job satisfaction. The efficiency and effectiveness of a higher education institution is measured by how successful it is in providing competent nurses to the market, an output which is highly dependent on the performance of its nurse educators.

As workload is observed to be one of the key factors associated with job satisfaction, management should not ignore the importance of nurse educator satisfaction. To

achieve this literature indicates that the volume and balance of their workload should be properly monitored. It is not only the nurse educators who benefit from job satisfaction, but also the higher education industry as satisfied nurse educators are more productive and maintain employment which reduces the cost of the healthcare institution in the long run. In the current higher education environment, it is the priority of the nurse educator to have a meaningful, satisfying career centralised around their personal needs. Relevant literature confirms that nurse educators with high job satisfaction will be better performers and more supportive to the private higher education institution, resulting in high productivity and an increase in overall performance.

It seems clear from the consulted literature that nurse educators are important links in the development process of nursing students and the practicing nurses of healthcare services. The 21st century, with its complex health challenges, needs and expectations of high quality healthcare services requires nurse educators to facilitate teaching of students in such a way that the produced graduates can successfully enter the profession with a high level of proficiency on completion of their learning phase. A typical nurse educator must meet the two main sets of skills, that of an academic as well as a clinical practitioner. In addition to the expectation of the nurse educator for continuous professional learning and development, the integration of nursing education into higher education has led to an increase in the selection of tasks to be completed. This resulted in an imbalance between the increase in the already loaded academic workload and the family life of the nurse educator.

Chapter 3 forms part of the exploration towards a relevant theoretical framework for the study. Hence, it addresses the context in which the study was conducted.

CHAPTER 3

CONTEXTUALISATION OF THE STUDY

3.1. INTRODUCTION

In Chapter 2 the key concepts related to this study were explored. It emerged those recent dynamic changes in nursing education worldwide and in South Africa impacted in different ways on the academic roles and working lives of nurse educators within private higher education institutions. A thorough investigation of the workload of nurse educators within private higher education necessitated an exploration of the organisational, professional, policy and national contexts of nursing education (Plowright, 2011:8). The main research question (cf. Chpt. 1 sect. 1.4) was formulated to prompt whether it was possible that the productivity and job satisfaction of nurse educators in a private higher education institution would be bettered by having a workload model designed specifically for their individual and unique needs. In this chapter, which forms part of the contextual exploration of this study project, the focus is on the contextualisation of the workload phenomenon as it is observed within private nursing education (also see Figure 1.2). The following contextual issues related to nursing education are addressed: the international context, the national context, private higher education, the professional context, the policy context and the institutional context.

Answer to research question
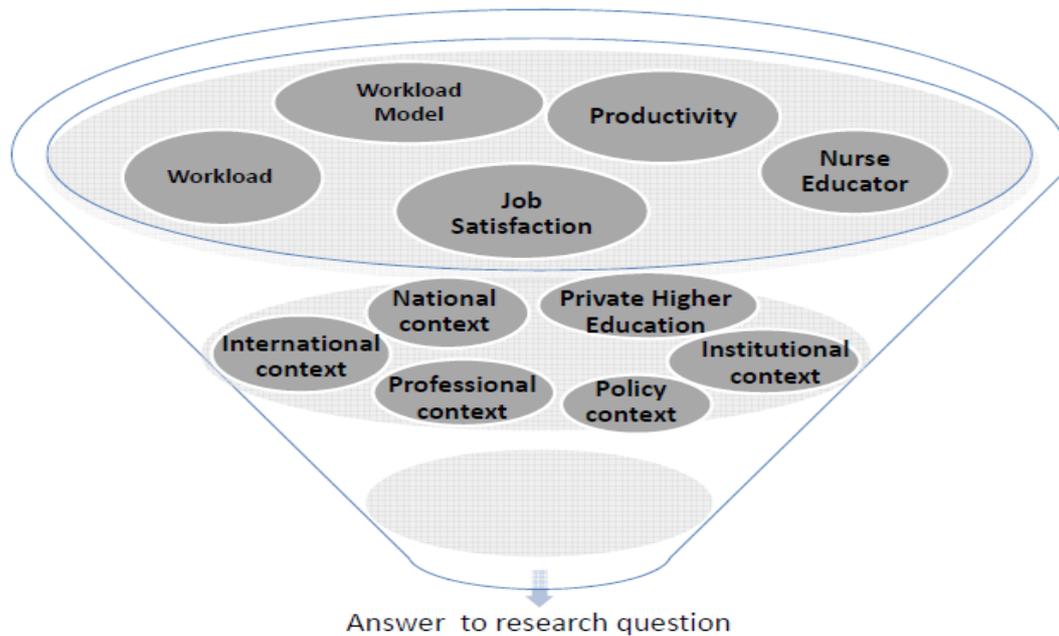
Figure 3.1: Graphic representation of the contextualisation of the study

3.2.   INTERNATIONAL CONTEXT

The International Council of Nurses (ICN) represents nurses internationally, ensures global quality nursing care and influences healthcare. Their goal is to improve nursing and strengthen the global nursing power through nursing policy standards, development, management, research and practice. The ICN developed a framework of competencies for the different levels of nursing between 2003 and 2006. Educational requirements were not linked to these different levels of nursing to allow each country to integrate the model into their own education system (Bruce & Klopper, 2016:66-67). Importantly though, is that one of the identified goals of the WHO published in their 2009 report on global standards for the training of professional nurses and midwives was to motivate for an international shift towards university-based nursing education (WHO, 2009:9).

Holding a baccalaureate degree in nursing is emphasised in literature. Since 1965, the American Nursing Association (ANA) has supported the admission of baccalaureate nurses into practice. Even the influential Institute of Medicine Monographs recommended that the total nursing staff should consist of 80% nurses

with baccalaureates by 2020 (Blaney, 1986:183; Institute of Medicine, 2011:620; Rich & Nugent, 2010:228). Having this degree is especially necessary when considering the relationship between levels of education and patient health outcomes as evidenced in many countries and nursing specialties (Ali & Watson, 2011:313; Blaauw, Ditlopo & Rispel, 2014:1).

In most developed countries, nursing is wholly or partly situated in the higher education sector and is influenced by the recommendations of the Bologna Declaration (1999:1-6). Worldwide, the training of health practitioners is being investigated due to the need to deliver more health workers who can immediately enter the labour market with the necessary skills to render high quality healthcare (Davies, 2008:935: Rispel & Bruce, 2014/2015:118-119). Appraisal of the current workforce conditions and research findings have led to health professionals considering different ways of addressing nursing shortages, improving nursing education and evaluating the possibility of making the bachelor degree a required standard for admission to nursing practice. Recently, high income countries such as Belgium, Norway, the UK, Australia and New Zealand made the bachelor degree a requirement for registration as a professional nurse (Ali & Watson, 2011:313; Blaauw *et al.*, 2014:1; El Haddad, Moxham & Broadbent, 2013:233; Pijl-Zieber, Gypma & Barton, 2014:28; Spitzer & Perrenoud, 2006:163).

In their 2013 report on the transformation and scaling up of health professionals' education and training, the WHO emphasises the guidelines on transformation and regeneration of healthcare as well as the importance of national management, leadership and planning of health education reform (WHO, 2013:21 & 29). There are major international concerns about the absence of nurses in nursing and policy formation within the broader health policy process (Fawcett & Russel, 2001:109; Gebbie, Wakefield & Kerfoot, 2000:308; Hewison, 2008:639; Leavitt, 2009:74; Scott & West, 2001:387). Although much has been done for the professional regulation of nurses, the focus has mainly been on the technical level with little attention paid to policy and political issues (Fullbrook, 2008:712).

In low- and middle-income countries the nursing education reforms differ because the emphasis is more on educational changes needed to address the global nursing shortage, meet the skills mix and the scope of nurses in order to strengthen their healthcare systems (Bell, Rominski, Bam, Donkor & Lori, 2013:244; ICN, 2006:5 & 6). Consulted literature on the international private training of nurses show many low- to middle-income countries like the Philippines, Thailand, Kenya and India are currently experiencing a rapid expansion of private nurse training institutions to address the growing nursing shortages and counteract the international migration of nurses (Oda, Tsujita & Rajan, 2018:1; Reynolds, Wisaijohn, Pudpong, Watthayu, Dalliston, Suphanchaimat, Putthasri & Sawaengdee, 2013:2). The general perception is that these institutions can make a positive contribution in the production of nurses to local and national health systems and even more so in rural areas where the nurse shortages are most severe. Legislation ranges from adapted regulation and accreditation in Thailand to simplified regulations in India to speed up the production and recruitment of nurses (Oda *et. al.,* 2018:1; Reynolds *et. al.,* 2013:2).

The quality of the nurses being produced in private institutions in lower income countries is a major concern. Therefore, strategies are being designed to ensure nurses who graduate from these private nursing institutions are enabled to meet the health needs of the different populations. It is important for countries to have policy coherence between the production of nurses for export and the sufficient provision of nurses for their own domestic needs, particularly in the under-served areas of countries (Ram, 2013; Reynolds *et al.,* 2013:2). In Thailand, the newly graduated professional nurses from private nursing institutions increased from 19.6% in 2006 to 24.1% in 2010. This is a clear indication of the growing importance of the private sector in the production of nurses in Thailand. Eighty-eight per cent of private nursing education institutions in India produce 95% of all their nurses – unfortunately, only 9% of all private nursing schools in the this country are located in areas experiencing nursing shortages (Reynolds *et al.*, 2013:4).

Reynolds *et al.*(2013:4) are of the further opinion that the private nursing training institutions in India (which is the second largest exporter of nurses) and the Philippines (the largest exporter of nurses) are consciously focusing on the production of nurses for the international labour market which gives good results in the overpayment of foreign currency for both countries. In the Philippines, the production of nurses led to financial benefits, but it also resulted in a worsening skills mix in hospitals within the country (Lorenzo, Galvez-Tan, Icamina, & Javier, 2007:1406). Senior nurses or nurses who had the competencies, skills and training required by the overseas market left and the local hospitals had to employ large numbers of newly graduated registered nurses with insufficient clinical experience.

The increase in the production of nurses came at a high cost as the quality of training at these private nursing institutions became substandard. It is evident the high educator-to-student ratio in a country like Kenya alone does not guarantee the quality of private nursing education offered. The study findings of Oda *et al.* (2018:1) and Reynolds *et al.* (2013:10) indicate although India experienced a major shortage of all categories of nurses, a large export market has evolved as a result of the private sector companies sending trained nurses overseas for a big profit. In Kenya again, the health sector's experience differs from that in the Philippines as this sector is becoming more impoverished as a result of exporting nursing staff. The operations of private nursing education institutions are largely determined by the changes in the labour market, the demand for trained nurses as well as national and international legislation.

Therefore, Oda *et al.* (2018:1) and Reynolds *et al.* (2013:10) strongly feel governments should make sure qualified nurse graduates from the private education institutions are of high quality and meet the health needs of their own populations before the international market is served. Another one of the variables in international standards is the length and duration of nursing programmes which vary from one country to another. It is essential for healthcare professionals in South Africa to take into account the impact of such global differences (Bruce & Klopper,

2016:57) to ensure that nursing education and training are both locally relevant and globally competitive (Klopper, 2009:43).

3.3.   NATIONAL CONTEXT

3.3.1. Historical overview

In South Africa, the historical development of nursing education is closely linked to the history of the country. Formal nursing education was introduced in 1877 with the implementation of a training programme at the Carnarvon hospital in Kimberley (Bruce & Klopper, 2016:23-24; Mellish *et al.*, 2003:45). The effect of these trained nurses spread throughout the country and by the end of the 19th century 18 hospitals in South Africa offered nursing training. In 1891 South Africa became the first country with state registration of health professions which included nurses and midwives (Geyer, 2017b:76; Bruce & Klopper, 2016:25; Mekwa, 2000:272). By 1900 professional nursing education was well instituted. Lectures were presented to students in dedicated areas by internationally trained sister tutors (educators) and later by South African nurses who received educator training in London (Bruce & Klopper, 2016:26).

The need for South African trained educators led to university education for nurses and the emergence of courses leading to the Diploma in Nursing Education at two universities, the University of Witwatersrand in Johannesburg and the Cape Town University in Cape Town (Bruce & Klopper, 2016:26). 1n 1955 the first BA nursing programme was presented at the University of Pretoria and in 1966 Professor Charlotte Searle became the first chair of nursing at a South African university at the Faculty of Medicine at the University of Pretoria (Bruce & Klopper, 2016:27).

In 1975, the establishment of the Department of Nursing Science at the University of South Africa (Unisa) was one of the most important developments in the development of higher education (Bruce & Klopper, 2016:27). Many universities followed suit by offering basic and post-basic nursing degrees. The chapter of the medical profession that governs nursing and nursing education in South Africa was

concluded with the announcement of the first nursing Acts in 1944 (Amstrong *et al.*, 2008:76). In accordance with the first nursing Act, Nursing Act 45 of 1944 for the statutory control of the nursing profession the South African Nursing Council (SANC) was established as the first nursing council (Ehlers, 2002:207; Bruce & Klopper, 2016:29).

Nursing education and the practice of nurses and midwives changed significantly over the next five decades as a result of the publication of new regulations by the SANC (Amstrong *et al.*, 2008:76). The Nursing Act 69 of 1957 provided for the training, certification and enrolment of sub-professional categories, namely an enrolled auxiliary nurse and an enrolled midwife. Then, with Nursing Act 50 of 1978 the SANC considerably expanded the scope and functions of certain nursing categories (Bruce & Klopper, 2016:29). The responsibility to monitor the process of nursing education and to maintain the standards in nursing education was delegated to the SANC as the statutory body as stipulated in the Nursing Act 50 of 1978 as amended (Mekwa, 2000:272).

The South African Qualifications Authority (SAQA) Act 58 of 1995 (Republic of South Africa, 1995) stipulates that the SANC is responsible for the accreditation, certification and maintenance of national standards in nursing education and training. Realising that new ways had to be implemented to educate and train nurses, the SANC consequently introduced a comprehensive healthcare course in all healthcare institutions in 1984 (Bruce & Klopper, 2016:29). However, only SANC accredited universities and nursing colleges were allowed to present these courses.

3.3.2. Changes since 1994

Since 1994, major changes and restructuring were part of the South African education system with the aim to close the gap between the demand and supply of critical skills (Bruce & Klopper, 2016:55). The National Department of Education (NDoE) was divided into the Department of Basic Education (DBoE) and the Department of Higher Education and Training (DoHET) in 2009. As a result, nursing education experienced a 'grey area' because nursing education was offered by

nursing colleges under the management of the Department of Health. The provincial department of health had established agreements under the then provincial ordinances with departments of nursing at universities for oversight of the four-year programme (Amstrong et al., 2008:77; Bruce & Klopper, 2016:56).

From 2009 higher education resorted under the jurisdiction of the Department of Higher Education as determined by the Constitution of the Republic of South Africa. The Higher Education Act 101 of 1997 (Republic of South Africa, 1997) was published to give execution to the relevant clause in the Constitution, declaring all universities as 'higher education institutions' - each with their own legislation that establish them as a legal entity. This means institutions that want to offer nursing education have to be accredited as a higher education institution with all learning programmes having to meet the requirements of the Higher Education Qualifications Sub-Framework (HEQSF) according to the Higher Education Amendment Act 39 of 2008 (Republic of South Africa, 2008). Private higher education institutions also have to be registered with the Department of Education in accordance with the Higher Education Act 101 of 1997 (Republic of South Africa, 1997). Also, according to SANC regulation 173, all the programmes offered at nursing education institutions offering higher education programmes in nursing must have their programmes accredited at the SANC and CHE which, following approval, will be submitted by the Council of Higher Education (CHE) to SAQA for inclusion of the National Qualifications Framework (NQF). Only three quality councils are recognised by the National Qualifications Framework Act 67 of 2009 (Republic of South Africa, 2009) namely the CHE, Umalusi and the Quality Council for Trade and Occupation (QCTO).This act further stipulates that all professional regulators become professional bodies. Nursing education is also regulated by the SANC which prescribes the minimum requirements for education and training to ensure competent and safe nurse practitioners. Provision is made in the Nursing Act 33 of 2005 for education, training, research, registration and practice of nursing (Republic of South Africa, 2005:25-31). It is stipulated in the Nursing Act 33 of 2005 if nursing education institutions are not accredited by the SANC, it is seen as a criminal offence. Hence, all undergraduate and postgraduate nursing programmes of universities and higher education institutions must therefore be accredited by the

SANC and the CHE (Republic of South Africa, 2005:28). These changes in legislation assist with the position of nursing education in relation to the relevant Acts.

In an effort to provide sufficient numbers of nurses to cater for the growing population's widely diverse health needs, a South African national strategic plan for nursing education, training and practice was published by the South African Department of Health in 2013 (Republic of South Africa, 2013). The nursing education system has to consider the impact of this national strategy announced by the Department of Health. The document contains strategic objectives, activities, output measures for nursing practice, measures for the education and training of nurses, nursing regulations, nursing leadership, social positioning and resources in an attempt to support the South African health system (Bruce & Klopper, 2016:69). A need for an integrated nursing education system was highlighted in the strategy which also aimed at promoting increases in the numbers of trained nurses as well as the promotion of nursing standards, nursing scholarship and nursing science (Geyer, 2017b:77-79).

Based on the global challenges and particularly challenges in the South African context, authors such as Geyer (2017b:78) draw attention to the new Higher Education Amendment Act 39 of 2008 which brought about further challenges to nursing education and training (Geyer, 2017b:78; Bruce & Klopper, 2016:64) including the alignment of the new nursing qualifications with the HEQF, the accreditation of public and private colleges as higher education institutions, the implementation of recognition of prior learning and the discontinuation of legacy nursing programmes. The SANC has developed the regulations for the new nursing programmes leading to professional qualifications which have been published in 2013. Nursing education institutions are thus currently developing new curricula, according to the new regulations for education and training leading to registration with SANC. These curricula are submitted to SANC for consideration and accreditation to obtain an endorsement letter required to submit their curricula to the CHE for approval and accreditation.

Rispel (2008:9) points out that nursing education is influenced by the alignment of nursing education programmes with the strategic plans of the South African DoH, the WHO, the policies of the SANC, the transformation of higher education institutions, the policies of the South African DoE and the critical shortages of nurses. Whatever the shifts in policies, regulations and legalities, however, nurse educators in private higher education institutions have been challenged throughout with adapting to new roles as academics and clinical facilitators while still continuing with their chosen careers as nurse educators. With the escalating workload, role changes and responsibility to produce empowered and highly skilled nurse graduates, it may be the appropriate time for nurse educators to redefine their academic and clinical roles as advised by Ntshoe *et al.* (2008:399).

3.3.3. Impact of transformation

Change and transformation from old to new policies is a challenging phenomenon (Mapesela & Hay, 2005:111) and even more so if it is to take place with a range of other sociopolitical and economic changes (Fourie, 1999:276). As part of the transformation of both the health and higher education sectors, there has been a renewed focus on nursing education since 1994 (Blaaw *et al.,* 2014:2). The transformation process in South Africa is governed by a number of Acts as indicated by two important laws, namely the Higher Education Amendment Act 9 of 2016 (Republic of South Africa, 2016) and the National Qualifications Act of 2009 (Republic of South Africa, 2009). These include the Constitution of the Republic of South Africa (1996) which assigned tertiary education to the Minister of Education; the Higher Education Act 101 of 1997 (Republic of South Africa, 1997) which governs higher education institutions and programmes; the South African Qualifications Authority Act 58 of 1995 (Republic of South Africa, 1995) with the aim of developing a National Qualifications Framework and criteria for the registration of programmes and qualifications as well as the Nursing Act 33 of 2005 (Republic of South Africa, 2005) which provides control of nursing education and training by the SANC.

Traditionally it was only the public nursing colleges that were managed under the jurisdiction of the Department of Health. Private nursing colleges and schools were managed as separate and independent nursing colleges and schools. While private nursing colleges have been able to take up the opportunity to register as higher education institutions and submitting their nursing programmes to CHE for accreditation, the situation for the public nursing colleges have not changed. The public nursing colleges currently (as in 2018) still fall under the jurisdiction of provincial departments of health while the political decision making to change this situation is very slow. Fundamental criteria such as the recognition of prior learning, changes in teaching approaches to ensure critical thinking and outcomes-based nursing curricula have been identified as part of the transformation process of nursing education in South Africa (see Mekwa, 2000:275).

The South African healthcare system consists of a large public sector and a smaller, but rapidly growing, private sector. As a result, the private healthcare sector plays an essential role in assisting government to provide its constitutional mandate of quality healthcare to all (Econex 2013:6). The private sector started training nurses for its own purposes because of the critical shortage of nurses and the South African government's inability to meet the needs of the entire healthcare system (Amstrong *et al.*, 2013:110). This requires nurse educators not only to be equipped academically but also to perform in the clinical areas of relevant nursing programmes as well as the realignment of nursing curricula to meet the requirements of the new nurse categories (Republic of South Africa, 2012).

The requirements for a nurse educator in the new dispensation of the SANC are: they have to be a registered nurse and midwife with a bachelor's degree and an academic qualification at least a level higher than the level of the programme offered. They should also be in possession of an additional qualification in nursing education backed up by a minimum of at least five years' clinical experience in a specialist nursing teaching field. The SANC also expects competences such as expertise, personal development and learning, academic and student management,

curriculum development, general management and leadership as well as research and knowledge creation of the nurse educator (SANC, 2013a:20).

Together with the changes in the higher education sector and transformation of nursing, the proposed nursing reforms indicated by Rispel and Bruce (2014/2015:119) include the bachelor degree as a professional qualification of nurses and the phasing out of the enrolled nurse. The latter is to be replaced by three years' of training in favour of a general nurse with a three-year diploma. Fourie (1999:276) points out that within this context the nurse educator is increasingly required to make paradigm shifts and adjustments as well as approaching their professional activities in new and innovative ways.

3.3.4. Culture

Nurse educators work in South Africa as educators in a diverse and culturally rich nursing education environment that needs to be managed for the benefit of nursing education. Cultural diversity, according to Mngomezulu and Geyer (2017:21), needs to be handled by nurse educators from the perspective of both a culturally diverse student body and culturally diverse health sector. The nurse educators are thus increasingly challenged to gain an understanding and knowledge of their own culture and those of other cultures. It is therefore imperative to create a harmonious multicultural environment in nursing education institutions to accommodate the nursing educators who come from various different cultural backgrounds.

The management of nursing education institutions has to make provision for the cultural differences of their nurse educators in order to understand the view of the nurse educator as an academic to balance individual needs and the requirements of the education programmes (Mngomezulu and Geyer, 2017:21). Other challenges faced by nurse educators as academics are the effect of language barriers on learning programmes, specifically where students are unable to read, write or speak English well and to socialise students into the nursing profession.

The nursing education institution is often faced by specific cultural characteristics such as time awareness, personal space, attraction and appearance, anger, tone of voice, gestures, nutritional deficiencies due to cultural beliefs and values, religious practices, ethnocentric behaviour, languages and communication, traditional healing and role and position differences among women and among men and women (Kotze, 2017:4-20). These authors point out that cultural characteristic requires the management of nursing education institutions to cater for the cultural differences of their nurse educators in order to balance the individual needs and the requirements of education programmes.

3.4. PRIVATE HIGHER EDUCATION

3.4.1 Higher education

The fast and dramatic changes that took place in the higher education environment over the past decade resulted in higher education having to function in the super complex modern world of today (Barnett, 2000:415-417; Barnett, 2009:440; McCowan, 2004:1). At the centre of these changes are higher education institutions and their educators – the latter who are expected to conduct research, provide graduates with the necessary skills and knowledge as well as address the national needs so that contributions can be made in the fast-changing and competitive global environment (Crawford, 2010:199; Hargreaves, 2000:175).

These expectations, together with the changing student demographics (Webster & Mosoetsa, 2001:79-80) led to unhappiness among academics worldwide about their work situation which is described as excessive workload with administrative burdens, low salaries and reduced autonomy (Delanty, 2008:127; Webster & Mosoetsa, 2001:75). The relationship between higher education institutions, government and society over the last few decades has changed significantly and international higher education institutions have become more performance- and market-driven with consequent changes for academics (Gumport, 2000:69; McDowell, 2004:149-151).

Much of what happens locally occurs as a result from international trends because the increase in global social relations connects far-off localities in such a way that local events are formed by events that have taken place elsewhere and vice versa (Held 1991:9). Also, since the 1994 transition to democracy, massive changes in the history of higher education in South Africa have been recorded (CHE, 2007:1).

The most important change in the higher education arena, according to the Council on Higher Education (CHE, 2007:162), was the total restructuring of the higher education system. The merger programme launched by the South African government in 1994 has since reduced the number of universities and technical colleges to 25 current public universities. Other major changes accompanying the institutional mergers were the changing nature of the academic workplace where the collegial model was largely replaced with a new managerial model. This change was characterised by increases in emphasis on performance, measurement, accountability, competition and the changing terminology where students were renamed to 'clients' and departments to 'cost centres' to name a few (CHE, 2007:163; Webster & Mosoetsa, 2001:76). Harman and Meek (2002:2) view the restructuring and merging of universities and technical colleges as the most challenging South African educational phenomenon while Kistan (2002:170) points out that higher education in South Africa was (and still remains) under increasing pressure to meet the social transformation and skills needs of the country. At the same time, there is internal and external pressure on South Africa for the improvement of policies and performance (De Clercq, 2002:81).

Higher education is also influenced by an increasingly globalised environment (Carnoy, 2005:6), internationalisation (De Wit, 2011:243; Knight, 2008:19), inadequacy of the public sector and massification (Altbach, 2012:128; Braun, 1999:2; CHE, 2007:8; Teichler, 1999:5) as well as diversification (Braun, 1999:1; Teixeira & Amaral, 2001:359; Van Vught, 2007:2). As a consequence, an explosion in the private higher education sector (Altbach, 2012:127; Fehnel, 2006:230-231; Mapesela, 2002:57), increases in the demand for quality distance education (Sanyal, 2013), government regulation of higher education, reduced availability of government

funding and the dominant tendency to move higher education from a social institution to an industry were experienced (Deem, 2001:8-9; Gumport, 2000:70; Scott, 2002:149).

Growth in private higher education can be further attributed to the unique developmental and educational barriers and challenges such as students with low literacy entering private higher education in South Africa (Fehnel, 2006:231). In addition, the regulation of the private higher education sector is subject to the same management, qualification and quality assurance regime as the public providers.

3.4.2 Private higher education

In many parts of the world, private higher education develops as a growing force that offers a variety of potential opportunities and challenges (Universities UK, 2010:3). Fielden (2013:6 & 7) points out in 2013 some countries such as the UK required no national formal registration of private higher education providers; consequently, public policy on private higher education providers is still in the formation phase. The success of the for profit providers depends on their credibility and reputation and therefore they offer low-cost programmes such as management, healthcare and accounting and focus only on teaching and not on research as further informed by this author. Private higher education providers will probably continue to grow, especially when looking at the experience of the USA where the enrollment of private higher education students grew from 5% in 2001 to 13% in 2013 of the total student population (Fielden, 2013:7).

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For nearly three decades, government-supported higher education was not questioned (Varghese, 2006:19). A decrease in higher education was experienced in many countries with the shift of public resources and public investments in higher education to lower levels of education. Pressures for the expansion of public higher education were felt in the 1990s due to the need for highly trained staff for an information technology dependent globalised world and the growth of a knowledge economy. Additional pressures were also exercised by the secondary education sector where there were increases in the number of school leavers who were looking

for degree qualifications. States or governments are not always able to provide adequate services in this regard; therefore, there seems to be an increased need for diversification of sources and funding and institutional arrangements to accommodate higher education needs. In many countries, including South Africa, this resulted in the privatisation of higher education and the establishment of private institutions (Teixeira & Amaral, 2001:388-389; Varghese, 2006:19).

At the turn of the 21st century, private higher education became the fastest growing sector of postsecondary education worldwide (Altbach, 1999:312; McCowan, 2004:1; Varghese, 2006:25). Not only did the demand for higher education overwhelm the governments' capabilities of provision, but there were also significant changes in the way higher education was considered, for example, the idea of a degree qualification that is internationally accepted (Altbach, 1999:311; Altbach, 2012:131; Sharma, 2009; Su, 2012:158).

Reduced education budgets and economic constraints led to the encouragement of The World Bank (1994) to expand private higher education in developing countries. In Froneman's (2002:38) opinion, the distribution of private higher education institutions worldwide is impressive, but these institutions differ vastly in nature, scope and quality (also see Su, 2012:157). In some countries, private higher education institutions are highly sought after while in others they occupy lower levels of hierarchy. The international blossoming of private higher education (Knight, 2008:20) takes place within a boundless education environment as part of the global trade transaction. Sharma (2009) also highlights the fact that private providers can fill an educational gap which cannot be filled quickly enough by publicly funded institutions worldwide.

In sub-Saharan countries private higher education institutions were promoted and encouraged. These private higher education institutions are divided into 'for profit' and 'not for profit' private higher education institutions of which some collaborate or are affiliated with private higher education institutions within other countries or within the same country (Su, 2012:160; Varghese, 2006:20-21). Market-friendly courses

are mostly offered by the for profit higher education institutions which create expansion and growth in the private sector. Varghese (2006:22-23) is of the opinion that private higher education makes a positive contribution to economic development and the expansion of tertiary education in the developing world. Legislative measures in many sub-Saharan countries also support the establishment of the private higher education sector.

Private higher education was welcomed in the higher education sector in South Africa by the White Paper on Higher Education (Department of Education, 1997) and the Higher Education Act 101 of 1997, irrespective of the Private Higher Education's associated problems. In a review report of the Council on Higher Education (CHE, 2007:163), the remarkable growth in the private higher education sector constituted the second major change in the higher education system in South Africa since it implies some competition for the public higher education system. This unforeseen development has created political, policy and legal disputes about the appropriate nature and extent of government action in response to what has become a dominant global phenomenon (Fehnel, 2006:230).

Both the government and the research community ignored private higher education in South Africa for most of the 20th century (Mabizela, 2002:41 & 42). However, in the late 1990s the picture changed drastically in the country when the public sector and political world received the message of the rapid expansion of private higher education. In South Africa, the government realised if they wanted to be part of a global economy, there had to be a shift towards a more skilled workforce (Fehnel, 2006:230). Within a few years, the private higher education sector had become one of the most regulated and well-studied sectors in education (Kruss, 2002:15; Levy, 2003:3; Mapesela, 2002:56-58).

Private colleges were regarded as the unfair competitor from the side of the public sector; a phenomenon where private providers benefitted from an unregulated situation and where moderate or weak programmes were offered to vulnerable students. According to the review report of the Council of Higher Education (CHE,

2007:174), the South African government had a series of conflicting thoughts regarding private education and especially private higher education. High expectations were cherished for an increase in the privatisation of education provision and for the government's investment in education with the democratic transformation in South Africa which accompanied the report of the National Commission of Higher Education (NCHE, 1996). It became clear, however, that the public higher education sector could not provide in the skills shortages of the labour market and thus the government looked at the private sector for assistance (CHE, 2007:174).

The Higher Education Act 101 of 1997 allowed, for the first time, private providers to offer degrees and diplomas (Fehnel, 2006:320). This measure was based on the additional role of private higher education to the public sector and to increase access, diversity and differentiation of academic programmes in order to address the human resource needs of the new democracy (Department of Education, 1997:10). Two major challenges of expanding the role of the private sector were firstly to create a healthy educational environment in which the sustainable private institutions were not suffocated by government regulations and, secondly, to prevent the poor quality of higher education provided by non-sustainable institutions (CHE, 2007:175).

The strategic positioning of the private higher education institutions to increase market share and diversity of income sources resulted in stricter regulations for the private sector (Republic of South Africa, 1997b:42). Other significant changes included quality assurance measures, expansion issues, increases in student diversity, a move towards outcomes-based education, an emphasis on lifelong learning and the rise of information technology – all with noteworthy effects on the increasing workloads of nurse educators as academics (Mapesela & Hay, 2005:111; Waldrop & Chase, 2014:96).

The challenges mentioned together with the limited number of staff members (Varghese, 2006:40) called for not only an increase in the already diverse role of nurse educators in a private higher education, but also for the adoption of new

policies, practices and paradigms (Fourie, 1999:280; Fourie & Alt, 2000:117). The effect of such challenges and changes implied significant increases in the workload of nurse educators (American Association of University Professors, 2002:69; Rhodes, Hollinshead & Nevill, 2007:72; Rothmann *et al.*, 2008:405).

3.4.3 Private nursing education

Information on private nursing education as an emerging sector is not readily available as it has only recently emerged in many countries. Internationally, there is a shortage of an experienced and trained health workforce which is worsened by the lack of quality health education programmes, healthcare personnel capacity, the production and availability of health professionals and a lack in the number of institutions and graduates (Cleary, McBride, McClure & Reinhard, 2009:634; Gwee, 2011:27; Hamdy, 2017:1082; Patelarou, Vardavas, Ntzilepi & Sourtzi, 2009:840). Another influencing factor raised by Cleary *et al.* (2009:639) and Gwee (2011:25 & 27) is the ongoing intensive and extensive complex curriculum reforms in healthcare professional education to meet the worldwide healthcare demands and challenges of the 21st century. This affects the workload of educators, practical solutions for education problems, the teaching and learning of students and also poses huge financial implications.

Cleary *et al.* (2009:634) see the situation as not merely a labour shortage in health services, but the health labour force must also have the right skills. One of the critical aspects of the nursing shortage is a lack of nurse educators. In the USA, for example, a bottleneck is experienced in the nursing education's capacity as the provision of clinical education at a clinical placement ratio is one educator to ten students (Cleary *et al.*, 2009). In South Africa, healthcare practitioners are trained in institutions with good clinical facilities where the volume of patients with serious problems is high, so students have the opportunity to gain intensive practical experience which is not available in many other countries. It is thus not surprising that the training of South African healthcare practitioners has a significant reputation worldwide (Econex, 2013:46).

However, like in the rest of the world, South Africa is also experiencing a shortage of healthcare professionals due to the current inadequate workforce production (Essack, 2012:1). Challenges resulting from this situation include a shortage of clinical mentors in the clinical environment in accordance with the requirements of the professional councils, an increase in operating costs, nurse educator unpreparedness and decreases in the health educator workforce such as is the case with nurse educators (Rispel, 2016:1&2).

More specifically, the nursing profession in South Africa is experiencing significant challenges regarding regulation, education and staffing. Critical shortages in specialist nurses and registered nurses are experienced (Oxford, 2016). According to this author, the possibility exists that future training may not be possible due to a sudden discontinuation of the implementation of new legislation by the South African National Department of Health. Oxford (2016) goes on to comment on the new array of legislation and changes in health education policy as part of the nursing education, training and practice strategy which demand specific competencies for nurses and a revised scope of practice in education and training programmes. The slow progress with the higher education accreditation of nursing programmes and the delay in the implementation of new legislation are highlighted as contributing factors to the possible disaster in nurse education that South Africa may be heading for (Oxford, 2016).

Reforms in nursing education in South Africa include a bachelor's degree for professional nurses at accredited higher education institutions. These changes are due to the challenges faced by nurses and to equip them with the necessary professional skills to meet population and patient health needs, maintain quality retention and graduates as well as to increase their numbers (Rispel, 2016:1). Rispel (2016:1) notes that nursing education takes place in public universities, public colleges, private hospital nursing colleges, private nursing schools and a military nursing college adding the quality of nursing education differs vastly among these institutions.

A study by Econex (2013:6 & 7) regarding the private healthcare sector's initiatives indicated a commitment by Netcare (SA) in 2011 to spend 5% annually on learning and development intervention with 3 294 enrolled nurses in 2012; Life Healthcare's commitment in 2012 to spend R 78 million over a 6-year period for the training of specialists and the training of 1 250 nurses and Mediclinic's annual spending of approximately 4% of their payroll on education. Econex's (2013:5) study also showed medical schemes contribute to large-scale training initiatives such as the Discovery Health Foundation which launched a 10-year training programme in 2006 for the training of 300 more professionals

In the South African public sector nurses are considered by Breier, Wildschut and Mgqolozana (2009:1) to be the backbone of the health system because they provide most of the health services. These authors highlight disturbing signs that nursing is in trouble because of nursing shortages and the nursing education system which fails to produce urgently needed nurses. They further note the education of nurses in the public sector has decreased since 1998 from 2 682 to 2 343 in 2007 while a drastic increase in the training of nurses in the private sector has taken place with a more than fivefold increase of 158 in 1998 to 832 in 2007 (Breier *et al.,* 2009:1). Four-year professional nursing training programmes are offered by public nursing colleges and universities while courses for nurse auxiliaries, nurses and general registered nurses are offered by both public and private institutions (Breier *et al.,* 2009:65).

Public hospitals are affected by the insufficient cooperation between the Department of Education and the Department of Health and the implications of the restructuring of nursing education which was not well thought through. Breier *et al.* (2009:73 & 74) report that with the rationalisation process nursing colleges have been incorporated into higher education and the four-year degree qualification has gained increasing emphasis as a choice due to South Africa's need for nurses who have to demonstrate research and management skills. This rationalisation of the colleges also resulted in a decline in the production of nurses through the public sector and rapid growth of private education. The training of nurses by the larger private hospital

groups is to cater for their own nursing needs – making a major contribution to the numbers of qualified nurses. It seems inevitable that in future large South African hospital groups as private higher education institutions may play an increasingly important role in nursing education and training due to the acute shortage of nurses (Breier *et al.,* 2009:75).

The SANC has prevented the private sector from training nurses since 2008 by banning the accreditation of new private nurse education institutions until the new nursing curriculum had been finalised. This prevented the training of many nurses because the new nursing curricula had not yet been finalised by 2017. Currently, the larger hospital groups as private higher education institutions are prevented from training new nurses until legislative problems have been resolved (Oxford, 2016). Another contributing factor to which Oxford (2016) refers is the basic South African school system that fails to produce students capable of meeting the demands of the nursing curriculum. This leads to a high dropout rate and the average time taken to complete a nursing education programme. As a consequence, the private sector recruits specialist nurses from other countries to provide training, supervision and dissemination of technical skills for local workers (Econex, 2013:48).

One may conclude that the shift of moving the training of professional nurses to higher education was a worthwhile endeavour which has moved the nursing profession into a more prestigious area. However, there is an urgent need for legislative, accreditation and nurse education issues to be resolved soon so that the goals of professional nurse training can be achieved (also see Oxford, 2016).

3.5.   PROFESSIONAL CONTEXT

In South Africa, with its diverse society, professional practice is mainly under the control of legislation that guides the profession. Outstanding professionalism and advocacy for the users of healthcare in South Africa is stipulated in the Nursing Act 33 of 2005 (Republic of South Africa, 2005) and the code of ethics for the nursing practitioners of South Africa (Bimray & Jooste, 2014:200). This code of ethics (SANC, 2013b:4) stipulates that the development of professional values and value-

based behaviour must be included in nursing training so that decisions can be made within a professorial ethical framework. Geyer, Mogotlane and Young (2015:21) refer to South Africa as a country rich in cultural diversity, which means that the professional status of nursing is built on professional solidarity, accountability and skill – and all have to comply with the code of ethics and public welfare.

Globally, there is a need for upgrading nursing educational programmes in order to increase the production of health professionals. This will improve the performance of the health system and address the health concerns of the patient and population (Blaaw *et al.,* 2014:1). What is further highlighted is the importance of significant strategies such as changes in production, the scope of practice and the education of nurses to improve the function and impact of healthcare systems. Over the last century the global trend in nursing education leaned towards greater professionalisation via the lengthening of training periods and the shift from a hospital-based apprenticeship model to professional education in institutions of higher learning (Blaaw *et al.*, 2014:2). These trends point to multiple pathways of registering as a professional nurse with either a nursing college diploma or a university degree which is still allowed in many countries.

A dynamic development in the professionalisation of nursing education (Blaaw *et al.,* 2014:2, 11-13) has been the request to implement a baccalaureate degree as a minimum entrance requirement for registration as a professional nurse. This is mainly due to the changes in patient disease profiles, the development in medical and information technology, the change to evidence-based practice, lifelong professional development, challenges of healthcare teams and the continued reforms of health systems.

The noteworthy changes in the reform of nursing education in South Africa (Blaaw *et al.,* 2014:16 &17) are the increase in professionalisation and the move of nursing education to university education. Nursing education qualifies as higher education according to the Higher Education Act 101 of 1997 which gives it the same

educational status as other professions (Mekwa, 2000:275) and placing it at a more prestigious level.

In South Africa the Higher Education Amended Act 26 of 2010 has created new challenges for the education and training of nurses. These include that all existing nursing colleges (public and private) have to apply for accreditation as higher education institutions, the streamlining of new nursing qualifications, the implementation of recognition of prior learning and the discontinuing of legacy nursing programmes (Blaaw *et al.*, 2014:2; Klopper, 2009:44).

The SANC regulates nursing education and training in South Africa through its accreditation and quality assurance systems. The SANC prescribes the minimum requirements for the education and training of nurses which ensure safe and competent nursing practice (Bruce & Klopper, 2016:66). Before commencing any nursing programmes, a nursing education institution and its clinical facilities should be accredited by the SANC as delivery sites (Amstrong *et al.*, 2013:109).

Chapter 2 of the Nursing Act 33 of 2005 (Republic of South Africa, 2005:25) makes provision for the education, training, research, registration and practice of nursing. This Act announced the SANC as an education and training quality authority (ETQA) in terms of the SAQA Act 58 of 1995 (Republic of South Africa, 1995). The latter arrangement is no longer valid as the NQF Act of 2009 recognises only the CHE, Council for Quality Assurance in General and Further Education and Training (Umalusi) and the Quality Council for Trade and Occupation (QCTO) as the three quality councils (Republic of South Africa, 2009:35). All professional regulators according to this act become professional bodies. The Nursing Act 33 of 2005 stipulates further that all institutions offering nursing education programmes should be accredited by the SANC. All universities, nursing colleges and higher education institutions should thus be accredited by both the CHE and the SANC (Bruce & Klopper, 2016:70).

Both academic and practical preparation of students is seen as a necessity for students to become competent and safe practitioners. Thus, one of the requirements of the SANC is that nurse educators who teach theory should also handle the practical preparation and accompaniment of students at the bedside of the patient (Alberts, 1991:39; Koen 1991:30). Hence, increasing pressure is placed on nurse educators as academics in the current tertiary environment as they are expected to improve their qualifications and have to accommodate students from the basic schooling system who failed to cope with the demands of the nursing curricula. The proper practical learning of students is also sacrificed due to increases in the workload of nurse educators as pointed out by Cele (1990:34) and confirmed by Alberts (1991:39). Interestingly, Cohen *et al.* (2009:51) are also of the opinion that professionalism is frequently mentioned as an excuse to measure and calculate the workload of educators.

3.6.   POLICY CONTEXT

The Higher Education White Paper of 1997 (Republic of South Africa, 1997a:2), the Higher Education Act 101 of 1997 (Republic of South Africa, 1997b:8), and the National Plan of Higher Education (Republic of South Africa, 2001:6) had significant policy changes in terms of legislation and regulations for the higher education sector (CHE, 2016:63; Mapesela & Hay, 2005:118). Policy development was fast, but policy implementation was harder and there are at the moment still many outstanding issues regarding implementation or effective implementation (Mapesela & Hay, 2005:112).

In accordance with the Nursing Act 33 of 2005, the SANC regulates nursing education and training in South Africa (Geyer*,* 2017b:83; Rispel & Bruce, 2014/2015:119; Seekoe, 2014:1). Therefore, it was expected of the SANC to start with the integration process of nursing education into the education system of South Africa. However, Rispel and Bruce (2014/2015:119) point out that the transformation of nursing education is complicated because the SANC is largely dysfunctional and offers sub-optimal leadership in policy development and implementation. This is confirmed by a study conducted by Armstrong and Rispel (2015) in which they

highlight the building blocks of the WHO on transformative education as it relates to nursing education.

Over the past few years, a wide range of policies and legislation have influenced the changes, transformation and quality assurance in higher education in South Africa (Mapesela & Hay, 2005:112 & 118). This also pertained to private higher education (Subotzky, 2002:1 & 2). The introduction of the legislative changes for a revised scope of practice in education and training programmes, the revised and new policies for nursing education and the training and practice strategy demand specific skills and competencies for nurses. Nursing education in South Africa is also influenced by the global frameworks of the WHO including task-shifting to address the impact of HIV and Aids and the International Council of Nurses (ICN) with the development of a competency framework for the different levels of nursing (Bruce & Klopper, 2016:56).

The rationalisation of nursing education training institutions in South Africa was included in the nursing education policy reforms in 1999 while in 2007 the scope of practice of nurses changed with the promulgation of the new Nursing Act 33 of 2005 accompanied by a review of nursing qualifications (Blaaw *et al.*, 2014:2). For these authors the need arose to review South African nursing qualifications since 1995 due to a number of factors. These factors included: increases in service demands, stress-free international migration, nursing shortages, a decline in the status of the profession, the ageing of the workforce, low morale of the staff, changes within the nursing profession and the importance to align the nursing qualification with the new National Qualifications Framework (NQF).

A landmark in the history of the transformation of the nursing profession in South Africa was the change in the regulation of the nursing profession with the implementation of the Nursing Act 33 of 2005 which created a new legislative framework (Subedar, 2017:106). This Act made provision for regulations specifying the requirements for the nursing profession, and education and training at accredited nursing education and training institutions. It also stipulated that the SANC has the

right to inspect and investigate accredited nursing education institutions as needed to address the quality of nursing provided by healthcare facilities for clinical training and education.

The SANC was always the regulator of nursing training and qualifications, but with the implementation of the South African Qualifications Authority (SAQA) in 1995 and the National Qualifications Framework (NQF) in 2008, the situation changed significantly (Geyer, 2017b:78; Mapesela & Hay, 2005:118) as nursing qualifications also had to comply with the policy of the Department of Education. With the review of SAQA and the NQF in 2007, the Higher Education Qualifications Framework (HEQF) was developed. The NQF then changed from eight to 10 qualification levels and, as a result, all qualifications offered by higher education institutions had to be aligned to the requirements of the Higher Education Qualifications Framework (HEQF) (Bruce & Klopper, 2016:63-64).

Blaaw *et al.* (2014:5) divides the reform of nursing education and training in South Africa in two phases. Phase one comprised of the period 2001 to 2009 during which the alignment of the legacy nursing qualifications with the NQF was unsuccessful due to a lack of resources and the change from the NQF to the HEQF. Phase two was from 2008 to 2013 when entirely new nursing qualifications were developed. At the National Nursing Summit in 2011 held in South Africa SA, nurses urged the National Department of Health to establish a task team for the development and implementation of a comprehensive national policy on nursing education and training (Amstrong *et al.*, 2013:24). A plea was also made to the SANC for speeding up the process and the implementation of the framework of the new nursing qualifications in collaboration with the Department of Health, the Council of Higher Education (CHE) and SAQA (Blaaw *et al.*, 2014:5). These authors point out that this phase of the policy process was completed by a task team appointed by the Minister of Health and in 2013 the regulations for the new nursing qualifications were published. Before any higher education institution can implement the new nursing qualifications, it must be approved by both the SANC and the CHE.

A highlight in 2013 was when the Minister of Health released the new national strategic plan for nursing education, training and practice which provided a roadmap for the development of nursing in South Africa (Republic of South Africa, 2013:17). Five major strategic objectives were identified in this national strategic plan to improve the quality of nursing services and patient care. These objectives included: nursing education and training, nursing practice, nursing leadership, resources for nursing and nursing regulation.

At the time of this study, a comprehensive nursing degree programme is offered at universities while a comprehensive diploma programme is offered at public nursing colleges. The latter is because of the public colleges' legal agreement between provincial health departments and universities (Bruce & Klopper, 2016:65). With the transfer of nursing education into higher education it was also required from nursing education institutions to meet the requirements for registration with the Department of Education, the Department of Higher Education and Training as well as meeting the accreditation criteria of the SANC and the CHE (Armstrong *et al.*, 2013:113).

The SANC (2005:5) serves as the education and training quality assurance body which establishes, improves and controls the standards of quality of nursing education and training and also accredits all nursing education in South Africa. All private or public nursing education institutions and their clinical facilities thus need to be accredited and approved by SANC before they can commence with nursing education and training (Geyer, 2017b:83; Armstrong & Rispel, 2015).

The policy of the South African Nursing Council (1992:1-8) with regard to professional nursing education stipulates the minimum requirements and standards for nursing education and clinical practice. It promotes standards for nursing education institutions, what students must do and achieve during their nursing programmes and the academic and clinical competence of nurse educators. In addition, it monitors the quality of nursing education; establishes new nursing programmes; has a scientific approach to nursing and set the minimum standards for accreditation and registration of nursing education sites. The policy also provides for

compliance assurance of nursing education sites and clinical facilities before allowing a programme to be presented and also the framework within which programmes must be delivered (SANC, 2013c:4-17).

Since 1994, the academic and clinical roles of nurse educators have changed significantly as a result of the changes in South African higher education policy (Ntshoe *et al.*, 2008:399). The authors state it would be best for nurse educators to redefine their academic role in the ever-changing higher education setting. In their policy analysis, Blaaw *et al. (*2014:9) posit the lack of policy development processes within the nursing sphere in South Africa may be ascribed to insufficient nursing policy expertise and leadership in the SANC and the DHET.

The multi-campus private higher education institution which served as the research site in this study was registered and accredited as a private higher education institution in 2008. This was in accordance with the requirements of the Higher Education Act 101 of 1997 and the regulations for the registration of private higher education institutions published in the Government Gazette no 24143 dated 13 December 2002. Changes in both health and higher education policy have a direct impact on the work, the workload and working lives of healthcare professionals (Amstrong *et al.*, 2013:23). For private higher education institutions it is of some concern that the implementation of the new nursing qualifications are limited and that policy development in the production of the supporting legislation as required by the new Nursing Act 33 of 2005 is slow (Blaaw *et al.*, 2014:8).

3.7. INSTITUTIONAL CONTEXT

The primary vision of the identified private healthcare provider involved in this study is to be respected internationally for delivering measurable quality clinical outcomes; to continue growing as a successful international healthcare group by enforcing good corporate governance and acting as a responsible corporate citizen. Indeed, to be preferred locally for its delivery of excellent patient care, ensuring aligned relationships with doctors and or in communities, being an employer of choice, appointing and retaining competent staff, building constructive relationships with all

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stakeholders and for being a valued member of the community (Private healthcare provider mission and value statement, 2005:1-3). At this private healthcare provider the nurse educators as employees of the company pride themselves on being committed to doing everything in their power to promote and improve the quality of patients' lives in a fair and courteous manner.

Based on the vision of the this private healthcare provider, the vision of the identified private higher education institution is to be respected for providing world-class training leading to the development of safe practitioners and the delivery of excellent patient care (Private healthcare provider mission and value statement, 2005:1-3). The mission of the same institution is to deliver measurable quality training outcomes governed by sound educational principles, evidence-based practice and adherence to legislation. Further, to contribute to the development of skills relevant to healthcare service delivery nationally. Its mission governs the main concerns and focus of an institution (Cohen *et al.*, 2009:50). Hence, in the case of the the identified private higher education institution its mission serves fundamentally as the guide bringing together the organisational drive, motivation and action to transform the thinking of nurse educators as academics. By releasing the nurse educators' creativity and empowering them to identify what is expected of each nurse educator's workload as an academic, productivity and job satisfaction can be accelerated and achieved.

Kotze (2017:17) interprets the mission statement as a declaration of the intent, belief and role of the nurse educators as academics of the nursing education institution. In an endeavour to capture the essence of the identified private higher education institution's mission and to uphold and fulfil the vision, the nurse educators as academics strive to prioritise quality training while maintaining intellectual integrity and executing all tasks competently to successfully contribute to the growth and development of the private higher education institution, the employees and the nursing working environment of the future. As academics and employees, the nurse educators actively embrace the value of ethical conduct, both personal and intellectual. This mind set allows nurse educators to focus on key personal and

organisational targets – individual competence by investing in a culture of lifelong learning, providing evidence-based training and maintaining safe and quality standards in healthcare service delivery and practice thereby accelerating safe and quality patient care by professional nurses (Private healthcare provider, Mission and Vision statement, 2005:1-3).

The educational philosophy of this private higher education institution is based on the principles of providing quality, comprehensive learning programmes to all students, ensuring a professional, independent practitioner upon completion of training, motivating learners to actively participate and take ownership of their own development and integrating theory into practice (Private healthcare provider mission and value statement, 2005:1-3). This educational philosophy is guided by the theories of progressivism and pragmatism due to the belief in the importance of experiential learning in the development of competent healthcare practitioners. The importance of an educational philosophy is stressed by Kotze (2017:17) because it represents the views of the nurse educator as an academic. It also serves as a framework for the development of the nursing education institution's policies and assists in day-to-day decision making.

Over the past seven years, the number of nursing and operating department assistance students increased at the institution. However, the increase in nurse educators was not proportional to the extended number of training programmes and courses currently offered. In other words, the current workload model for nurse educators at this private higher education institution is also not a formal workload model but a needs-based arrangement whereby guidance is provided by the work profile and competencies of the nurse educators, the curricula of the different programmes and courses as well as the regulations, standards and legislation of the applicable legislative bodies.

This private higher education institution is managed by a higher education and training manager and the nursing education sites (NES) are managed by the nursing training manager. The seven nursing education sites, as indicated by the

organogram (cf. Figure 3.2) are distributed over six of the nine provinces in South Africa. Currently, this private higher education institution offers 64 different courses and accredited programmes as well as funding to employees who want to do university programmes not internally offered in this private higher education institution (van Zyl, 2015:1-2).
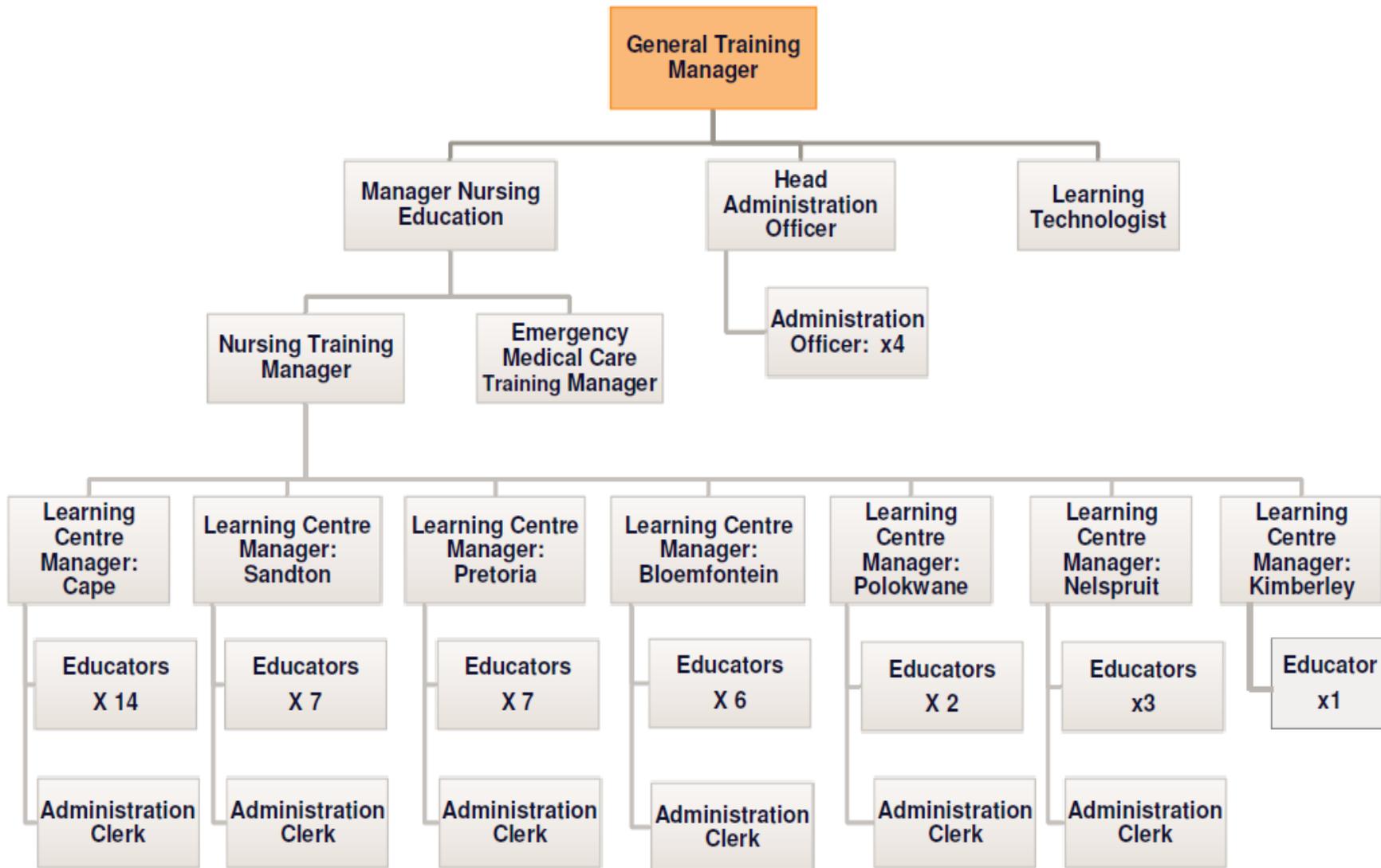
Figure 3.2: Organogram of the nursing education sites of the private higher education institution

This privately own higher education institution has 46 full-time nurse educators, an average of 1 000 students on formal programmes and an average of 1 800 students on non-formal programmes annually. A typical academic year consists of 44 weeks as stipulated by the SANC and the the work week of each nurse educator consists of 40 hours in which lecturing, administration, clinical accompaniment of the students and research for lecturing purposes are performed. What follows is a discussion of the workload situation of the nurse educators at the seven nursing education sites.

3.7.1. The nursing education site in Cape Town

This nursing education site is managed by a learning centre manager with 14 educators reporting to this manager. The two-year programme leading to an enrolled nurse qualification, the two-year bridging course for staff nurses leading to a registered nurse, the three-year operating department assistance (ODA) programme, the two-year emergency medical care (EMC) programme, six-month short courses, ten-month in-house courses, life support courses and four-month continuing professional development (CPD) courses are offered by the NEI as well as clinical accompaniment of the critical care, operating theatre and maternity post-graduate diploma students of Stellenbosch University. The students at this learning centre are employed at 13 affiliated private hospitals in the region. The educators of this learning centre also provide an education and training service to the affiliated private hospital situated in the Northern Cape region and the two affiliated private hospitals in Namibia provide the life support courses, short course and CPD courses. The geographical location of these affiliated private hospitals obviously implies the nurse educators have to travel extensively. Table 3.1 indicates the current workload distribution of the educators at the nursing education sites in Cape Town.

Table 3.1: Workload distribution of the educators at the nursing education sites in Cape Town

	Enrolled nurse course	Bridging course	EMC programme 1st year	EMC programme 2nd year	ODA programme	ODA programme (Module coordinator)	Postgraduate diploma	CPD course	Number of CPD courses (Coordinator)	Short course	In-house course	Basic life support	Advanced cardiac life support	AHA faculty	AHA coordinator
Learning Centre Manager		X						X	1						
Educator 1			X												
Educator 2					X	X	X	X	2	X	X	X			
Educator 3		X					X	X	1	X		X	X	X	
Educator 4		X							1						
Educator 5		X						X	1	X		X	X	X	X
Educator 6				X											
Educator 7		X						X	1						
Educator 8		X						X	1			X			
Educator 9					X	X		X	2	X					
Educator 10	X	X					X	X	2	X					
Educator 11	X	X						X	1	X					
Educator 12	X	X						X	2	X		X			
Educator 13															
Educator 14					X	X		X	3	2					

In the above table the 'X' indicates the courses and/or programmes each educator is responsible for and the numbers in the 'Number of CPD courses (Coordinator)' column indicate the number of courses the specific educator coordinates. For example, 'Educator 14' has three courses to coordinate. Those educators indicated as a 'Module coordinator' has to set and mark all tests, assignments and examination papers of all students nationally of the private higher education institution. The responsibilities of the CPD, short course and in-house course educators involve theoretical contact sessions, clinical accompaniment of students, formative and summative evaluation of students and writing of student reports (monthly, three-monthly and summative). It also involves completion of training, student record-keeping, the setting and marking of tests, assignments and examination papers.

The CPD, short course and in-house coordinators' responsibilities include the setting and marking of tests, assignments and examination papers of their own region only. They also conduct all the contact sessions within their region, mark all examination papers nationally, oversee students' training records, do the completions of all students at the end of the course and regularly revise the study material. The responsibilities of a programme educator include 10 to 19 weeks' theoretical contact sessions per annum, six hours' clinical accompaniment per student per month and formative and summative assessment in the clinical environment. It further involves the setting and marking of tests, assignments and examination papers of the modules they facilitate, up-to-date record-keeping, monthly- and three-monthly and summative reports and the completion of training when a student completes the study programme successfully.

The additional functions of an educator coordinating an operating department assistant (ODA) programme module are setting tests, assignments and examination papers, marking nationally all examination papers for their module and do the internal moderation of other modules as requested. Basic life support (BLS) and advanced life support (ACLS) training is monthly additionally provided by those educators indicated in Table 3.1. The responsibilities of an American Heart

Association (AHA) faculty member (educator) is to present and evaluate students doing the different life support courses, monitoring of life support instructors, doing audits of their training sites at the affiliated private hospitals and keeping record of all life support training statistics.

3.7.2. The nursing education site in Bloemfontein

A learning centre manager currently manages this nursing education site and six educators report to this manager. The two-year programme leading to an enrolled nurse qualification, the two-year bridging course for staff nurses leading to a registered nurse, the three-year operating department assistance (ODA) programme, six-month short courses, ten-month in-house courses, life support courses and four-month continuing professional development (CPD) courses are offered by this NEI as well as the clinical accompaniment of the critical care and operating theatre post-graduate diploma students of the University of the Free State. The students of this learning centre are employed at seven affiliated private hospitals in this region. The educators of this learning centre also provide an education and training service to the affiliated private hospital in Kimberley and three affiliated private hospitals in KwaZulu-Natal, namely the life support courses, short course and CPD courses. The geographical locations of the affiliated private hospitals in this region are distributed over three provinces which mean excessive travelling for the educators as indicated in Map 4.1. In Table 3.2 the current workload distribution of the educators of the nursing education site in the Central region.
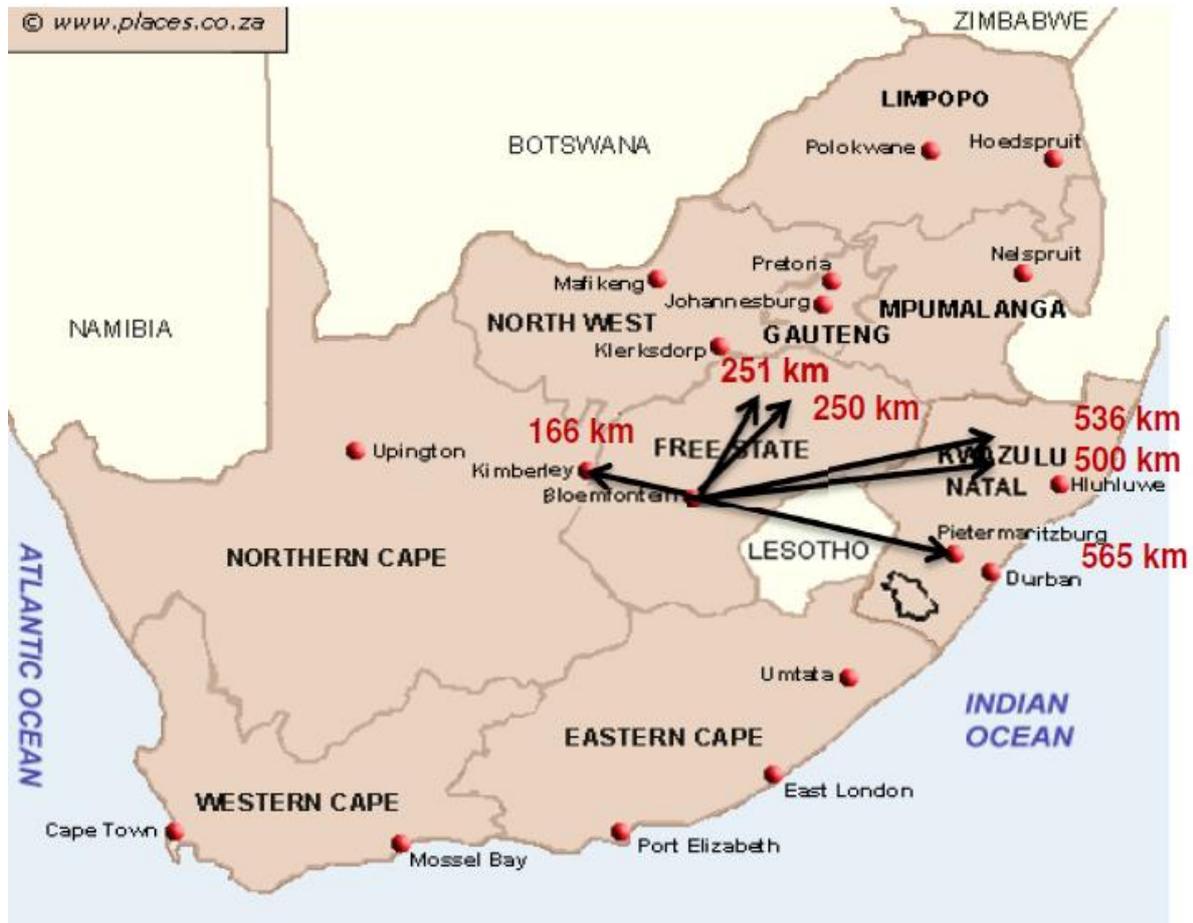
Map 4.1: Traveling distances between the nursing education site in Bloemfontein and the affiliated private hospitals (adopted from South African Places, 1997)

Table 3.2: Workload distribution of the educators of the nursing education site in Bloemfontein

	Enrolled nurse course	Bridging course	ODA programme	ODA programme (Module coordinator)	ODA programme (Coordinator)	Post-graduate diploma	CPD course	Number of CPD courses (Coordinator)	Short course	Number of short courses (Coordinator)	In-house course	In-house course (Coordinator)	Basic life support	Advanced cardiac life support	AHA faculty
Learning Centre Manager		X	X						X	1					
Educator 1		X	X				X	1	X				X	X	X
Educator 2			X	X	X	X	X	1	X		X				
Educator 3		X	X												
Educator 4		X				X	X	1					X	X	X
Educator 5	X	X	X				X	1			X	1			
Educator 6		X	X					1	X						

The educator 2 in Table 3.2 who coordinates the ODA programme nationally has to set her own module tests, assignments and examination papers, coordinate all module tests, assignments and examination papers. She also has to ensure that all tests, assignments and examination papers are internally and externally moderated, liaise with external moderators, distribute tests and examination papers to all nursing education sites according to policy, keep all student results up to date, check and finalise completion documentation for the issuing of diplomas and revise all study material of the ODA programme.

In Table 3.2 the 'X' also indicates the courses and/or programmes each educator is responsible for. Also, those educators indicated as a 'Module coordinator' has to set and mark all tests, assignments and examination papers of all students nationally enrolled at this private higher education institution. The responsibilities of the CPD, short course and in-house course educators involve theoretical contact sessions, clinical accompaniment of students, formative and summative evaluation of students, writing of student reports (monthly, three-monthly and summative). It further involves completion of training, student record-keeping and the setting and marking of tests, assignments and examination papers. The CPD, short course and in-house coordinators' responsibilities include setting and marking of tests, assignments and examination papers of their own region. They also conduct the contact sessions in their region, mark all examination papers nationally, oversee students' training records, do completions of all students at the end of the course and regularly revise the study material.

The responsibilities of a programme educator include 10 to 19 weeks of theoretical contact sessions per annum, six hours' clinical accompaniment per student per month and formative and summative assessment in the clinical environment. It also involves the setting and marking of tests, assignments and examination papers of the modules they facilitate, keeping records up to date, writing monthly- and three-monthly and summative reports and the completion of training when a student completes the programme of study successfully. The additional functions of an educator coordinating an operating department assistant (ODA) programme module

are setting tests, assignments and examination papers, marking nationally all examination papers for their module and doing the internal moderation of other modules as requested. Basic life support (BLS) and advanced life support (ACLS) training are additionally provided on a monthly basis by those educators indicated in Table 3.2. The responsibilities of an American Heart Association (AHA) faculty member (educator) are to present and evaluate students doing the different life support courses, the monitoring of life support instructors and the audits of their training sites at the affiliated private hospitals as well as keeping life support training statistics updated.

3.7.3. The nursing education site in Polokwane

This new nursing education site is managed by a learning centre manager with two educators reporting to the manager. The following courses are offered here: a two-year programme leading to an enrolled nurse qualification, a two-year bridging course for staff nurses leading to a registered nurse, a three-year operating department assistance (ODA) programme, six months' of short courses, ten months of in-house courses, life support courses and four months of continuing professional development (CPD). Clinical accompaniment of the operating theatre post-graduate diploma students of the University of Pretoria also takes place at this site and the students graduating from the site are employed at two affiliated private hospitals in the Limpopo province. Table 3.3 shows the current workload distribution of the educators at the nursing education site in Polokwane.

Table 3.3: Workload distribution of the educators at the nursing education site in Polokwane

	Enrolled nurse course	Bridging course	ODA programme	ODA programme (Module coordinator)	Post-graduate diploma	CPD course	Number of CPD courses (Coordinator)	Short course	Number of short courses (Coordinator)	In-house course	Basic life support
Learning Centre Manager		X				X	1				X
Educator 1			X	X	X	X		X	1	X	
Educator 2	X	X									

In the Table 3.3 the 'X' also indicates the courses and/or programmes each educator is responsible for as well as those educators indicated as a 'Module coordinator' who has to set and mark all tests, assignments and examination papers of all students nationally enrolled at this private higher education institution. The CPD, short course and in-house course educators indicated are involved in the theoretical contact sessions, clinical accompaniment of students, formative and summative evaluation of students and the writing of student reports (monthly, three-monthly and summative). These educators are also involved in the completion of training records, student record-keeping, the setting and marking of tests, assignments and examination papers. The CPD, short course and in-house coordinators' responsibilities include the setting and marking of tests, assignments and examination papers in their own region. They also conduct the contact sessions in their region, mark all examination papers nationally, oversee students' training records, do completions of all students at the end of the course and regularly revise the study material.

The responsibilities of programme educators in Table 3.3 include 10 to 19 weeks' theoretical contact sessions per annum, six hours' clinical accompaniment per student per month and formative and summative assessment in the clinical environment. It also involves the setting and marking of tests, assignments and examination papers of the modules they facilitate, up-to-date record-keeping, monthly- and three-monthly and summative reports and the completion of training when a student completes the programme of study successfully. The additional functions of an educator coordinating an operating department assistant (ODA) programme module are setting tests, assignments and examination papers, marking nationally all examination papers for their module and doing the internal moderation of other modules as requested. Basic life support (BLS) training is provided additionally on a monthly basis by the educator indicated as indicated in Table 3.3.

3.7.4. The nursing education site in Nelspruit

This nursing education site in Nelspruit, Mpumalanga is managed by a learning centre manager with three educators reporting to the manager. The following courses are offered at this site: a two-year programme leading to an enrolled nurse qualification, a two-year bridging course for staff nurses leading to a registered nurse, a three-year operating department assistance (ODA) programme, six months of short courses, ten months of in-house courses, life support courses and four months of continuing professional development (CPD) courses. The clinical accompaniment of the critical care post-graduate diploma students of the University of Johannesburg also takes place here and the students of this learning centre are employed at the affiliated private hospital in Nelspruit. In Table 3.4 the current workload distribution of the educators at the nursing education site in Nelspruit is indicated.

Table 3.4: Workload distribution of the educators at the nursing education site in Nelspruit

	Enrolled nurse course	Bridging course	ODA programme	ODA programme (Module coordinator)	Post-graduate diploma	CPD course	Number of CPD courses (Coordinator)	Short course	Number of short courses (Coordinator)	In-house course	Basic life support	Advanced cardiac life support	AHA faculty
Learning Centre Manager			X	X	X	X		X	1	X			
Educator 1		X				X	1						
Educator 2	X										X		X
Educator 3					X	X		X				X	

In Table 3.4 the 'X' indicates the courses and/or programmes each educator is responsible for as well as the educator indicated as a 'Module coordinator' who has to set and mark all tests, assignments and examination papers of all students nationally enrolled at this private higher education institution. The responsibilities of the CPD, short course and in-house course educators involve theoretical contact sessions, clinical accompaniment of students, formative and summative evaluation of students and writing of student reports (monthly, three-monthly and summative). It also involves completion of training, student record-keeping and the setting and marking of tests, assignments and examination papers. The CPD, short course and in-house coordinators' responsibilities include the setting and marking of tests, assignments and examination papers in their own region. They also conduct the contact sessions in their region, mark all examination papers nationally, oversee students' training records, do completions of all students at the end of the course and regularly revise the study material.

The responsibilities of programme educators include 10 to 19 weeks' theoretical contact sessions per annum, six hours' clinical accompaniment per student per month and formative and summative assessment in the clinical environment. It also involves the setting and marking of tests, assignments and examination papers of the modules they facilitate, record-keeping, monthly- and three-monthly and summative reports and the completion of training when a student completes the programme of study successfully. The additional functions of an educator coordinating an operating department assistant (ODA) programme module are setting tests, assignments and examination papers, marking nationally all examination papers for their module and doing the internal moderation of other modules as requested. Basic life support (BLS) and advanced life support (ACLS) training is provided additionally monthly by those educators as indicated in Table 3.4. The responsibilities of an American Heart Association (AHA) faculty member (educator) is to present and evaluate students doing the different life support courses and the audits of their training sites at the affiliated private hospitals as well as keeping the life support training statistics.

3.7.5. The nursing education site in Kimberley

This nursing education site is managed by a learning centre manager. At the time of the study the nurse educator posisition is vacant. The following courses are offered at this site: A three-year operating department assistance (ODA) programme, a life support course and a four months continuing professional development (CPD) course. The clinical accompaniment of bridging students from the Central region nursing education site also takes place here and the students of this learning centre are employed at the affiliated private hospital in Kimberley. Table 3.5 below indicates the current workload distribution of the learning centre manager of the nursing education site in Kimberley.

Table 3.5: Workload distribution of the learning centre manager at the nursing education site in Kimberley

	Enrolled nurse course	Bridging course	ODA programme	ODA programme (Module coordinator)	Post-graduate - diploma	CPD course	Number of CPD courses (Coordinator)	Short course	Number of short course (Coordinator)	In-house course	Basic life support	Advanced cardiac life support	AHA faculty
Learning Centre Manager		X	X			X	1				X		
Educator 1		X				X					X		

In Table 3.5 the 'X' indicates the courses and programmes the learning centre manager is responsible for. She is a 'Module coordinator" who has to set and mark all tests, assignments and examination papers of all students nationally at this private higher education institution. The responsibilities of the CPD course she is involved with require theoretical contact sessions, clinical accompaniment of students, formative and summative evaluation of students, writing of student reports (monthly, three-monthly and summative). It also involves completion of training, student record-keeping, the setting and marking of tests, assignments and examination papers. The CPD coordinator's responsibilities include setting and marking of tests, assignments and examination papers in her region. She also conducts the contact sessions in her region, marks all examination papers nationally, oversees students' training records, does completions of all students at the end of the course and regularly revises the study material.

The responsibilities of her as programme educator include 10 to 19 weeks' theoretical contact sessions per annum, six hours' clinical accompaniment per student per month and formative and summative assessment in the clinical environment. It also involves the setting and marking of tests, assignments and examination papers of the modules she facilitates, record-keeping, monthly- and three-monthly and summative reports and the completion of training when a student completes the programme of study successfully. As basic life support (BLS) instructor she has to provide monthly basic life support training.

3.7.6. The nursing education site in Sandton

This nursing education site in Gauteng is managed by a learning centre manager with seven educators reporting to the manager. The following courses are offered at this site: a two-year programme leading to an enrolled nurse qualification, a two-year bridging course for staff nurses leading to a registered nurse, a three-year operating department assistance (ODA) programme, six months of short courses, ten months of in-house courses, life support courses and four months of continuing professional development (CPD) courses. The clinical accompaniment of the critical care, operating theatre and emergency care graduate diploma students of the University of

Johannesburg and University of Pretoria also takes place at this site. The students of this learning centre are employed at seven affiliated private hospitals in the region. The head nurse educator of this learning centre provides education and training services to all the affiliated private hospitals' oncology courses nationally. The emergency care educator provides an education and training service by means of emergency care programmes and courses to the affiliated private hospitals nationally. The geographical locations of the affiliated private hospitals in this region also involve travelling extensive distances for all educators. Table 3.6 indicates the current workload distribution of the educators at the nursing education site in the Northern region.

Table 3.6: Workload distribution of the educators of the nursing education site in Sandton

	Enrolled nurse course	Bridging course	ODA programme	ODA programme (Module coordinator)	Post-graduate diploma	CPD course	Number of CPD courses (Coordinator)	Short course	Number of short courses (Coordinator)	In-house course	In-house course (Coordinator)	Basic life support	Advanced cardiac life support	AHA faculty
Learning Centre Manager		X	X			X		X	1					
Educator 1		X			X	X		X	2			X	X	X
Educator 2			X	X		X		X	1					
Educator 3			X	X	X	X		X		X	1			
Educator 4		X					1							
Educator 5		X						X	1					
Educator 6	X	X			X	X	2	X	1			X	X	X
Educator 7		X												

In Table 3.6 'X' indicates the courses and/or programmes each educator is responsible for and the numbers in the 'Number of CPD courses (coordinator)' column indicates the number of courses the specific educator coordinates. For example, 'Educator 1' has two courses to coordinate. Those educators indicated as a 'Module coordinator' has to set and mark all tests, assignments and examination papers of all students nationally enrolled at this private higher education institution. The responsibilities of the CPD, short course and in-house course educators involve theoretical contact sessions, clinical accompaniment of students, formative and summative evaluation of students, the writing of student reports (monthly, three-monthly and summative). It also involves completion of training, student record-keeping, the setting and marking of tests, assignments and examination papers.

The CPD, short course and in-house coordinators' responsibilities include the setting and marking of tests, assignments and examination papers in their own region. They also conduct the contact sessions in their region, mark all examination papers nationally, oversee students' training records, do completions of all students at the end of the course and regularly revise the study material. The responsibilities of a programme educator include 10 to 19 weeks' theoretical contact sessions per annum, six hours' clinical accompaniment per student per month and formative and summative assessment in the clinical environment. It further involves the setting and marking of tests, assignments and examination papers of the modules they facilitate, up-to-date record-keeping, monthly- and three-monthly and summative reports and the completion of training when a student completes the programme of study successfully.

The additional functions of an educator coordinating an operating department assistant (ODA) programme module are setting tests, assignments and examination papers, marking nationally all examination papers for their module and doing the internal moderation of other modules as requested. Basic life support (BLS) and advanced life support (ACLS) training is provided additionally monthly by those educators as indicated in Table 3.6. The responsibilities of an American Heart

Association (AHA) faculty member (educator) is to present and evaluate students doing the different life support courses, monitoring of life support instructors and auditing their training sites at the affiliate private hospitals as well as keeping life support training statistics.

3.7.7. The nursing education site in Pretoria

This nursing education site in Pretoria is managed by a learning centre manager with seven educators reporting to the manager. The site offers the following courses: a two-year programme leading to an enrolled nurse qualification, a two-year bridging course for staff nurses leading to a registered nurse, a three-year operating department assistance (ODA) programme, six months of short courses, ten months of in-house courses, life support courses and four months of continuing professional development (CPD) courses. The clinical accompaniment of the critical care and operating theatre graduate diploma students of the University of Pretoria takes place at this site while the students of this learning site are employed at eight affiliated private hospitals in this region.

The critical care educator of this learning site provides education and training services to the two affiliated private hospitals in Limpopo in advanced cardiac life support and clinical accompaniment of the critical care programme and courses. The neonatology educator provides education and training services to the affiliated private hospitals nationally with regard to neonatal programmes and courses. The geographical location of the affiliated private hospitals in this region and nationally means extensive travelling have to be done by all the nurse educators. Table 3.7 shows the current workload distribution of the educators at the nursing education site in Pretoria.

Table 3.7: Workload distribution of the educators of the nursing education site in Pretoria

	Enrolled nurse course	Bridging course	ODA programme	ODA programme (Module coordinator)	Post-graduate diploma	CPD course	Number of CPD courses (Coordinator)	Short course	Number of short courses (Coordinator)	In-house course	Basic life support	Advanced cardiac life support	AHA faculty
Learning Centre Manager		X	X	X		x	2						
Educator 1		X				X	1	X	1				
Educator 2		X				X		X			X		
Educator 3			X	X		X	1	X	1	X			
Educator 4	X	X				X		X					
Educator 5			X	X	X	x	1						
Educator 6		X			X	X		X	1	X	X	X	X
Educator 7	X	X				X	3	X	2		X	X	X

In Table 3.7 the 'X' indicates the courses and/or programmes each educator is responsible for and the numbers in the 'Number of CPD courses (coordinator)' column indicate the number of courses the specific educator coordinates. For example, 'Educator 7' has two courses to coordinate. Those educators indicated as a 'Module coordinator' has to set and mark all tests, assignments and examination papers of all students nationally enrolled in this private higher education institution. The responsibilities of the CPD, short course and in-house course educators involve theoretical contact sessions, clinical accompaniment of students, formative and summative evaluation of students, writing of student reports (monthly, three-monthly and summative). It also involves completion of training, student record-keeping, the setting and marking of tests, assignments and examination papers.

The CPD, short course and in-house coordinators' responsibilities include the setting and marking of tests, assignments and examination papers in their own region. They also conduct the contact sessions in their region, mark all examination papers nationally, oversee students' training records, do completions of all students at the end of the course and regularly revise the study material. The responsibilities of a programme educator include 10 to 19 weeks' theoretical contact sessions per annum, six hours' clinical accompaniment per student per month and formative and summative assessment in the clinical environment. It further involves the setting and marking of tests, assignments and examination papers of the modules they facilitate, up-to-date record-keeping, monthly-, three-monthly and summative reports and the completion of training when a student completes the study programme successfully.

The additional functions of an educator coordinating an operating department assistant (ODA) programme module are setting tests, assignments and examination papers, marking nationally all examination papers for their module and doing the internal moderation of other modules as requested. Basic life support (BLS) and advanced life support (ACLS) training is provided additionally monthly by those educators as indicated in Table 3.7. The responsibilities of an American Heart Association (AHA) faculty member (educator) is to present and evaluate students doing the different life support courses, monitoring of life support instructors and

auditing their training sites at the affiliated private hospitals as well as the keeping of life support training statistics.

All nurse educators in all the nursing training sites are expected to do revision of nursing procedures and assessment tools every three years and write new procedures and assessment tools as needed. They also assist the personnel of the affiliated private hospitals on an ad hoc basis with training interventions as well as the nursing specialists with the writing of training material and the provision of training where necessary.

The number of students enrolled in basic nursing programmes is determined by the SANC and the students of the other basic programmes, short courses, CPD courses, in-house courses and post-basic courses are determined according to the needs of the affiliated private hospitals. Annually, in January and June, there are intakes of the basic nursing programmes in four of the nursing education sites and only a January intake in two nursing education sites. The ODA programme commences in January in seven nursing education sites and at all the nursing education sites the in-house courses commence in January, the short courses and 18 of the CPD courses in April and the other 23 CPD courses in August of each year.

A formal contract in the form of a memorandum of agreement is signed between each affiliated private hospitals and the nursing education site of each region as required by the SANC (SANC, 1992:7) and as proposed by Saxe *et al.* (2004:166). This makes nursing education at the private higher education institution unique because the clinical placement of the nursing students of the nursing education sites at regional level is immediately available. Importantly, it establishes the relationship between the clinical and academic sectors of the identified private healthcare company, integrates clinical and theoretical systems, closes the theory-practice gap and creates the opportunity to change the attitudes, beliefs and values with regard to direct patient care (Premji *et al.*, 2011:876).

The private hospitals in the relevant private hospital group does not only provide educational opportunities for students, but also serve as practice sites for nurse educators as academics to enhance their clinical competence (Becker *et al.*, 2007:45). The SANC perceives adequate clinical accompaniment of student nurses in the clinical practice environment as critical for the integration of theory and practice. The organisation is firm in their expectation for student nurses to develop from dependent novices to competent independent practitioners (SANC, 1992:7). At present, nurse educators as academics provide clinical accompaniment to the nursing students with the assistance of the learning and development facilitators and mentors in the private hospitals.

The SANC still has to establish a continuous professional development (CPD) system for the nursing profession. Until such time that this system is in place, all nurses and midwives are recommended to utilise professional development opportunities independently to ensure they maintain their competence and update their skills and knowledge continuously (Amstrong *et al.*, 2013:115). The identified private health care company thus commenced with the development of CPD courses to ensure all the nursing employees of the identified private health care company retain their competencies and update their skills and knowledge on an ongoing basis. The private sector started training their own nurses due to the critical shortage of nurses and the government's inability to meet the needs of the entire healthcare system (Amstrong *et al.*, 2013:110).

The training function of the identified private healthcare company expanded tremendously over a period of 30 years. The immense growth gave birth to a private higher education institution offering accredited training programmes and courses for persons in the nursing profession. Unfortunately, in spite of the success it achieved as an educational and training institution evidenced by the exceptional increase in the number of students and the varied programmes and courses offered, the nurse educator employee numbers remained almost static. This meant the nurse educators' workload increased to the extent that was becoming quite critical. It became evident that if this private company wanted to be the employer of choice; the

private higher education institution would have to address the emerging problematic issue of the nurse educators' workload. They have to also realise the current need-based workload model is replaced with an appropriate achievable workload model to assure optimal productivity and job satisfaction for nurse educators to maintain the high quality of nursing education (Vardi, 2009:500).

3.8. SYNTHESIS

In this chapter a number of contextual elements that pertain to the present study were explored. These included the international context, the national context, the professional context, the private higher education context, the policy context and the institutional context.

From an overview of the international nursing education context three prominent features emerged. Firstly, the goal for future university-based training of nurses that is supported by the American Nursing Association is already implemented in high-income countries while low- and middle income countries are more focused on changes in nursing education in their efforts to address the global nurse shortage. Secondly, the shortage of trained nurses worldwide has created the need for qualified nurses who must be immediately ready for the labour market with applicable skills to provide quality healthcare. Thirdly, much is being done internationally for the professional regulation of nurses, but there are still major concerns about the absence of nurses in the policy-making process in the broader healthcare policy processes. The insight and experience of nurses who work with patients and their families in a variety of institutions can help improve the quality of health service delivery. Currently, international pioneer organisations such as the WHO, the American Nursing Association and the International Council of Nursing still appear to have a significant influence on nursing education in South Africa (Bruce & Klopper, 2016:56).

Highlights that emerged from an overview of nursing education in the national context included the first South African Nursing Act 45 of 1944 which was promulgated for the statutory care of the nursing profession and supported by the

SANC. Another highlight was the shift of nursing education from nursing colleges and hospitals to higher education institutions (Blaaw *et al.*, 2014:16 & 17). Probably one of the low points in South African nursing education was the negative impact of the unsuccessful implementation of the 2008 nursing strategy by the Department of Health. New challenges arose with the discontinuation of the legacy nursing programmes and the alignment of the new nursing qualifications with the Higher Education Qualification Framework. The SANC has developed the regulations for new programmes leading to professional qualifications which have been publish in 2013 in order to meet the necessary qualification requirements as specified by the Higher Education Qualifications Sub-framework (HEQSF). Nursing education institutions are thus developing new curricula according to the new regulations for education and training which may result in major delays in the training of nurses and which will probably lead to nurse shortages adding to the current shortage of trained nurses.

The most important policy elements in professional nursing education context that were highlighted were the promulgation of the Nursing Act 33 of 2005 and the role of the SANC. According to this Act, the SANC was assigned the role of quality authority for nursing education and training in South Africa. It is also a requirement of this Act that all institutions offering nursing education have to be accredited by the SANC. Policy development in the policy context was fast, but implementation thereof slow. Policy development was complicated even more in 2013 when the regulations for new nursing qualifications were published before the SAQA and the CHE approved it. New nursing qualifications cannot be implemented in any higher education institution before it has been approved by both these regulating bodies.

Dramatic changes took place in the private higher education context in the past decade as highlighted by the contextual overview. For instance, the development of private higher education and training has grown to the extent that it increasingly fills the education-training gap for which the government could and still cannot provide. However, filling this gap is taking place in the midst of a variety of opportunities and challenges such as private nursing education institutions that meet the necessary

criteria to be accredited and registered as private higher education institutions. In private nursing education there are signs of global nursing shortages and curriculum reforms that need to be in step with worldwide healthcare demands and the health challenges of the 21st century. Such reforms and demands obviously impact on the roles of nurse educators as well as on the workload of these educators with their respective academic responsibilities.

An overview of the institutional context of an identified private higher education and training facility for nursing education also indicated a number of important issues relevant to this study. One issue was the registration of the facility as a private higher education institution in 2008. Over the past seven years the number of nursing and operating department assistance students increased, but the increase in nurse educators failed to be in proportion with the extended number of training programmes and courses offered. It seemed to be important for the institution to provide quality comprehensive nursing education and to support nurse educators to develop appropriate competencies through a culture of continuous learning, maintaining high healthcare standards, conducting research and providing cost-effective education and training. The heavy workload of the nurse educators in the seven learning sites and the distances that some of them have to travel justified an investigation and inquiry into the possibilities for a workable nurse educator workload model.

The challenges and changes indicated by the relevant contexts all have a direct or indirect impact on the workload and working lives of nurse educators. A concern emerged about the effect of the limited planning regarding the implementation of new nursing qualifications as well as the slow policy development in the production of the supportive regulations as required by the new Nursing Act 33 of 2005.

This chapter contributed to show the complexity of the nursing education and training environment as well as the challenges posed by unrealistic nurse educator workloads. Chapter 4 provides a theoretical framework and grounding for the empirical part of the study.

CHAPTER 4

THEORETICAL CONTEXT

4.1.   INTRODUCTION

In Chapter 2 the key concepts that featured in this study were explored and Chapter 3 elaborated on contextualising nursing education – particularly in relation to the workload of nurse educators. To extend the contextualisation further and provide a theoretical lens for the study, this chapter explores the theoretical context which informed the study's research questions, the research design of the empirical part of the study as well as the findings that emerged from the research as they relate to workload, productivity and job satisfaction of nurse educators within private higher education. Figure 4.1 provides a graphical representation of the funnel approach being followed to distil the key understandings and culminate towards a theoretical lens.

Figure 4.1: Graphic representation of the contextualisation of the study

The systems theory and expectancy theory are proposed here as appropriate theoretical constructs to form a theoretical lens for this section of the study.

4.2.   SYSTEMS THEORY

Since 1947 when the systems theory was introduced by the Austrian biologist Von Bertalanffy (1969:7), literature expands on the long history of improvement and personal and applied concept contributors that led to the birth of the general systems theory. Cordon (2013:14-16) draws attention to Von Bertalanffy's identification of the need for an integrated disciplined general theory that could explain and manage complexities. Cordon (2013:14) also claims the systems theory is "a model of the general aspects of reality" whereby real systems are open, independent and in interaction with the internal and external environment. The interaction of the system with its internal and external environment creates powers that have the potential to change or improve the stability of a system. Huber (2013:43) considers Von Bertalanffy's systems theory as a way in which an organisation as a whole can be studied. The fact that the systems theory is based on a scientific exploration, understanding and control of systems revealed Von Bertalanffy's work to the world (Cornell & Jude, 2015:2; Friedman & Allen, 2011:4). In the dynamic and fast changing modern times, organisations have adapted the systems theory to assist them in being more efficient and effective.

Nel *et al*. (2011:7), Huber (2013:43) and Van der Walt (2016:690) consider a system as a whole formed by a number of interdependent components working together to achieve a common goal. Whereas Sullivan and Decker (2005:14) see a system as a group of interrelated parts arranged in a unified whole, Smit, Cronje, Brevis and Vrba (2011:61) describe a system as a group of subsystems (elements) functioning as a whole. For Yoder-Wise (2011:121&122) the systems theory focuses on the interaction between the elements of structure, technology, people and their environment within an input, throughput and output framework. Germain (2015:8) describes the systems theory as a study of both simple and complex systems, their structures and the interrelationships of these structures and its interaction. The

author sees it as a mutual engagement of the identified elements that assist to understand how systems work.

Ng, Maull and Yip (2009: 378) view a system as a whole unit with a boundary separating the internal and external elements to allow awareness of inputs and outputs associated with the developing unit. Mele, Pels & Polese (2010:127) focus on the relationship and interaction between the parts of a unit so that the organisation, the function and the outcomes of the unit can be understood. In the opinion of Njite, Kim and Kim (2008:200-211), the systems theory involves holism, inputs, transformation processes, outputs, regulation, entropy, goal-setting, differentiation, equality and simplification of the integration of concepts to view the world and its phenomena as logic.

4.2.1   Principles of systems theory

Regardless of the origin of the systems theory and its applications in physics, biology, chemistry and mathematics, the theory consists of elementary principles or characteristics that are shared by all systems. Several authors like Germain (2015:15), Kissen (1980:31-33) and Stichweh (2017) highlight these general principles also contained within the systems theory.

(a) The system is 'open' as it continues to develop and its resources continue to develop through interaction with the environment.

(b) The system is 'holistic' as it acknowledges the arrangement and relationships between the parts to integrate into a whole. The whole is larger than the parts themselves due to the mutual interaction of the parts.

(c) It is 'purposeful' in the sense of providing feedback to the environment. All parts of the system are interdependent on and interrelated with each other and work together towards goals.

(d) It is 'self-organised' in that it involves adaptability of the systems to environmental changes.

(e) It has 'boundaries' as it separates the systems from its environment; (f) It 'establishes mutual relationships' in that it changes inputs into outputs through processing by the subsystems.

(g) It emphasises 'the importance of communication' to exchange relevant information between systems and its environment, thus providing links between subsystems.

(h) It is 'dynamic' as it tries to maintain an own integrity and own boundaries while adapting to inevitable changes that are taking place.

(i) It assists to better understand 'interactions' (often of people) with one another and with their environments.

The systems theory is also concerned with the interactions between systems; thus, with accommodating the overlap and interrelationships between individual disciplines (Ponomaryov, 2006:724). Covington (1998:11) considers everything in the universe as a system which consists of interdependent and interrelated components implying the whole. Thus, one thing influences the other with the result that the individual parts of the system may not be as effective on their own as when they are merged into a working system. Huber (2013:43) agrees with Covington (1998) on the issue that changes in one part of the system cause a ripple effect that extends and affects the system as a whole. It is therefore also important to consider the less important components of a system within the context of the larger system because the components of a system do not operate in isolation – mainly due to interactions involving energy, humans and information from the external environment. By thus overlooking the interrelatedness of subsystems or elements of the system, the larger system can collapse (Cordon, 2013:21; Mele *et al.*, 2010:127; Von Bertalanffy, 1969:91).

The structure of systems often determine the behaviour, outcomes and purpose of such systems (Germain, 2015:15 & 16). A classic feature of the systems theory, as pointed out by Mele *et al.* (2010:127), is the generation of knowledge and concepts that have developed across different disciplines of knowledge fields resulting in

different types of system perspectives and contributions that provide a better understanding of a particular phenomenon.

4.2.2.   Systems theory approach

Figure 4.2 illustrates an 'open system' perspective whereby each open system receives input from the environment which is then processed to deliver an output with feedback (Bruce & Klopper, 2016:45). In Figure 4.2 a system is illustrated as an interrelated set of elements functioning as a whole. It illustrates the four elements of the open system framework, namely input, throughput, output and feedback. All systems receive input from their environments which is transformed by throughput processes to generate outputs (Friedman & Allen, 2011:7). Germain (1978:536) as well as Townsend, Lawrence and Wilkinson (2013:3064) state an organisational system requires inputs from the environment, uses system processes internally as throughputs to transform inputs into performance outcomes. The products, services and employee behaviour are then passed back as outputs to the environment in the form of information, energy and other properties which can be used by the same system or other systems.

Germain *et al.* (1978:536) remind us that a feedback system is vitally important because it is used to determine whether outputs are what they should be for an effective and efficient system. It is therefore important that the feedback process functions efficiently and effectively in a constantly changing environment. When the system does well, the processes of input, throughput and output will keep the system in a specific state of equilibrium. Germain *et al.* (1978:537) goes on to comment on the feedback processes of systems and environments that serve as a control of what is happening so that they can remain within the optimal range of changes. The process of feedback thus regulates the flow of information between the system and its environment. The levels of input and output are a type of control the system has over the interactions with the environment that can lead to better performance and higher levels of quality (Friedman & Allen, 2011:8). The use of a feedback response in the systems theory reinforces and assists in correcting and minimising errors when executing certain operations.
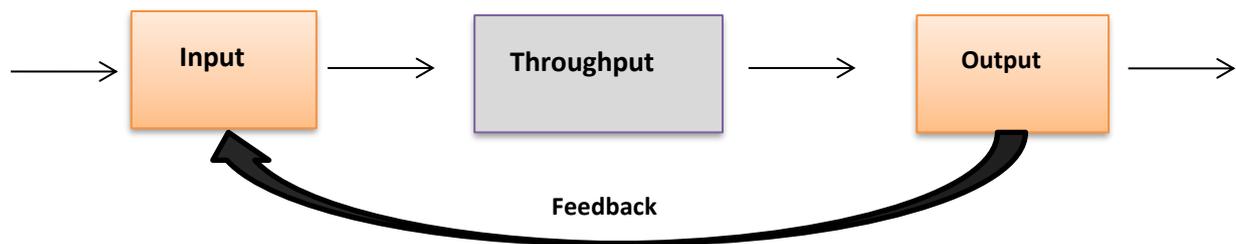
Figure 4.2: Adapted systems theory model of Von Bertalanffy (Von Bertalanffy, 1969:43)

The interchange between a system and its environment takes place via input, throughput and output and is in the form of information, energy and other properties (Van der Walt, 2016:69). Open systems strive for stability in order to maintain a balance between internal and external forces (Bruce & Klopper, 2016:45) and equilibrium (Cordon 2013:16). Changes in the environment of the system will naturally cause a reaction to compensate for the change. Friedman and Allen (2011:4) believe that such change can be measured with the observation of the outputs in relation to the outcomes of the system. Changes in the system are often fueled by environmental factors and the adjustments made (such as by employees) to improve the input.

This way of thinking in terms of systems assisted in this study with the viewing, analysing and interpreting of the workload of nurse educators in a private higher education institution environment (also see Huber, 2013:43).

4.2.3 Key concepts

In order to apply the basic concepts of the systems theory, it was important to be familiar with the meaning of the key concepts and terminology related to the theory as displayed in Table 4.1.

Table 4.1: Key concepts within a systems framework

Concept	Definition	Example
Boundaries	This is the point where a system or subsystem can be differentiated from its environment. Therefore, the elements, resources or qualities bounding the system together separate it from external elements. Barriers can define a system and can distinguish the system from another system in the environment Boundaries range from close to open.	Private higher education institution, nurse educator, nursing education institution.
Open system	System interacts with the environment thus energy passes through a boundary to the environment and from the environment to the system.	Nurse educators as an open system interact with their environment.
Interface	This is the point of contact where energy as input passes through the boundary to the system.	Regulations and information from legislative bodies.
Input	Energy passes through a boundary into a system.	Education, time, effort of the nurse educator and the input from other people that shape the perception of the nurse educator.
Throughput	The system transformed the energy from the environment into a usable product which can be used by the system or its environment. The energy never stays the same as it was before entering the system.	Group discussions, planning, sharing of information and decision making.
Output	The service or energy results in coming out of the system into the environment.	Records, training programmes, institutional policies and learner support.

Concept	Definition	Example
Feedback	This is output results or information (positive or negative) which can be redirected back into the system as new input used to evaluate and monitor the system and used to guide the system to more effective performance.	Student results, performance results of a nurse educator, accreditation results.
Homeostasis or equilibrium	The tendency of a system to maintain nature and status quo. It does not mean change does not occur but external or internal change does not overwhelm the system.	Quality standards.
Differentiation	The development of a system from simple to complex.	As nurse educators mature, they perform more complex tasks in organisations.
Synergy	The system as a whole is greater than the sum of its parts.	Investigate the whole system and not one or two of its aspects.
Reciprocity	Circular interactions that systems engage in such a way that they influence one another. Thus, change in one part of the system pulsates throughout the system.	Changes in one component of the nurse educator's workload mean changes in all the other components of the nurse educator's workload.
Subsystem	Is a system on its own within a system.	Nursing education sites within the private higher education institution.

Source: Adapted from Flood and Carson (1993:6-8), Ferreira and Bothma (2015:55), Germain (2015:16) and Smit _et al._ (2011:62)

4.2.4   Application of the systems theory

The systems theory can be used to observe the world or any part of it within its relational context (Caws, 2015: 517; Meadows _et al._, 2004:4-5). The simplification of the theory provides concepts of integration to view the world and phenomena as logic (Njite _et al._, 2008:211). It explains which things are interdependent, the effect these things have on one another and the change that takes place over time as a

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result of such interactions (Germain, 2015:25). In addition, it aims at interpreting a systemic problem and developing strategies that promote the 'fitness of purpose' between the elements of a system and their environments (Friedman & Allen, 2011:3). As these authors further note, within the context of human societal interaction each system is a unit of wholeness with a unique boundary defined by legislation, group membership and organisations. A system grows with tangible or intangible energy – thus determining the amount of energy allowed by the system boundary –, the degree of interaction between the system and its environment as well as the interaction with other systems (Friedman & Allen, 2011:3). Positive growth and adaptation of a system depends upon how well the system adjusts in its environment to accomplish the common purpose of its existence.

It is evident that change in one part of a system affects the whole system which then demonstrates predictable patterns of behaviour. In the systems theory much attention is paid to the coordination of a system's structure and its integrated parts for efficiency and effectiveness; thus, a study of the functioning of these individual parts is the best way to understand a system (Cornell & Jude, 2015:1; Heylighen & Joslyn, 1992). The elements of the system can be a person seen as a complex system or agent within a larger complex system, depending on how it is viewed (Larsen-Freeman & Cameron, 2008:27). The elements of a system can also be seen as processes such as creating a system model to visualise the components of the system. The activities within each of these components are elements represented by logical symbols that can be displayed in the visual system model (Germain, 2015:16).

In today's modern world, the systems theory assists to understand and solve challenging problems. The systems theory can assist to view a problem as a need for improvement because of its inappropriate operation. This does not mean something is necessarily wrong, but that the situation has to be understood and a solution needs to be determined. Organisations often operate as holistic open systems and interact with the external environment while solving problems (Von Bertalanffy, 1969:7).

In the current highly regulated environments it is of utmost importance for an organisation to be adaptive to the changes of the external environment for its survival. A major advantage of the systems approach is thus to develop a holistic view of the problem by investigating it from more than one perspective (Van der Walt, 2016:71). This allows for answers to the complex questions. A systems perspective can be used to view productivity as a function of the relationship between the employee, technology, structure and the environment (Sulliven & Decker, 2005:14). The total cooperation and coordination of subsystems therefore may result in better productivity (Van der Walt, 2016:70).

The suitability of the systems theory is indicated by Covington (1998:14 & 15) as: (a) it deals with complexity and open-ended settings with many changeable variables at work; (b) it takes a holistic view which is suitable for describing the status quo as it exists; (c) it focuses on the environment and how changes can impact the organisation – thus it can easily manage change through interaction with the environment; (d) it utilises feedback for improvement; (e) it recognises the importance of super systems, interdependence of personnel, the impact of the environment on the organisational structure and the functions and effects of the outside stakeholders on the organisation; (f) it seeks and explains synergy and interdependence, and (g) it shows the complex network of relationships in action as the system moves towards goal achievement as well as what can be expected in future.

In the next section the expectancy theory is discussed to broaden the theoretical perspective of this study and better interpret the research findings.

4.3.   EXPECTANCY THEORY

The expectancy theory (ET) is based on the principle that people try to do what they think will yield the desired results. Individuals, according to ST the systems theory become involved in work situations and behaviours that in their view will lead to certain outcomes. Job-related activities may be regarded as positive or negative valences (i.e., the attractiveness of the outcome). Outcomes of behaviour are also

seen as negative or positive assessments so the worker is motivated to reveal the behaviour with the highest valences or highest levels of good results (Huber, 2013:204).

Research conducted by Houston *et al.* (2006:18) with regard to academic role satisfaction emphasises the importance of intrinsic motivators such as discipline-based recognition and educator-student relationships. Literature also indicates that there may be strong links between workload, motivation and productivity because motivated employees experience job satisfaction when their needs are met thus allowing for an increase in productivity (Dugguh, 2014:22; Kim *et al.*, 2011:724). Parijat and Bagga (2014:4-5) support the opinion of Mamiseishvili and Rosser (2011:101-102) that ET the expectancy theory, developed by Viktor Vroom in 1964, is often used by researchers in academic contexts to investigate the workload and productivity of academic staff as well as the relationship between academic productivity and job satisfaction.

The driving force behind job satisfaction and productivity is intrinsic and/or extrinsic motivation (Parijat & Bagga, 2014:1). The expectancy theory is concerned with the process used by an employee to make behavioural decisions based on different behavioural alternative choices to maximise pleasure and minimise pain (Abadi, Jalilvand, Sharif, Salimi & Khanzadeh, 2011:158; Chiang & Jang, 2008:328). In particular, Abadi *et al.* (2011) view the process theory of expectation as a working model for decision-making processes used by employees to determine whether their motivation is sufficiently strong to pursue a particular activity and maintain a certain level of productivity.

The expectance theory provides a general framework to interpret, evaluate and assess employee behaviour in attitude formation and decision making (Chen & Lou, 2002:2). Vroom's (1964) theory of expectancy focuses on outcomes; therefore, 'motivation' implies concentrating on the results of work as being the ultimate goal which is divided into three categories: effort, performance and outcome (Lunenburg,

2011:2). The performance of an employee is based on individual factors such as personality, skills, knowledge, experience and ability.

Moreover, the expectancy theory explains why people follow the path they do in an organisation. The behavioural choices they make where the choice exists to do something else are explained – employees will do what works out best for them in terms of the outcomes rendered (Lunenburg, 2011:2). The decision making process is characterised by effort (E), performance (P) and outcomes or rewards (O) as illustrated in Figure 4.3. This means, when an employee's effort (E) is more than the performance (P), the performance of the employee will increase. When an increase in the employee's performance occurs, it leads to better outcomes (O) or rewards.
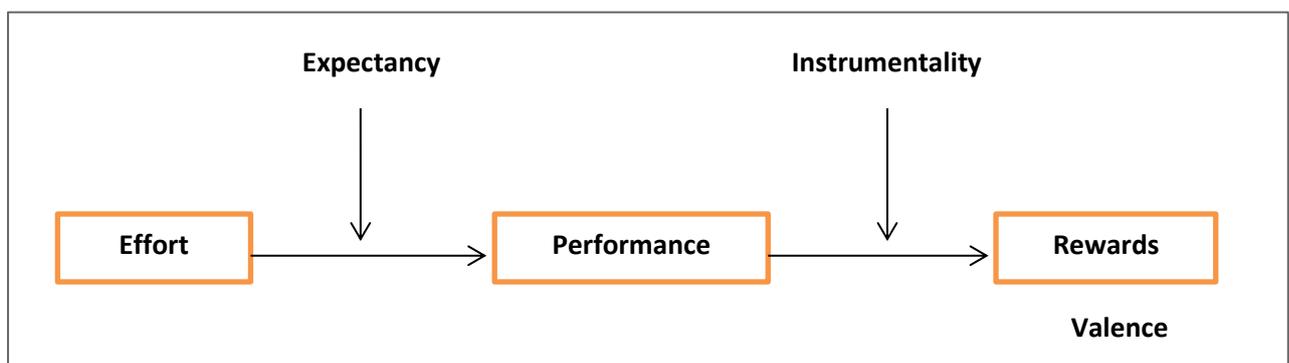
Figure 4.3: Basic expectancy model (adapted from Lunenburg, 2011:2)

Authors emphasise that greater employee effort does not happen by itself as a satisfactory outcome because one individual may not work for another person. For instance, behaviour and motivation is viewed by Nel *et al*. (2011:296) as a function of beliefs, expectations, perceptions and values. According to Smit and Cronje's (1997:318) understanding of the expectancy theory, by implication an employee has three key beliefs, namely valence, expectancy and instrumentality. Indeed, it is also on these three elements or beliefs held by individuals that Vroom (1964) built the theory of expectancy on as discussed in the next three sections (cf. sect. 4.3.1; 4.3.2 & 4.3.3).

4.3.1.   Valence

Valence refers to the relationship between rewards and personal goals (Smith, Botha & Vrba, 2016:413). Awakening the element of valence in employees to complete a task in the workplace will be successful if the outcome is desirable for the employee, e.g., to offer something of value to the employee. Needs, values, preferences and goals are kinds of value propositions an employee places a reward on (Abadi *et al*., 2011:159; Chiang & Jang 2008:328). Valence is the positive or negative value that an employee places on the reward or outcome (Lunenburg, 2011:2). In the view of Tomey (2009:104), valence pertains to the strength of a person's performance for something which can be positive or negative. Simply put, valence is put into function in an individual or employee by his/her values, needs and objectives. For example, when an employee has to choose between the value of a raise in salary or more time off, he/she knows there will be an outcome; whether it will be negative or positive, but there will be an outcome. So, how does valence feature in this scenario? The choice is between a task has to be completed but is not. So the employees have the choice to work overtime and complete the task for an increase in salary or leaving at the normal time.

Valence is the emotional orientation in respect of the outcome where the importance is placed by the individual on any expected outcome. For instance, if time off is more important to the individual employee than an increase in salary, less value will be placed on the outcome and this will lead to a reduced effort to complete the task. The seriousness of the want of the employee to obtain the reward can be determined through two types of rewards, namely extrinsic (e.g., time off) and intrinsic (e.g., personal satisfaction). For this reason, ensuring that the valence of a task must be at a level suitable for employer and employee to be a significant motivator to the employee (Vroom, 1995:17-19). Desirable outcomes must be rewarded with what the employee desires or wants if it is expected of him/her to make an attempt or effort to complete the task. This is perhaps the most important level of the effort (E) greater than performance (P) greater than outcome (O) equation as illustrated in Figure 4.3. The effort of an employee will increase to reach the desired outcome; therefore, how it is used in the workplace will depend on what the employer is willing to put in or provide from his/her side.

4.3.2.   Expectancy

As explained by Vroom (1995), the use of the expectancy element in the workplace, also known as an effort-performance expectation, represents the belief that the result of an increased attempt will lead to an increase in performance. For example, if the employee believes that if she/he puts more effort into an activity, the result will improve. However, greater effort might not necessarily lead to better results, especially if the person is not the right employee, have the right skills, use the right tools or where people with limited interest in their job, work to achieve the same outcome (Vroom, 1995:20-21).

Every employee has different expectations about what they are capable of doing. Moreover, their levels of confidence also differ. It cannot be expected from an employee (nurse educator in the case of this study) to meet goals if the right conditions are not presented to the individual to make it possible. Factors influencing employee expectations will be: (a) the employee's possession of the appropriate skills to perform the job; (b) the availability of the right resources; (c) the availability of the crucial information to the employee, and (d) the support given to the employee to complete the job.

Tomey (2009:104) describes expectancy as the probability or belief of a reward on completion of a specific action or as a result of an outcome. Tomey (2009) therefore allocates a value of 1 to expectancy and a value of zero if no probability is perceived. The author further asserts to motivate an employee, the relationship between the work and the outcome should reward the required behaviour to improve the productivity and job satisfaction of the employee.

Expectancy is the expected probability based on the perceived effort-performance relationship of more effort leading to good performance and the achievement of a desired goal(s) of the employee (Chiang & Jang, 2008:328; Lunenburg, 2011:2). Self-efficacy, goal-related problems and perceived control are variables stated by authors (Chiang & Jang, 2008:328; Lunenburg, 2011:2) as influencing an employee's perception of expectation. If it is the expectation of an employee – an

expectation based on past experience, self-confidence and how difficult the goal is to achieve – that effort will lead to the desired performance, it may lead to improved productivity. For instance, an employee works harder than his / her colleagues, his / her student results will be the best (Abadi *et al.*, 2011:159).

Expectancy therefore is the employee's perception and belief of effort that leads to a desired outcome of performance and, in turn, performance is related to the individual's belief of receiving a reward. Similarly, valence is the individual's value to the gained reward (Dugguh, 2014:18; Sloof & Van Praag 2008:798).

4.3.3. Instrumentality

The use of the instrumentality element in the workplace, also known as a performance-outcome perception, implies that employees will perform to a certain level if they will be rewarded with an outcome which will be beneficial to them (Lunenburg, 2011:3). The expectancy theory suggests that the perception of an employee is key as it highlights the cognitive ability to anticipate effects of behaviour. The perception of employees may involve that they will actually get what they want and, if an outcome is really sought after, the employee will work harder to achieve recognition (Vroom, 1995:20-21).

The perception of an employee is affected by trust in the people who make decisions about the outcome of work performance and the transparency of the decision process. An important factor in instrumentality is an understanding of the fact that performance equals outcome plus rewards and depends on how satisfactory the performance is (Vroom, 1995:308). The theory is honoured if employees recognise the need to perform and trust the people in control who judge their performance on delivery.

Instrumentality is considered by Chiang and Jang (2008:328) and Lunenburg (2011:2) as the suspected probability based on a perceived performance-reward relationship. The belief is good performance will lead to the desired outcomes, e.g.,

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when an employee believes that those who perform the best will achieve the best reward. Policies, control and trust are factors that affect instrumentality.

The foundation of the expectancy theory is that employees make conscious behavioural choices which allow them to achieve the desired combination of expected outcomes. The theory has become a commonly accepted one to explain how employees make decisions regarding various behaviour alternatives. The theory also explains why people engage in certain behaviours and act in a certain way when there are a variety of alternatives available to them. The strength of the theory seems to reside in suggesting an employee's decision on behavioural options that result in the greatest motivational power. The use of a motivational power for a behaviour or task is a function of three employee perceptions, namely expectation, instrumentality and valence (Huber, 2013:204; Vroom, 1964:17-23).

A mathematical equation is used to represent Vroom's theory of expectancy. It serves as an information-gathering set for the three variables of motivation, namely prediction of a person's choice, his/her effort and his/her persistence (Latham & Ernst 2006:183). The expectancy theory justifies why an individual reveals a specific behaviour in actions towards another person (Leadership-central, 2010). A mathematical model was formulated by Vroom in his book, Work and motivation published in 1964, where a motivational force is seen as equivalent to the following formula: Expectancy x Instrumentality x Valence.

The motivational force (MF) is seen as the product of the three perceptions: MF = expectancy x instrumentality x valance. It is stated further that this cognitive process calculates the motivational force (MF) of various behavioural options constructed by an individual's own perception of the possibility of achieving her/his preferred outcome, therefore the equation MF = Expectancy x Instrumentality x $\sum$ (Valence) summarises the motivational force as indicated in Figure 4.4. If any one of these values is zero, the whole equation becomes zero (Vroom, 1995:21-22). Generally, the expectancy theory is supported by empirical evidence and is one of the more widely accepted theories of motivation.
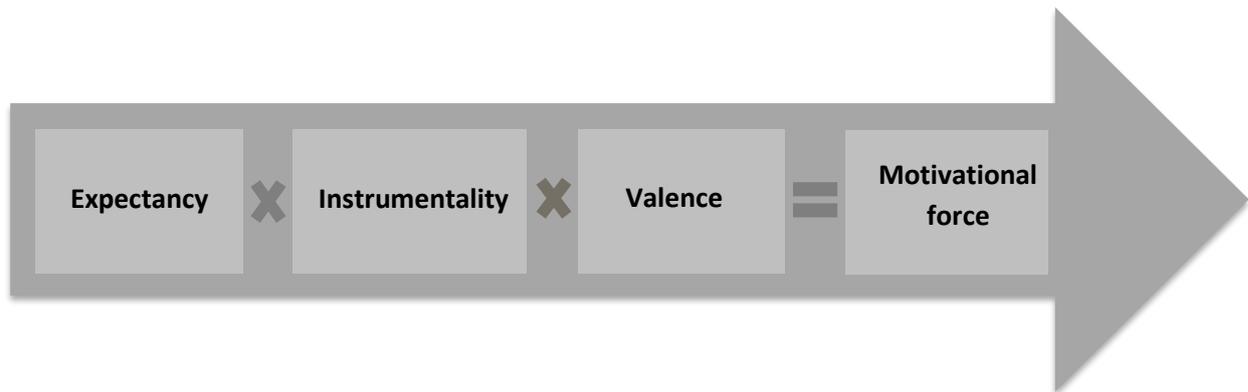
Figure 4.4: Motivational force model (adapted from Lunenburg, 2011:2)

Motivational force is the extent to which a person is likely to engage in a certain course of action. Human beings have a number of alternatives to engage in, especially in terms of their behaviour in workplace settings. Lombardi, Schermerhorn and Kramer (2007:284-286) comment on Vroom's theory by suggesting there are variables related to valence (the value allocated to potential rewards and other work-related outcomes), instrumentality (the belief that successful performance will be rewarded) and expectancy (the belief that working harder will result in the desired level of task performance being achieved). For these authors, the expectancy theory (ET) is based on a person giving preference to certain outcomes of their behaviour over others and that their motivation to work is influenced by the relationship between valence, instrumentality and expectancy. For this reason, and if the preferred outcome has been achieved, the employee experiences satisfaction.

The foundation of the ET is that employees are often inspired by the expected results of their actions. Nel *et al.* (2011:14) consider the behaviour and motivation of an employee as a function of beliefs, expectations, perceptions and values. Vroom suggests that different employees have different expectations of different outcomes and direct their behaviour towards achieving these desired outcomes (Nel & De Beer, 2015:74; Parijat & Bagga, 2014:3). Similarly, Sullivan and Decker (2005:264) are of the opinion that the ET respects employees as knowledgeable and active in their respective employment environments and thus emphasises the role of rewards and its relationship to the performance of desired behaviour. For Sullivan and Decker

(2005:264) employee behaviour is further affected by beliefs (expectancies) about the future consequences of behaviour (outcomes) and by the value placed on those outcomes. The three important components in the prediction of how much effort an employee will invest into work tasks are: (a) expectancy, which is the level to which an employee expects he/she can do something, (b) instrumentality, which is the belief that certain behaviour may lead to some outcome (positive or negative), and (c) valence, which is the attractiveness or unattractiveness of an outcome.

Brevis and Vrba's (2016:481) as well as Du Plessis's (2015:109) understanding of the worth of the ET is that workers are motivated by their determination and belief that their effort (for instance, working after hours at home) will lead to achievement (better results) and performance towards rewards (promotion). The total effort (hard work) for a task, according to the aforementioned authors, is subject to the opportunity to achieve the outcome as well as the degree of valuation that the individual attaches to the expected outcome (reward).

Four assumptions underpin the ET as described by Lunenburg (2011:1 & 2). First, when employees enter an organisation they have expectations which are influenced by their needs and experiences. Secondly, employees are considered as being able to make sensible choices about their own behaviour. Thirdly, different things are expected by different employees in the work context and in the fourth instance, in the long run employees will make choices based on getting the most out of the outcomes they pursue. Lunenburg (2011) comes to the conclusion that the ET is related to a cognitive process of motivation because employees believe there are connections between the effort they put forward at work, the performance they achieve from these efforts and the reward they achieve from the invested efforts.

Vroom (1995:17-22) and Nel and De Beer (2015:74) suggest three key variables in the ET, namely expectation (a person's essential outcomes are possible), instrumentality (a person's credentials will be rewarded) and valence (a person's value or value towards how effective a specific outcome is). These variables can,

according to the ET, be directly linked to the productivity of employees and the relationship between productivity and job satisfaction.

Nel and De Beer (2015:74) also see job satisfaction as linked to the variable of valence because job satisfaction will increase as an employee values an outcome at work such as recognition, workload release time and promotion. The expectancy theory is thus proposed by Vroom (1995:17) and Candela *et al.* (2015:583) as a cognitive theory which explains the sensible choices that motivate a person towards or away from a particular behaviour. For Du Plessis (2015:109) expectancy constitutes the relationship between a preferred course of action and its expected outcome.

A study by Chiang and Jang (2008:313) shows when expectation is measured, performance improved with hard work; when intrinsic instrumentality is measured, it leads to good performance, success and good self-esteem, and when valence is measured, it leads to personal growth and development, job satisfaction and an increase in productivity. These researchers recorded a significant relationship between all these factors. Chiang and Jang (2008:329) also highlight their finding that employees will be more motivated when a combination of the three functions of expectancy, instrumentality and valence occur. The advantages of the ET are that it is mainly based on the self-interest of employees who want to achieve maximum satisfaction from rewards and outcomes.

Lombardi *et al.* (2007:285) explain motivation (M) is determined by expectancy (E) times instrumentality (I) times valence (V), thus mathematically indicated as M = E x I x V. With the application of ET, effort and performance are linked, performance is linked to work outcomes and the decision on work outcomes is valued by the individual. These authors also conclude that expectancy can be improved by creating a feeling of capability with an employee to achieve the preferred performance level; that instrumentality can be improved by giving the employee the reward and accomplishing outcomes, and that valence can be improved when the employee is aware of the value of various rewards and working outcomes.

According to the ET, motivation emerges from the dynamic interaction between an employee and the work situation as represented in the formula of Abadi *et al*. (2011:159), thus the motivational force = Expectancy x Instrumentality x Valence. Chiang and Jang (2008:328) observe the motivational force is designed for a task, behaviour or action and is seen as the factors or function of the three elements expectancy, instrumentality and valence. Van der Walt (2016:202) reckons the foundation of the ET is that the employee will work harder if she/he sees the reward for work done as worthwhile. Rewards are determined by each employee's value of reward and whether the reward is adequate within achievable performance levels.

Abadi *et al*. (2011:157) see situation, expectancy, intrinsic instrumentally and intrinsic valence as influential factors in terms of employee motivation. The motivational force must be used in decision making when there is a different behavioural option, because the motivational force directs specific behavioural alternatives. As these authors further explain, an employee's behavioural choices will be based on the expected outcomes (valence) and the predicted estimates (expectancies) of the possibility to achieve these expected outcomes. This will give rise to the employee's decision to participate only in the given behaviour if he/she perceives the behaviour as the reward and outcome that he/she needs and values.

It is further stated by Abadi *et al*. (2011:157) if an organisation wants to have a competitive advantage, its employees must be committed to the demands of a rapidly changing environment. The improvement of productivity thus largely depends on the motivation of employees who are seen as being responsible for achieving work outcomes. The ET claims it is important to understand the employee's level of effort towards a task, the employee's beliefs about the situation and what is important to the employee.

In the opinion of Dugguh (2014:17), the effectiveness and efficiency of an organisation largely depend on the motivation, job satisfaction, skills and commitment of its employees. The author maintains employee confidence is created by motivation and job satisfaction with improved productivity as an end result. Job

satisfaction is developed by motivated employees because their needs are met and therefore the level of their productivity increases in the organisation. The productivity of employees is thus a function of job satisfaction and the motivation to produce (Dugguh, 2014:22).

4.4.   A MERGED THEORY FOR THE PRESENT STUDY

From the deeper explorations and subsequent discussions of the systems theory (cf. sect. 4.2) and the expectancy theory (cf. sect. 4.3) it was evident that both theories were relevant to the present study. The systems theory and expectancy theory were therefore merged to serve as a 'merged theory' providing a theoretical lens to explore and interpret workload data generated from nurse educators at a multi-campus private higher education institution.

The systems theory (ST) provided a general analytical framework for viewing the workload of educators in real life situations. The theory holds that open, living, independent human systems interact with their internal and external environments which in turn influence phenomena such as employee workload (Van der Walt, 2016:69). In the present study, connections among related issues such as of workload, job satisfaction and productivity required an in-depth exploration of the academic role satisfaction of nurse educators which can further be clarified and explained by the expectancy theory (ET) (cf. Fig. 4.5).

The workload of nurse educators consisted of subsystems such as teaching, administration, research and clinical practice within an educational and institutional system. It was important to investigate and better understand the relationships and interactions of different workload activities within these subsystems (cf. Fig. 4.5). Also, understanding broader systems such as private higher education and (private) healthcare was important to gain deeper awareness of how workload components and activities of nurse educators in general play out and interact (Caddy & Helou, 2007:319).

As the ST indicates, each subsystem of a systemic whole is also a system on its own. In order for the whole system to be effective and efficient, certain activities must be carried out within each subsystem (Ferreira & Bothma, 2015:52). Within nursing education, for instance, the teaching subsystem implies the settings of assessments, preparation of classes, alignment of electronic sources, planning of lessons and many more activities. Educators, as human actors, need to work together to the benefit of students and educational institutions. Roussel and Swansburg (2009:415) state the expectations and behaviours of educators as well as their beliefs that their efforts will result in successful performance and achievement of educationally valued outcomes are appropriate to the ET. As regards the present study, the ET suggested the performance and productivity of nurse educators were dependent on their expectations regarding their efforts to achieve the nurse training outcomes as expected by themselves, their students and the institution that employed them. The ET also suggests that, in order to encourage desirable behaviours in educators, they would require forms of positive feedback, recognition and appreciation to improve their productivity and job satisfaction.

Within the realms of the ST, nurse educators might need to maintain openness towards sustained growth and development. Therefore, it is important that the boundaries of each system within the educational domain remain adequately permeable with regard to changes within the environment. The prerequisite, however, is that the system remains sufficiently secure so that it does not dissolve into the external, generic and thus irrelevant environment (Germain, 1978: 536). Similarly, one of the key features of the ET is the fact that an educational system takes into account the feelings of self-worth of the nurse educators as human or educational actors. It thus speaks to the development of educators which, in turn, facilitates personal and professional growth thereby contributing to the improvement of the quality of the educators' work life as well as their perceived self-worth, confidence and their relationships.

The expectancy (effort) factor of the ET can contribute to educators' competency and their ability to achieve desired performance levels while the instrumentality

(performance) factor of the ET relates strongly to educators' understanding of the rewards and outcomes that will follow when achieving their performance. Similarly, the valence (reward) factor can enhance educators' understanding of the value of the achievement of various work outcomes (Lombardi *et al.*, 2007:286).

The ST indicates the various related systems have a major influence on human behaviour leading to behavioural choices (Huber, 2013:43). The ET accepts educators make voluntary behavioural choices, thus an educator will always make the choice with the best expected outcome. Educators are also constantly confronted in the workplace with behavioural choices that require informed decision making. The factors of influence such as effort (expectancy), performance (instrumentality) and rewards (valence) proposed by the ET assist educators with informed decision making. The underlying principle being that educators will do what works best for them. In this study, the ET pointed out how educators can be respected as skilled, knowledgeable, active employees in a professional working environment who honours performance, excellence and desired professional behaviours.

The ST provided a holistic view for investigating the educators' workload by taking into account the complexity of the workload and the environmental factors that influenced the phenomenon of workload. As mentioned earlier, the workload of the educator is an open system; thus, according to the ST, changes in the workload of the educator will depend on the response to the changing environmental forces within a certain timeframe (Germain, 2015:25). For this reason, and to better understand the workload situation of educators, the ET assisted with better understanding each educator's individual problems, the effect of their own studies, family contexts, societal contexts, organisational contexts and the effect of other systems that might have influenced their workload. In view of the ST, all systems are interrelated parts of the whole. This means each subsystem has an effect on the other parts of the whole. It was therefore important to understand the interrelationship of the individual educators with other systems that influenced their professional workload position as addressed by the ST and the ET.

The nurse educators' workload was seen as a dynamic system with inputs, processes (throughput) and outputs that influenced and changed the environment (quality education) and was being influenced by the environment (legislation of legislative bodies) as addressed by the ST. Each educator as component of a higher education institution and private healthcare systems was influenced by private healthcare systems, higher education systems, legislative systems, public healthcare systems and other systems that formed the socioeconomic system within which they lived in terms of employment or socially. In all of this action, focus ET on outcomes, therefore motivation is to concentrate on the results of work as being the ultimate goal divided into the categories of effort, performance and outcome.

As an open system educators received input from the environment (students) which was being processed (teaching and clinical practice) to deliver an output (pass rate) on which feedback was given. Feedback can reinforce or balance actions (Roussel & Swansburg, 2009:499). Feedback can be positive or negative and is given in the form of a report, a key performance index, a monitoring system or guidelines for more effective performance. Feedback is not only important to determine whether the output was effective and efficient, but also to keep the balance between the input and output in terms of the ST (Germain, 1978:536; Townsend *et al.*, 2013:3064).

A system strives for stability which is important for the balance between the internal and external forces of the system (Bruce & Klopper, 2016:45). The current workload of the nurse educator is an example of the aforementioned. The nurse educators did not have time to reach all tasks and activities during working hours and had to take work home to be completed. This situation created an imbalance between the working environment and the social environment of the nurse educators; hence, the stability of the workload system was compromised. In terms of the ET, the use of motivational power for a task will be a function of the three key beliefs (valence, expectation and instrumentality) of an employee who will determine how much effort she/he will put into the feedback to recover the balance between the input and output.

The ET points out the individual needs of an educator influence their behaviour. In the work environment motivated behaviour can be increased if a person experiences a positive relationship between effort and achievement. Motivation can increase even more with a positive correlation between good performance and rewards (outcomes), especially when it is valued (Yoder-Wise, 2011:12). In the case of the ST, the workload of educators is affected by the elements within the environment. Therefore, to be effective and efficient the educator must continuously adapt to the responses received from the environment that have to be aligned regularly with each other because of their interdependence. The internal environment of a private higher education institution consists of many subsystems such as risk management, quality assurance, clinical services, marketing, human resource systems, financial, information and communication technology systems and so forth. A minor event such as a student scheduled for a clinical assessment who for whatever reason does not cancel the appointment in time may have a serious effect on the other subsystem, e.g., an unnecessary petrol claim (financial), rescheduling of the appointment (clinical services, communication technology and human resources) (Cornell & Jude, 2015:2). The workplace, the internal and the external environment plays an important role in the workload of an educator (Van der Walt, 2016:70).

The workload of an educator is a complex system composed of various components (teaching, clinical practice, administration and research) that also interact and are in a mutual relationship with each other with each having clearly defined boundaries addressed by the ST. The focus of the ET was on the effort-performance, performance-outcomes and rewards-personal goals relationships. The effort-performance relationship is based on the probability that the educator will exercise a certain amount of effort if it will lead to good performance. To achieve a high expectation here, the educator must have the ability, previous experience and necessary opportunity to perform. In the case of the performance-outcomes relationship, the educator who performs at a particular level will achieve the desired outcomes. In the event that the performance-outcomes expectancy is high, the educator will be highly motivated and if the expectation is high, but the performance does not deliver the desired outcomes, the motivation will be lower and consequently productivity and job satisfaction will be affected. The rewards-personal goals

relationship is the extent to which the organisational rewards comply with the personal needs of the educator as well as the attractiveness of those potential rewards for the educator concerned (Jooste, 2017:66).

The ET principles highlighted the importance of assisting the current nurse educators in achieving their needs and goals, as they would at the same time contribute to the productivity and job satisfaction improvement goals of the higher education institution in which they functioned. The ST allowed for the investigation into the workload problem of the nurse educators to be conducted from more than one perspective. Subsequently, a more holistic view could be obtained to answer the research question(s) regarding the workload of an educator within the private higher education environment (Van der Walt, 2016:71). These research findings were important for the development of a clear and achievable workload model for educators at the identified private higher education institutions (Vos, 1994:269).

With the application of the ST and the ET in the conceptual framework (cf. Fig. 4.5) the open system perspective was applied in a real life situation. The educator was seen as the agent of the input-throughput-output process responsible for the integration, coordination and facilitation of information, legislation and changes of the environment in the identified private higher education institution. Inputs referred to the legislation, resources, higher education requirements and financial to name a few; throughput referred to the workload processes of the educator to generate the outputs of productivity, job satisfaction, profit and supply of qualified registered nurses for the private and public healthcare sectors. The use of a feedback system in this process would improve the productivity and job satisfaction of an educator. The research questions (cf. Ch. 1 sect. 1.4) of the study to generate data for the empirical part of the study were based on the workload of the nurse educator and their productivity and job satisfaction as presented in Figure 4.5. The relevant generated data were analysed and interpreted by the use of the theoretical lens as set in Chapters 2, 3 and 4.

4.5   CONCEPTUAL FRAMEWORK FOR THE STUDY

Considering workload, productivity, job satisfaction and the academic role of the nurse educator as the relevant key concepts identified for the study (cf. Ch. 2), the contextualisation of the study (cf. Ch. 3) as well as the theoretical context (cf. sect. 4.2, 4.3 & 4.4), a preliminary conceptual framework for the study was established. This framework accounted for a theoretical view of the broader problem of workload within the context of higher nursing education in the health environment (cf. Fig. 4.5).

The workload of a nurse educator as suggested by the conceptual framework was the combination of all the teaching, clinical practice, research and administrative tasks within their professional duties and responsibilities. The concepts in this framework represented the key elements as well as their interrelationships and interconnections which added to the complexity in describing and measuring the workload of a nurse educator. The particular context was a multi-site identified private higher education institution and the wider healthcare environment.

The conceptual framework represented the following main elements:

- The nurse educator: This person was central to the conceptual framework. He/she was a registered nurse with a formal qualification in nursing education and appointed by an identified private higher education institution to perform a dual nurse educator role in both the classroom and the clinical practice setting. The nurse educator was seen as an open system that was in interaction with both the internal and external environments.

- Teaching workload: This element referred to all education and teaching related activities such as class and workshop facilitation, preparation for class, the setting of tests and examinations, marking of tests and examinations, moderation and developing study material.

- Clinical practice workload: This referred to all clinical related activities such as the scheduling and allocation of clinical activities of the students, student accompaniment, clinical assessments, demonstrations of clinical procedures and practical examinations.

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- Administrative workload: This element referred to the administrative activities of nurse educators such as electronic communication, the writing of reports, record keeping, student counselling, audits of the life support training sites at the hospital of the identified private healthcare company, reviews of study material and other service activities which referred to meetings, conferences and travelling.

- Research workload: This referred to literature and other research that needed to be conducted by nurse educators for own professional development and to inform their teaching.

- Input: This element pointed towards the external environmental-related inputs such as international changes in nursing education, legislation, policy reforms, higher education requirements, South African Nursing Council regulations and others.

- Throughput: This referred to actions such as attending to the learning needs of hospital staff, contributing to student throughput and CPD activities, ensuring quality training, supplying qualified and competent registered nurses and complying with legislative requirements.

- Output: This element referred to the contribution of nursing education to profit through the development and offering of formal programmes, CPD and in-house courses, supplying qualified registered nurses to private and public healthcare institutions, improvement of teaching, clinical and administrative productivity as well as the improvement of job satisfaction of the nurse educators.

- Feedback: This referred to responses from the internal environment, e.g., performance indicator reports and the external environment, e.g., accreditation audits to improve the productivity and job satisfaction of nurse educators.
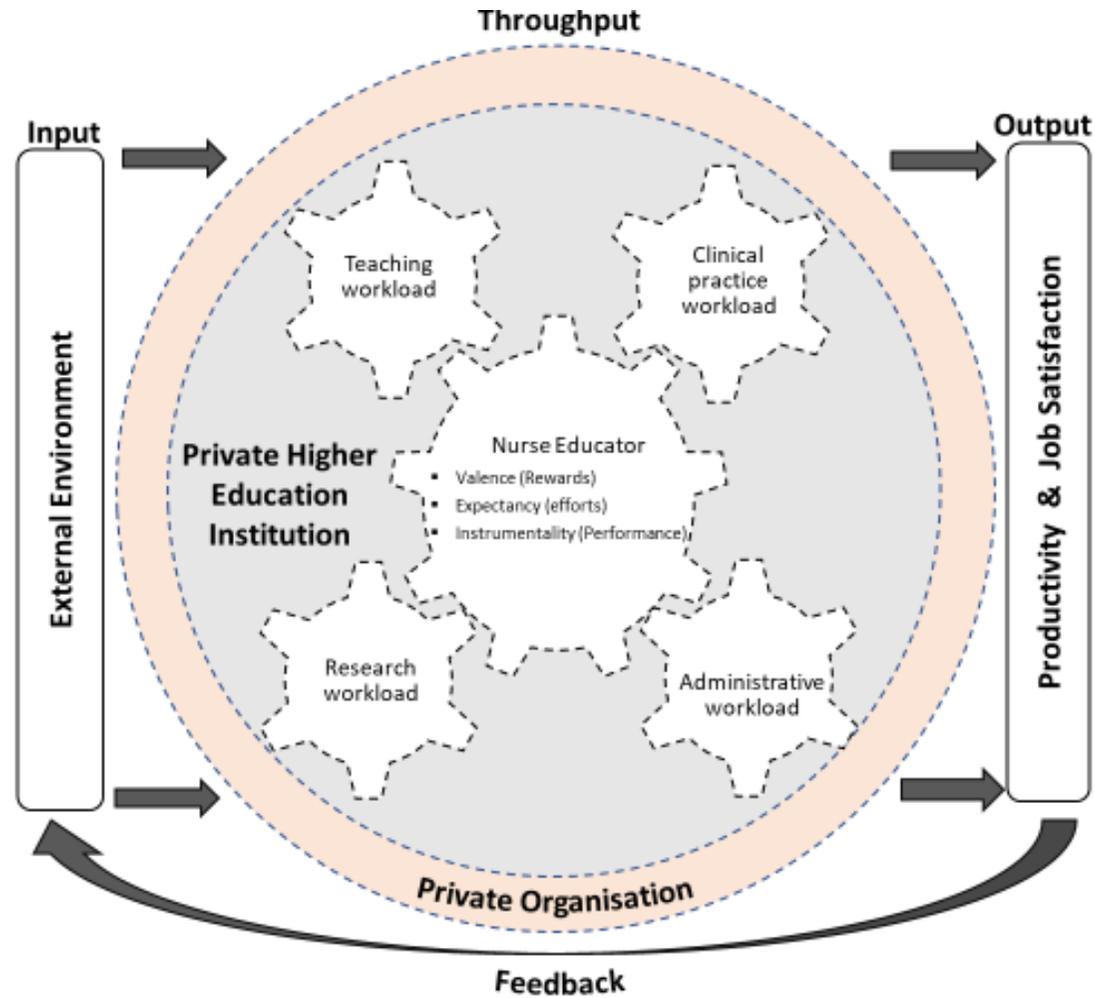
Figure 4.5: Conceptual framework

As illustrated in Figure 4.5, the structural form of the conceptual framework (also see Chinn & Kramer, 2015:178) is presented in the form of (a) an outer circle representing the identified private higher education institution within a private hospital group; (b) the interrelated 'gear' structures of the nurse educator, teaching, clinical practice, research and administrative workload represented by 'open' or permeable boundaries which separate the internal and external environment of each element and indicates the continuous activities associated with the development of each element; (c) the rectangular structure of the environment representing the external inputs while the rectangular structure of productivity and job satisfaction represents the expectations of the nurse educator and the identified private higher education institution. The linear structure of the lines and arrows indicate the flow of the input- throughput-output process and the feedback to determine whether the output of the system was in accordance with the expectations of both the nurse educator and identified private higher education institution.

The nurse educator 'gear' structure in Figure 4.5 represents the nurse educator as a dynamic system addressed by the ST with certain expectation, goals and needs based on performance, efforts and rewards addressed by the ET. The identified private higher education institution also had certain expectations of the nurse educator so both continuously interacted with each other to reach their shared goals addressed by the ST. In the daily work environment, nurse educators were constantly confronted with behaviour choices; therefore, the factors of influence as indicated in the nurse educator gear and proposed by the ET assisted the nurse educators to make informed decisions. The ultimate purpose of the identified teaching, clinical practice, research and administrative workload 'gear' structures was to address the current workload of the nurse educator.

Because of the holistic and comprehensive perspective of the ST part of the merged theories and the focus of the ET on efforts, performance and rewards, the nurse educator could be studied as a whole within her/his interaction and interrelationship with other systems. The ET also postulates nurse educators can voluntarily control most behaviour. Therefore, when confronted with choices they would choose the one with the best expected outcomes. The 'gear' structure of the nurse lecturer, teaching, clinical, research and administration workload indicates that these concepts were interrelated and constantly

moving together like clockwork in order to achieve the required set goals and objectives addressed by the ST.

The workload of the nurse educator changed constantly and was influenced by the growing demands from the identified private healthcare hospital group and private higher education industry, i.e., better trained nurses with high competency levels (the narrow pink space formed between the inner and outer circles of the framework) as well as other inputs from their external environment such as new legislation and regulations (the rectangular structure on the left hand side of the big circle forming inputs in Figure 4.5). It is evident from the conceptual framework that these concepts and the current workload of the nurse educator could be addressed by the ST. The ET addressed the clarification and understanding of the academic role satisfaction of the nurse educator.

It is also clear that an understanding of the activities of the subsystems teaching, administration, research and clinical practice, their interaction and relationships with each other and their environment in the throughput process (represented by the four short arrows – two at the left hand side top and bottom and two at the right hand side top and bottom of the big circle – pointing from left to right in the figure) was important for the development of a suitable workload model for nurse educators at private higher education institutes. As indicated in the conceptual framework, the internal processes of the subsystems were used to transform inputs into performance outcomes such as the supply of highly skilled registered nurses to private and public healthcare facilities (indicated by the rectangular structure on the right hand side of the big circle representing outputs in Figure 4.5). The nurse educator functioned within a dynamic higher education environment and had to maintain a balance within this environment in order to survive. The workload of the nurse educator as a dynamic system needed feedback to determine whether the output of the system was in accordance with the expectations of both the nurse educator and identified private higher education institution (represented by the long, curved horizontal arrow pointing from right to left below the big circle in the figure) (Van der Walt, 2016:100).

The educator satisfies the needs of private and public healthcare by providing skilled registered nurses in order to promote quality healthcare. The transformation of the inputs

(legislation) takes place through the operation of structures and functions (procedures and regulations) of the identified private healthcare institution and private healthcare group of hospitals to deliver outputs (new standards). The effect of the outputs such as new standards provides feedback that lead to changes in the function of the system (Van der Walt, 2016:101; Yoder-Wise, 2011:450). Hence, the ET set attainable standards for nurse educators and provided the necessary support (personal development) to assist the nurse educator in achieving these standards (Swanepoel, Erasmus, Schenk & Tshilongamulenzhe, 2016:368-369).

Nurse educators are under pressure due to their increased workloads within a rapidly changing national and international nurse education dispensation. This conceptual framework will hopefully assist to address the workload of nurse educators.

4.6   SYNTHESIS

This chapter served to explore the theoretical context of the systems theory and the expectancy theory which informed the research questions, the research design of the empirical part of the study. It also informed the findings that emerged from the study (see Chapter 6 and 7) as they related to the workload, productivity and job satisfaction of the nurse educators within the private higher education fraternity. The main insights generated from the theoretical exploration are highlighted next.

The theoretical understanding of the complexity of the phenomenon under discussion, the workload of a nurse educator, was discussed. Reference was made to the high workload that includes teaching, clinical practice, research and service workload as well as its effect on job satisfaction and productivity. Nursing as a practice-oriented profession includes academic and clinical practice education. It was therefore important to have a clear understanding of the different types of workloads and the time spent on each of the teaching, clinical, research and service workloads.

The workload of the nursing education faculty is unique because the clinical contact hours must be calculated as part of the workload of the nurse educator. The teaching load is the largest and most important of all types of workload. The clinical practice workload is

demanding and it complicates the workload of the nurse educator because it is difficult to meet the academic expectations and clinical competence.

Research generates new knowledge, promotes the future of the nursing profession and healthcare. Although it is time-consuming, it is vital that higher education institutions support research and takes it into account when calculating the workload of the nurse educator. Traditionally the service and administration workload of the educator is seen as less important in relation to the teaching and research workload, but it also has an influence and must be calculated as such. This multifaceted role of the nurse educator has been complicated even more with the integration of nursing education into higher education as it resulted in a wide range of changes and challenges such as student diversity. The challenges and changes in all these contexts have a direct impact on the workload and working lives of nurse educators.

Future university-based training of nurses, immediately ready qualified nurses for the labour market and nurses participating in the healthcare policy processes complicated the nurse education environment even more. Further new challenges which arose were the discontinuation of the legacy nursing programmes and the alignment of the new nursing qualifications with the Higher Education Qualification Framework. The delay in the implementation of the new nursing qualifications by the South African Nursing Council has a major impact on the execution of the nursing training programmes. It also has a ripple effect bringing a large shortage of trained nurses in addition to the current shortage of trained nurses. The current delay increases the workload of the nurse educator even further as they are expected to be prepared to start rolling out the new qualifications once accredited.

The theories that best represented the research question comprised of an integration of the systems and expectancy theories. The systems theory provided a holistic view of the workload of the nurse educator and viewed the workload as an open independent system with interaction between the different concepts and their environment. This implied that the interaction of nurse educators with each other and their work environment had to be thoroughly understood for the development of a realistic workload model in collaboration with the educators. Expanding this theoretic perspective, the expectation theory was

incorporated as it provided a strong link between workload, job satisfaction of motivated employees and productivity. The expectancy theory claims that employees have individual differences in motivation, job satisfaction and productivity and employees are balanced people whose behaviour is influenced by their beliefs, perceptions and probability estimates. Motivated employees develop job satisfaction when their needs are met, resulting in an increase of their productivity.

The over-extended workload of the nurse educators justified an in-depth investigation and development of a workable workload model involving all staff in the development and finalisation thereof. The conceptual framework was developed from the knowledge, concepts and theories gained from Chapters 2, 3 and 4. In the next chapter, Chapter 5, the research design and methodology used to explore the empirical part of this study are explained.

CHAPTER 5

RESEARCH METHODOLOGY AND DESIGN

5.1 INTRODUCTION

Chapter 4 introduced the conceptual framework for this study to assist in addressing the main research question (cf. Ch. 1 sect. 1.4). In this chapter the research methodology and design are outlined. The study adopted a pragmatic knowledge position and a mixed methods research design.

The aim of this study (cf. Ch. 1 sect. 1.4) was to critically inquire into an existing needs-based workload model for nurse educators at an identified private higher education *institution* in South Africa. The study results might contribute to improve workload options and enhance educator productivity and job satisfaction within the boundaries of private higher health education.

The main research question for the study was thus formulated as:

> *"What constitutes a suitable workload model related to productivity and job satisfaction of nurse educators?"*

To address the main research question, four subsidiary questions were stated:

5.1.1. How may the concepts 'workload' and 'manageable workload' of nurse educators be better understood in private nursing education contexts?

5.1.2. How do nurse educators at one multi-campus private higher education institution view the influence of their current workload on productivity and job satisfaction?

5.1.3. What constitutes an expert view of the realistic time spent regarding workload activities of nurse educators at a private higher education institution?

5.1.4. What are the characteristics of a suitable workload model to possibly improve the productivity and job satisfaction of nurse educators within a private higher education context?

In this chapter the data management, sampling decisions, the various data generating methods used, the pilot study and the ways in which the generated data were analysed are explained. The chapter concludes with a brief discussion of the quality of the data, warrantability of the study and ethical considerations related to the study.

5.2   PRAGMATIC STANCE

A pragmatic worldview was adopted as the philosophical approach in support of the mixed methodology study. This provided more freedom to the research with the choice of appropriate methods, techniques and procedures for inquiring into the research problem as well as to justify pragmatic research choices (Cohen, Manion & Morris, 2011:23; Creswell, 2009:10-11; Creswell, 2011:11; Plowright, 2017:13-23). The general characteristics of pragmatism are identified by Johnson and Onwuegbuzie (2004:18). Pragmatism provides (a) a feasible solution to the problem; (b) it has a high consideration of the human experience in action; (c) provides for the construction of knowledge based on the reality of people's experience in their world; (d) it regards meaning, knowledge and truth as temporary which can change over time; (e) it prefers action; (f) endorses pluralism and (g) holds that theory can be put into practice.

The use of a philosophical paradigm in small-scale social research is most useful when research results are interpreted and discussed (Plowright, 2011:181). It should thus not necessarily direct a study as Plowright (2011) is of the opinion that pragmatism can act as a lens to understand, explain, consolidate and synthesise research results. The centralisation of the research question is important to enable the researcher to plan data generation and data analysis methods while the theoretical context is provided by relevant literature (Creswell, 2009:21; Plowright, 2011:7).

5.3   RESEARCH APPROACH

The approach to inquiry in this study was one of abductive reasoning. As the current workload position of nurse educators at the identified private higher education institution was empirically unknown, workload activities and the time duration of each activity had to be identified and assessed before validating such activities through inductive and deductive reasoning. An abductive approach thus allowed for investigating the workload activities of nurse educators and, by applying a theoretical lens (cf. Ch. 4) to consider a possible adapted workload model for nurse educators in a private higher education context. Plowright (2011:112) states abduction as a research approach within pragmatism applies to all research as every research question presupposes a problem or a 'becoming aware' of a problem. Abduction thus aims at arriving at the best available question and answer to the identified problem. Abductive logic thus fits mixed methods research designs where both qualitative and quantitative data are used for addressing a problem.

5.4   RESEARCH DESIGN

A research design is the plan or strategy for carrying out investigations and serves as a guide from the beginning to the end of the study (Brink *et al.*, 2012:200; Creswell & Plano Clark, 2011:68; Polit & Beck, 2012:13; Polit & Hungler, 2004:155; Schwartz-Shea & Yanow, 2013:16). The research process is guided and directed by the research design to achieve the intended research goal (Berg 2001:21). Some authors see the design of a research project as a blueprint to generate detailed and interpretable evidence (Brink *et.al.,* 2012:92; Burns & Grove 2005:211; Creswell, 2007:49; Polit & Beck 2012:13).

Plowright (2011:2-3) suggests the Framework for an Integrated Methodology (FraIM) as an alternative mixed methods design. The FraIM design was applied in the present study to achieve the stated research aim and to make best use of the data to address the research questions under scrutiny. The basic structure of the FraIM is linear and relatively straightforward as outlined in Figure 5.1.
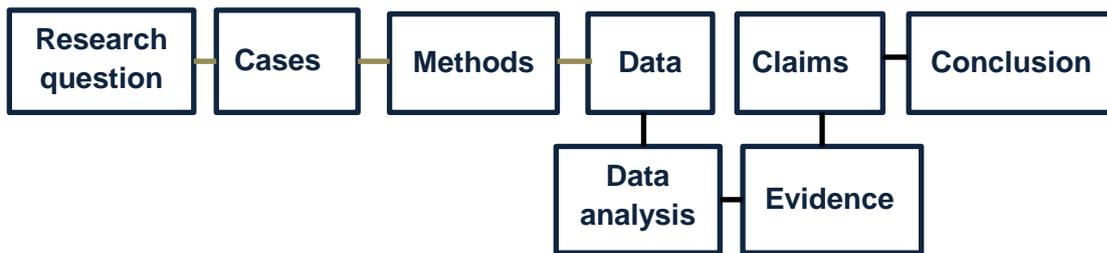
Figure 5.1: The basic structure of the FraIM (Plowright, 2011:7)

The basic structure of the FraIM consists of a number of components (eight in total) giving a systematic and general overview of the activities and processes of the research process. The research question is seen as the first and most important component of the FraIM on which the rest of the design components are based. Figure 5.2 illustrates the extended FraIM with its additional elements, forming the basis of the research design in this study (Plowright, 2011:8-21).
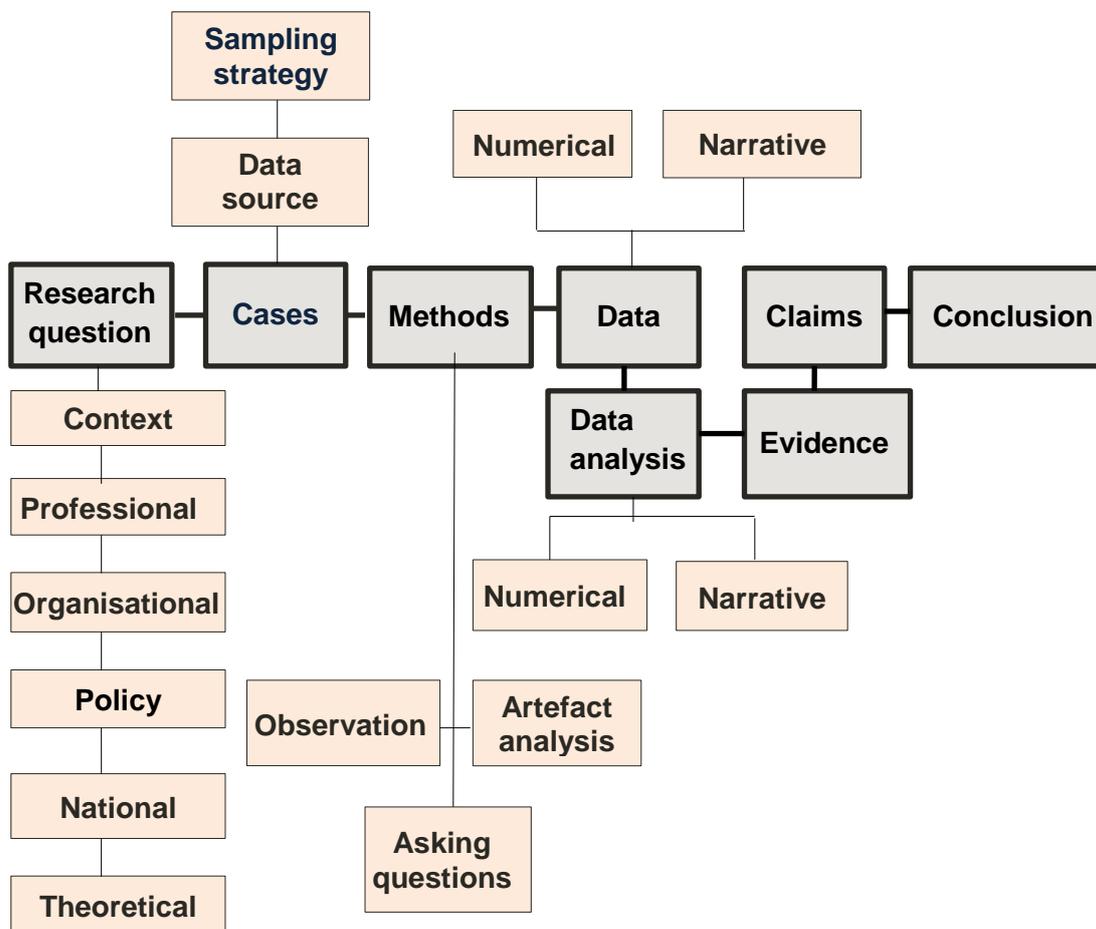
Figure 5.2: The extended FraIM (Plowright, 2011:9)

Mixed methods designs enable researchers to use a combination of different methods to investigate the research problem, to draw on both qualitative and quantitative data and to use different methods and techniques to generate such data (Creswell, 2011:3-4). Plowright's FraIM (Plowright 2011:2) was employed in the present study to promote a responsive, flexible and open design (Plowright, 2011:7). Teddlie and Tashakkori (2009:33) see mixed methods as best to generate exploratory and confirmatory views that can be addressed simultaneously.

In an integrated mixed methods design the research commences with the formulation of a main research question. In the present study, the main question was underscored by four sub-questions (cf. sect. 5.1.1 – 5.1.4). These questions originated from contextual information, including the professional, organisational, policy, national and theoretical contexts. These contextual factors play an important role at all times during the research and provides justification for the research questions. What is also important is that the relevance, balance and emphasis of each of these contexts may change according to the emphasis of the research being conducted (Plowright, 2011:13).

The second component in the extended FraIM constitutes the cases needed as data sources. Case selection thus takes place through data source management and sampling decisions. The number of cases that feature in the research, the degree of control the researcher has over these cases and the degree of naturalness are typical criteria used in the decision-making process to organise the cases (cf. sect. 5.4.2.). In the present study numerical data were generated from the electronic workload diaries of nurse educators (artefact analysis) and a Delphi exercise (expert survey) while narrative data were collected through individual and focus group interviews with nurse educators (asking questions). Within the choice of the data generation methods, the degree of structure and the level of mediation of the researcher were considered (cf. sect. 5.4.3 & 5.4.4.). The three-dimensional, eighteen-cell model of Plowright (2011) illustrated in Figure 5.3 indicates the planned integration of the cases, methods of data generation and types of data components.
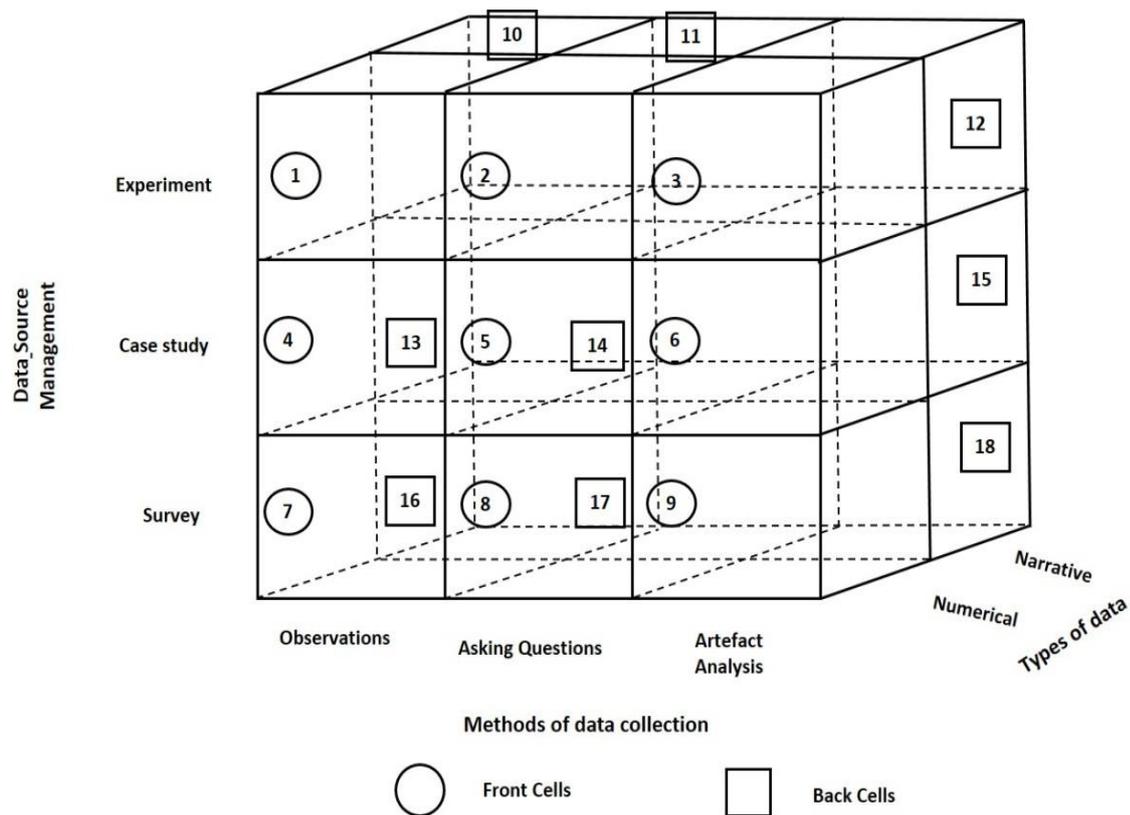
Figure 5.3: The three-dimensional model of an integrated approach to designing research (Plowright, 2011:19)

Each cell in the Plowright's FraIM design represents a combination of each of the three elements from Plowright's original FraIM (Plowright, 2011:19). To indicate the choices for data generation within Plowright's overall mixed methods design, the following configuration applies. Cell numbers 1 to 9 represent numerical data while cell numbers 10 to 18 represent narrative data. The underlying idea is that both numerical and narrative data can be generated by using the same data collection method. For example, in the case of an experiment, the same method of data collection (asking questions) can be used to generate numerical data (cell 2) through an interview schedule built on a Likert scale measure as well as to generate narrative data (cell 11) through asking open questions through 'unstructured' interviews. The integration of a case selection strategy, methods of data generation and types of data can thus present the possibility of 18 different research strategies joined together in one project to form a coherent whole (Plowright, 2011:20). Plowright describes the complete design process through a number of examples in his work.

The integration of a combination of cases, methods of data generation, and types of data components used for the present study was based on the FraIM design. The particular choices are illustrated in Figure 5.4.
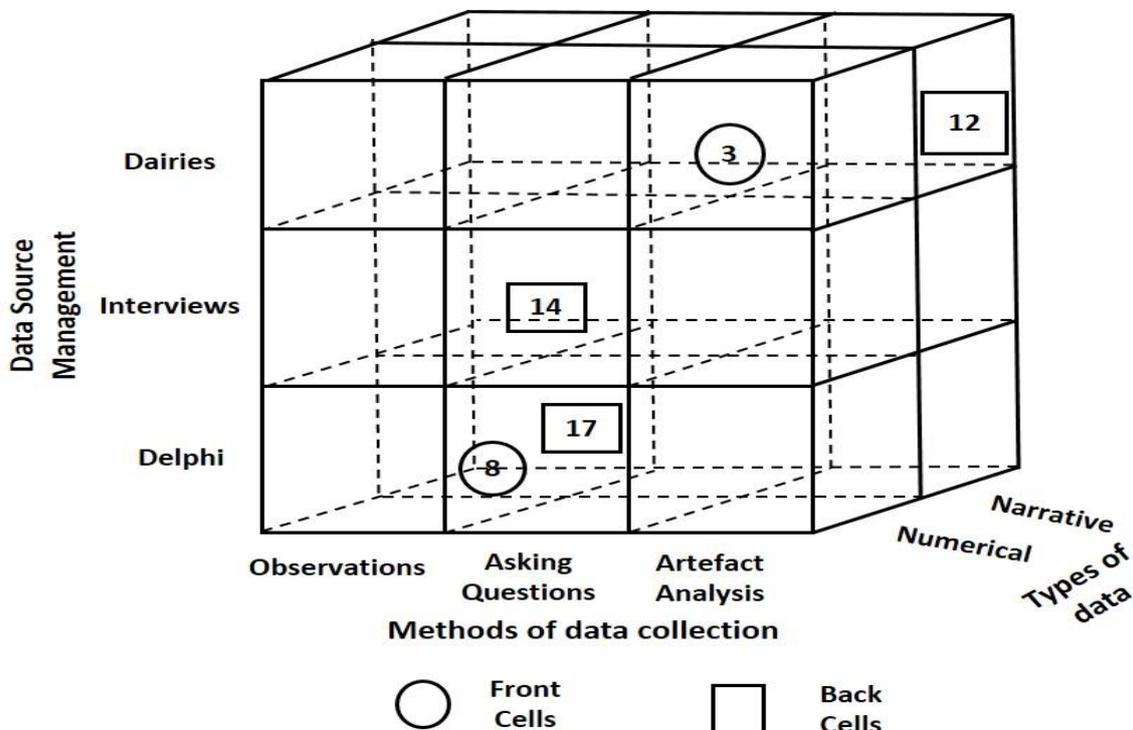
Figure 5.4: Adapted three-dimensional model of an integrated approach to designing the research (Plowright, 2011:19)

In the present study, the following four sets of data were selected and used as illustrated in Figure 5.4. Cell 3 represents the numerical data generated from analysing the work diaries of a group of nurse educators as artefacts; cell 8 represents the numerical data generated from asking questions in a three-round Delphi survey consisting of expert participants; cell 14 represents narrative data generated through focus group interviews and individual interviews with the nurse educators and cell 17 represents narrative data generated from asking open questions in the three-round Delphi survey. These sets of numerical and narrative data were analysed (cf. sect. 5.4.5.) as sources to arrive at evidence. This evidence allowed for making empirical claims about the phenomenon of nurse educator workload which ultimately assisted the researcher to draw informed and valid conclusions (Plowright, 2011:7).

5.4.1 Data methods

Methods to generate data constitute the actual research steps and processes followed to address the research problem and answer the research questions (Brink, *et al.*, 2012:199). According to Polit and Beck (2012:741), research methods are defined as "the steps, procedures and strategies of gathering and analysing data in a study". Plowright's (2011:189) FraIM suggests a two-phased process that enables the researcher to firstly consider data source management strategies and, secondly, to decide on case sampling strategies.

In the FraIM, data source management constitutes the first phase of the case selection procedure where the research question determines the sources of data. This mechanism assists the researcher in the decision making about the choice of research participants or cases. In small-scale social research, where a relative small group of participants participate in, the data source management potentially consists of three possible choices: (1) case studies, (2) experiments and (3) surveys (Plowright, 2011:24). The criteria on which such choices are based are: the number of selected cases, the degree of control the researcher has over which cases to include or exclude, and the degree of naturalness which refers to ecological validity of the case groupings.

The second phase in the case selection of the FraIM is the sampling strategy used. The case selection process includes decisions and reasoning of whom or what the cases or participants are, how they were chosen and why they were chosen. The research question determines the context for the researcher, the location, the purpose of the research and the choice as to whom or what the cases are. Most research in workplace contexts is undertaken with convenience and purposive sampling strategies due to the small-scale nature of the research and the need to address a specific problem identified in a particular professional or work context (Plowright, 2011:42 & 43).

It is possible to incorporate randomisation in the selection process if the total number of participants in an organisation may be too large for the researcher to manage. The importance of case selection is indicated by the decisions about the choice of participants or cases which need to take into account the sampling strategy as well as data source management. The researcher can, with each of the three data source management

approaches, draw on decisions about a sampling strategy to allocate participants or cases either probabilistically and/or non-probabilistically. It is important to note that an integrated methodology encourages different sampling strategies to be included in data source management decisions (Plowright, 2011:36-45).

Selected cases for an inquiry can be individuals or organisations (Plowright, 2011:14). Individuals as data sources can be referred to as "participants, respondents or informants". For the purpose of this study the term 'participant' was used. Plowright (2011) also indicates that observation, asking questions and artefact analysis can be used as data generating methods. In the present study the methods to generate data were asking questions and analysing artefacts (see Figure 5.4).

Asking questions and artefact analysis both imply a level of mediation by the researcher and a degree of structure (Plowright, 2011:49-50). Artefact analysis has a relatively low level of mediation because the researcher is more distant from the phenomenon being studied while asking questions has a high level of mediation because of the presence of the researcher when questions are constructed and answered by participants (Plowright, 2011:49-50). The limited pre-structuring of the data via asking more 'open-ended' type of questions makes the degree of structure low because generated data are only coded after the data are generated (Plowright, 2011:54-56). By using more open-ended questioning, participants themselves have a higher level of control over the direction of their responses and the information disclosed. The researcher, on the other hand, has more freedom in the interpretation of the data because there are no predetermined categories decided on before data generation (Plowright 2011:55).

Artefact analysis in the present study had a high degree of structure as the researcher had more control over the data generation process but less choice over what was recorded during data generation as the diaries were completed by nurse educators themselves (Plowright, 2011:58-61). A relative high degree of structure was created by the modified Delphi survey in the present study because the questions and statements were pre-structured and responses were analysed via closed coding (Plowright, 2011:56).

5.4.1.1   Data management

The cases selected for the present study involved the data of 44 nurse educators who were employed in 2016/17 by a private higher education institution in South Africa where nurses are trained. There was a low degree of control in over case (number of participants) selections as all nurse educators employed at the time were included in the study (Plowright, 2011:26). The main concern in selecting these participants was to determine patterns and themes in the workload activities of nurse educators within a particular context.

The 44 participants (cases) were geographically distributed among seven nursing education sites of the private higher education institution. The seven nursing education sites are situated in the following South African provinces as indicated in Map 5.1: Free State, Gauteng, Limpopo, Mpumalanga, Northern Cape and the Western Cape. The level of ecological validity achieved was thus relatively high as the study involved practising nurse educators in a natural occurring situation within relevant learning centres and in real life contexts without any intervention of the researcher (Plowright, 2011:30).

Map 5.1: Provinces of South Africa (adopted from South African Places,1997)

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5.4.1.2   Sampling decisions

Both qualitative and quantitative data are required in mixed methods designs. This implies that participants for each study phase are chosen using different sampling strategies. In this study purposive sampling, also known as non-probability sampling, was used in all phases of the study based on the characteristics of the population (Brink *et al.*, 2012:138; Hasson, Keeney & McKenna, 2000:1010; Plowright, 2011:42-43; Polit & Hungler 1997:229; Somekh & Lewin, 2004:217). Where specialised skills and experience are considered as important features, as was true in the present study, Singh and Mangat (2013:7) agree that purposive sampling is ideal, especially within smaller organisational contexts.

The 44 potential study participants were all nurse educators employed by this institution at the time of the study. These educators were considered to be in the best position to contribute relevant information and rich data on the issue of nurse educator workload (Plowright, 2011:45; Polit & Beck, 2012:271).

In the end a total of 37 nurse educators were selected as participants on the basis of a non-probable sampling using the following inclusion criteria: (a) being a full-time nurse educator, (b) being employed as a nurse educator for more than two years at the particular higher education institution (Plowright, 2011:42). From a communicative perspective all participants had to be able to read, speak and write in English.

In Phase 1 of the study the 37 selected nurse educators were invited to complete workload diaries over a nine-month period from March to November 2016. In Phase 2 the same group of nurse educators was invited to participate in individual and focus group interviews over a period of two months stretching from July to August 2016. Due to staff turnover a panel of 33 of the original selected experts participate in the Delphi survey in their capacity as nurse educators registered with the SANC, qualified as participants because of their knowledge of and experience in nursing education as well as their involvement with nurse educators' workloads in private healthcare environments on a daily basis (Ab Latif, Mohamed, Dahlan & Mat Nor, 2016:90; Delbecq *et al.*, 1975:23; Nugent *et al.*, 1993:295). In Delphi literature, the size of an expert panel can vary between 12 and 50 panel members. The panel of 33 members chosen for the study was considered acceptable as

there is no general agreement on the size of such a panel (Ab Latif *et al.*, 2016:90; Keeney, Hasson & McKenna, 2011:48-53).

5.4.1.3 Workload diaries

Over the past few years, the interest of organisational researchers has increased in diary studies for the investigation of everyday experiences and activities of employees (Ohly, Sonnentag, Niessen & Zapf, 2010:79; Van Eerde, Holman & Totterdell, 2005:151). These authors point out that workload diary analysis is based on self-reporting and the employee's activities are seen as the unit of analysis. Furthermore, this method of data generation is done on a daily basis which spans a variety of occasions. Although the data of diaries are self-recorded and more time-consuming and complex to collect (Bonke, 2005:349; Kitterød & Lyngstad, 2005:15), it is considered to be a trusted source (Juster, Ono & Stafford, 2003:20; Schulz & Grunow, 2012:622).

In the present study, workload diaries created the opportunity to generate data within the natural work context and the work situation of nurse educators over a period of nine months, covering many different occasions. These diaries were thus useful to capture the short-term dynamics of experiences within the nurse educator's natural work context (Ohly *et al.*, 2010:84-85; Ebner-Priemer & Kubiak, 2007:214-215; Bolger, Davis & Rafaeli, 2003:597). Another advantage of the workload diaries were that daily and hourly activities were recorded which reduced retrospective bias (Reis & Gable, 2000:192) and increased data validity.

The group of nurse educator participants was requested to complete their individual electronic workload diaries (see Addendum D) daily for a period of nine months. They were further requested to anonymously submit their diaries every month via a link to an anonymous electronic file. A sheet of 'tip' instructions (see Addendum K) was provided to the participants as a guideline. Provision was made for all teaching activities, clinical practice activities and other activities that constituted the workload of a nurse educator in the workload diary to facilitate easier completion of these documents. The diaries provided self-recorded information about the activities nurse educators spent their time on and the amount of time spent on each activity (Bolger *et al.*, 2003:580).

5.4.1.4   Individual and focus group interviews

Individual and focus group interviews were scheduled to accommodate the participating nurse educators and their busy schedules and to generate narrative data (Cohen *et al.*, 2011:436). Interviews usually generate quality data if planned and conducted properly and provide thick descriptions with rich and detailed data. Interviews also allow for obtaining additional data through observing participants (Polit & Beck, 2012:267-307).

The interview guide used in the individual and focus group interviews were aimed at inquiring into the context of the workloads of nurse educators (Ary, Jacobs, Razavien & Sorensen, 2006:480; Charmaz, 2006:14). To provide a logical flow of questions and to prevent confusion, open-ended, simple and clear questions were prepared (Brink, van der Walt, & van Rensburg, 2006:149; Maree, 2007:160). For more detailed information and exploration, probing questions were also included (Brink *et al.*, 2012:158; Polit & Beck, 2012:537). An example of the interview guide is attached as Addendum E.

Both individual and focus group interviews were facilitated with the assistance of an independent competent researcher (with a PhD degree) within the natural working environment of nursing teachers. The interviews were conducted in venues easily accessible to the researcher and the independent researcher as well as the participants. Particular care was taken to create a welcoming and stress-free environment where interviews could be conducted in a relaxed manner with no outside interruptions as advised by Polit and Beck (2012:538). There were strong similarities between the focus group interviews and the individual interviews in terms of the number and quality of the ideas that have been generated (Kidd & Parshall, 2000:294). As mentioned before, the individual and focus group interviews were scheduled to accommodate all the participating nurse educators and their busy schedules. The interaction of the groups during the focus group interviews has highlighted two events. It firstly served as a cross-check and secondly allowed for additional information where some participants may fail to provide information, thus resulting in a more complete and reliable set of data (Cohen *et al.*, 2011:432 & 436; Arksey & Knight, 1999:76).

5.4.1.5   Modified Delphi

The suitability of the modified Delphi survey for the present study was primarily based on the work of Rowe, Wright and Bolger (1991:236). These authors consider the Delphi survey as particularly useful when there is no relevant historical data available in the context of the phenomenon studied, when it is based on the suitability of available data and in cases where the group of experts cannot be brought together.

The four distinctive features of the Delphi survey method identified by Rowe *et al.* (1991:236) are iteration, anonymity, statistical group response and managed feedback. These elements were all utilised in the design of the Delphi exercise to inquire into the workload activities of nurse educators in the present study. All participants were offered an equal opportunity to contribute to the decision making process which, in turn, contributed to a valid argument for improving the workload of nurse educators in the context of a private higher education institution. Keeney *et al.* (2011:3) consider the Delphi as a group facilitation technique and describe it as a multiple survey to reach the ultimate consensus of a group of experts using a series of questionnaires combined with controlled feedback. Ab Latif *et al.* (2016:89) note the Delphi is an accepted way of generating data from participants within a domain of expertise.

How the Delphi survey was implemented is described later (cf. sect. 5.4.2.3) in this chapter as it related to the three phases of the research process.

5.4.2   Phases of generating data

The researcher obtained permission to conduct the study at the different nursing education sites from the training and development general manager and the higher education and training manager of the private higher education institution (see Addendums B and C). Data were generated in three phases from March 2016 to December 2017 (see Figure 5.5).

5.4.2.1   Phase 1

Thirty-seven (37) nurse educators of six nursing education sites of the identified private higher education institution received an electronic invitation from the researcher (see

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Addendum O). Consent to participate was included in the research invitation (see Addendum F) as well as an electronic tracker sheet (see Addendum D) and the workload tracker quick sheet (see Addendum K). The workload tracker sheets were returned electronically on a weekly or monthly basis by each nurse educator via an anonymous link to where the workload diaries were kept electronically (cf. sect. 5.4.2). The only person who had access to these electronic files was the learning technologist. Educator workloads were thus recorded and derived from the workload diaries (see Addendum D) kept by 37 nurse educators over a nine-month period from 1 March 2016 to 31 November 2016. To ensure a high level of confidence in the quality and accuracy of data, a thorough screening and evaluation process of the data were followed. This resulted in the workload diaries of only 18 of the 37 nurse educator diaries to be considered for inclusion as data. The main contributing factor for the very close to 50% rejection level was incomplete workload diaries. It was the assumption that this was caused by the additional workload generated by the study on a substantial number of participants already working in an overloaded work environment (cf. Ch.7 sect. 7.2.1 Overtime).

5.4.2.2   Phase 2

Five (5) focus group interviews and ten (10) individual (face-to-face) interviews were conducted with nurse educators of seven nursing education sites (see Addendum E). The study was conducted in the private higher education institution where the nurse educators were subordinates of the researcher. It was therefore important to create a relaxed safe environment for the participants where they could freely give their views without feeling intimidated by the interviewer. An independent competent consultant who was trusted by all participants was employed to conduct the individual interviews and focus group interviews. The assistance of this consultant also eliminated possible bias from the researcher's side and ensured a true reflection of the views of the nurse educators about their workload (Polit & Beck, 2012:176 & 191).

Although focus group interviews were considered to be time-saving for the already work-burdened participants, individual interviews had to be included due to the tight work schedules of some of the nursing educators who could not attend the focus group interviews. An interview guide containing both open- and closed-ended questions (De Vos,

Strydom, Fouche & Delport, 2005:296) was used to explore the views of the nurse educators about their workload experiences (Plowright, 2011:57).

The interview guide consisted of eight questions divided into three sections (Brink *et al.*, 2012:154-160; Cohen *et al.*, 2011:377-400; Creswell, 2011:139-142; Polit & Beck 2012:639) as indicated in Addendum E. Section one focused on the actual workload of nurse educators, section two on their perceived job satisfaction and section three on their perceived productivity. The interview guide that was used (Addendum E) consisted of eight questions that were divided into three sections, namely (a) workload, (b) job satisfaction and (c) productivity. Although all interviews were conducted by the independent consultant, the data analysis and interpretation were done by the researcher and cross-checked by the independent consultant. Inter-researcher triangulation occurred with the consultant who generated the data to ensure that (a) the researcher remained as unbiased as possible, and (b) the consultant who collected data on behalf of the researcher understood exactly how the process of data generation had to be done.

The interviewer informed the participants before each individual and focus group interview about the purpose of the study and explained the nature of the interviews. All participants were informed that interviews would be audio-recorded and would be transcribed verbatim (Maree, 2007:89). All participants gave their permission for the interviews to be recorded. Recording the interviews ensured accurate data generation and proof that the verbatim transcribed data would accurately and truthfully reflect the interviewees' responses during the interviews (Polit & Beck, 2012:534). Where appropriate, issues were further explored by asking probing questions. Each individual (face-to-face) and focus group interview took approximately 40 to 55 minutes. They were conducted over a period of two months, from 5 July 2016 to 31 August 2016. To enhance the ecological validity of the data, participants were encouraged to provide their views on the relationships and processes within their workloads within a natural (institutional) context (Polit & Hungler, 2004:262; Creswell, 2009:203; Doyle *et al.*, 2009:184; Plowright, 2011:85).

The individual interviews and focus group interviews were conducted in a relaxed positive environment where the participants felt comfortable (Cohen *et al.*, 2011:176). A lecture room in each of the different nursing education sites were booked by the researcher for the

individual interviews and focus group interviews. These lecture rooms were prepared beforehand with comfortable chairs to ensure that the participants would feel at ease. Outside disturbances were prevented by a sign on the door of the lecture room. The participants were requested to turn off all mobile phones. The researcher was not present during the interviews to prevent distractions and to make the participants more comfortable to talk freely (Burns & Grove, 2005:540-541). The interviewer was alerted to check for data saturation as the process continued and the last individual interview took place on 12 August 2016 (Creswell, 2014:189; Cohen *et al.*, 2011:601; Polit & Beck, 2012:742).

5.4.2.3   Phase 3

An online survey method, the e-Delphi, was used in Phase 3 of data generation. A structured questionnaire was sent via email to 33 survey participants involving three rounds. These participants were selected from six nursing education sites of the private higher education institution based on the following inclusion criteria: (a) employed as a nurse educator, (b) registered with the SANC, (c) more than two years' experience of nursing education, and (d) involvement on a daily basis with nurse educator workloads in a private healthcare environment.

The participants in the panel of experts were also part of the focus group interviews. The participants were viewed as experts because they were knowledgeable, highly experienced experts in their specialised field of nursing education representing the nurse educators of the private higher education institution (Duffield, 1993: 228; Goodman, 1987:73 (Keeney *et al.*, 2011:24) who could provide an expert opinion on the realistic time spent on the different workload activities of the nurse educators (Nworie, 2011:25).

The purpose of the Delphi survey questionnaire which contained both closed- and open-ended questions and statements was to generate qualitative and quantitative data from experts to achieve a measure of consensus on the realistic time spent by nurse educators on the different teaching, clinical, research and administrative workload activities. The final aim was to arrive at and suggest an achievable workload model for nurse educators within a private higher education context (also see Baumfield, Conroy, Davis & Lundie, 2012:8; Keeney *et al.*, 2011:7).

Participants responded to open-ended and structured questions in the three rounds to recall estimations and concerns regarding the realistic time spent on different nurse educator workload activities as well as their comments on each statement or question for modification if applicable. An initial email of invitation, providing brief information of the Delphi method and an explanation of the study, was sent to all panel members. Participants ranked each item on a 4-point Likert scale where 1 = "Strongly disagree"; 2 = "Disagree"; 3 = "Agree" and 4 = "Strongly agree". The pre-existing information concerning the realistic time spent by nurse educators on each workload activity (cf. Ch.7 sect. 7.2.1) was used for responses in the first round (Ab Latif *et al.*, 2016:89; Hasson *et al.*, 2000:1011).

The construction of questions for each of the follow-up rounds was based on the feedback and the responses of the previous round. The opportunity existed for the panel members to exit or modify their answers based on the responses of other panel members (Hasson *et al.*, 2000:1010).

The e-Delphi survey process was repeated three times until consensus at a level of 80% was obtained among expert group members (Ab Latif *et al.*, 2016:90; Hasson *et al.*, 2000:1011-1012; Larson & Wissman, 2000:45; Polit & Beck, 2012:268). With each round a cover letter (email) accompanied the questionnaire with a summary of the feedback from the previous round. It also provided instructions on how to complete the questionnaire for the particular round (Ab Latif *et al.*, 2016:92; Hasson et al., 2000:1010; Keeney *et al.*, 2011:57-59). Each round of the Delphi survey took approximately 10 minutes to complete which was within the recommended 30 minutes' timeframe recommended by most authors. Further, over a period of one-and-a-half months a response time of two weeks for each round was allowed (Ab Latif *et al.*, 2016:90; Keeney *et al.*, 2011:56).

The advantages of using a Delphi survey for this study included a user-friendly environment as participants could complete the questionnaires at work or home at their convenience. In addition, participants' anonymity was guaranteed; they could focus on the issues at hand; a deep exploration and production of perceptions as well as distinctions due to repeated feedback rounds was possible and equal consideration of contributions was assured (Boberg & Morris-Koo, 1992:29; Hasson *et al.*, 2000:1010; Nugent *et al.*,

1993:295; Pilot & Beck, 2012:267). The 4-point Likert-scale items made it possible to apply simple mathematical calculations and analyses to determine the degree of consensus among participants on any particular question or item. The data generated in the three phases over the period March 2016 to December 2017 is summarised in Figure 5.5.
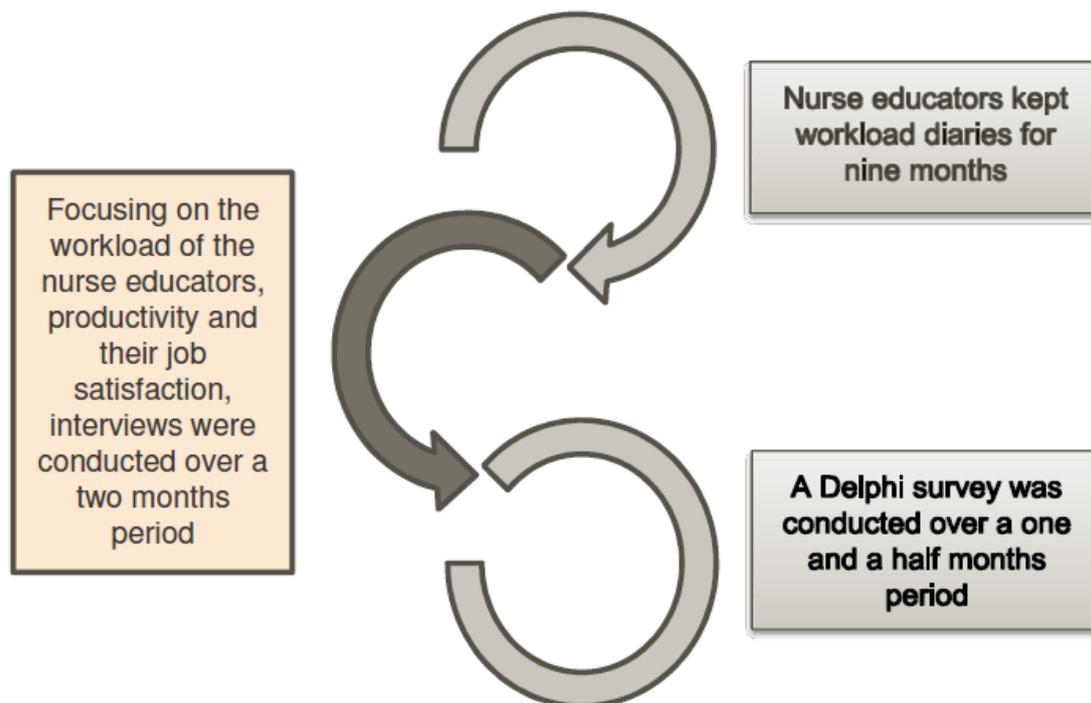
Figure 5.5: Phases of generating data

5.4.3   Data analysis

The analysis of data relates to the process of disassembling, classifying and sorting of the data so that it can be interpreted (Stake, 2010:133 & 150). The data in this study were analysed in three phases. The data generated from Phases 1 and 2, namely the numerical and narrative were analysed, interpreted and integrated (Plowright, 2011:119). The numerical and narrative data collected in Phase 3 via the Dephi survey were analysed, interpreted and integrated (Plowright, 2011:119) in relation to the data of Phases 1 and 2. In Phase 3 the numerical data generated in Phase 1 were used as a basis for consensus of a panel of experts on the realistic time spent by nurse educators on each workload activity.

5.4.3.1 Analysis of data from workload diaries

The analysis of the numerical data generated by the workload diaries was done in stages as indicated and described in Figure 5.6.

Organise data for analysis
- Electronic workload diaries to collect data
- Exported to Mcrosoft excel
- Coding of data

Explore data
- Descriptive analyses from external statistical consultant
- Inspect data visually
- Look for trends and relationships

Presenting data
- Descriptive statistics
- Show trends with histograms, bar charts and pie charts
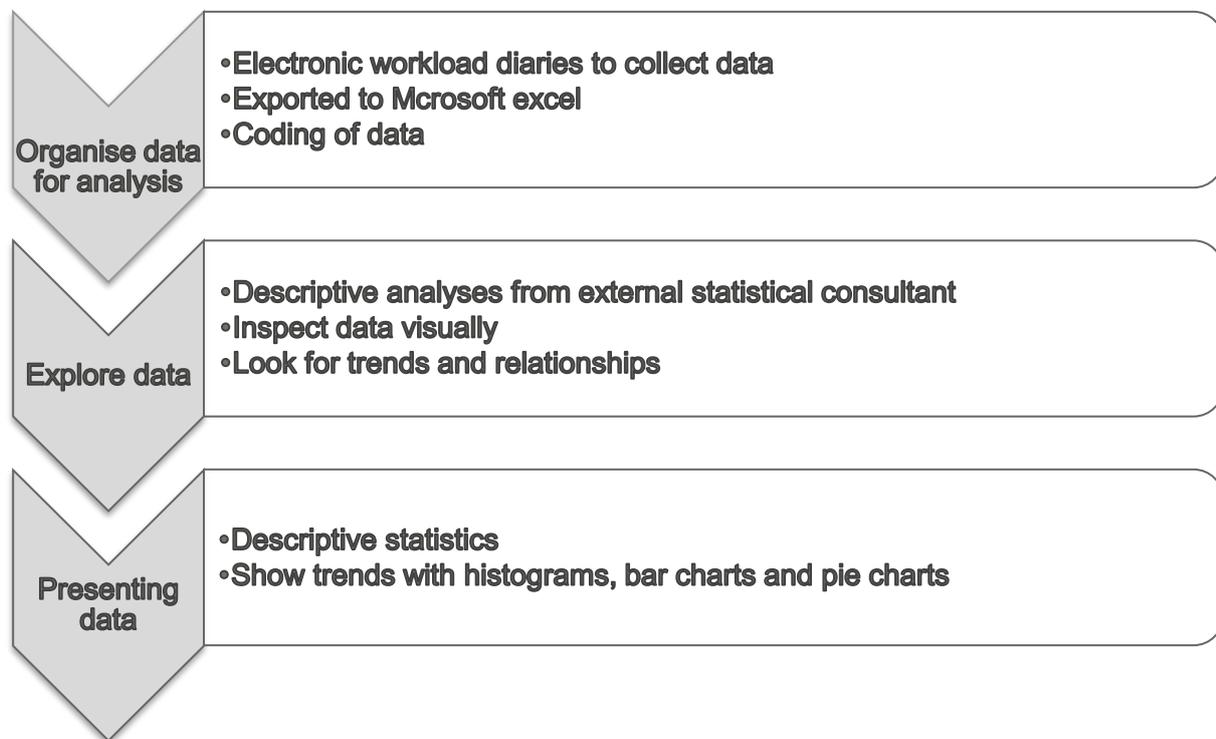
Figure 5.6: Stages of workload diary analysis

The nurse educators captured their workload activities on an electronic data sheet. In preparation for analysis, the raw data of the electronic workload diaries were checked for completeness (Brink, 2006:55) and numerical codes were assigned before being captured onto a Microsoft Excel spreadsheet developed by the consultant statistician of the statistical consultation services at Stellenbosch University. Simple descriptive statistical data were created by the STATISTICA 13.2 software computer program to enable the researcher to interpret the data (Brink *et al.*, 2012:179). StatSoft developed this user-friendly software package to provide spreadsheets and configurations. This software package does not only provide general statistical, analytical and graphical data management procedures, but it also provides specialised data analysis methods as well as the comprehensive implementation thereof (Dell Inc, 2016).

In an attempt to provide a clear picture of the results, the frequency distribution and frequency counts were summarised (Brink *et al.*, 2012:179-181). The central tendency was measured and the data were calculated to percentages to correlate and compare the data before communicating the values in tables, distribution graphs, pie charts and bar charts to illustrate the proportions, highest and lowest values (Creswell, 2009:152). The visual application of these graphics resulted in a closer analysis of the research data by the reader (cf. Ch. 7 sect. 7.2.1). The workload diaries as source of data generation were used to complement the qualitative data generated by the individual and focus group interviews.

5.4.3.2   Analysis of data from interviews

The narrative data generated from the individual and focus group interviews were analysed by using a 'level approach' to analyse the qualitative data as indicated in the adapted analytical abstraction ladder of Miles and Huberman (1994:92) shown in Figure 5.7.
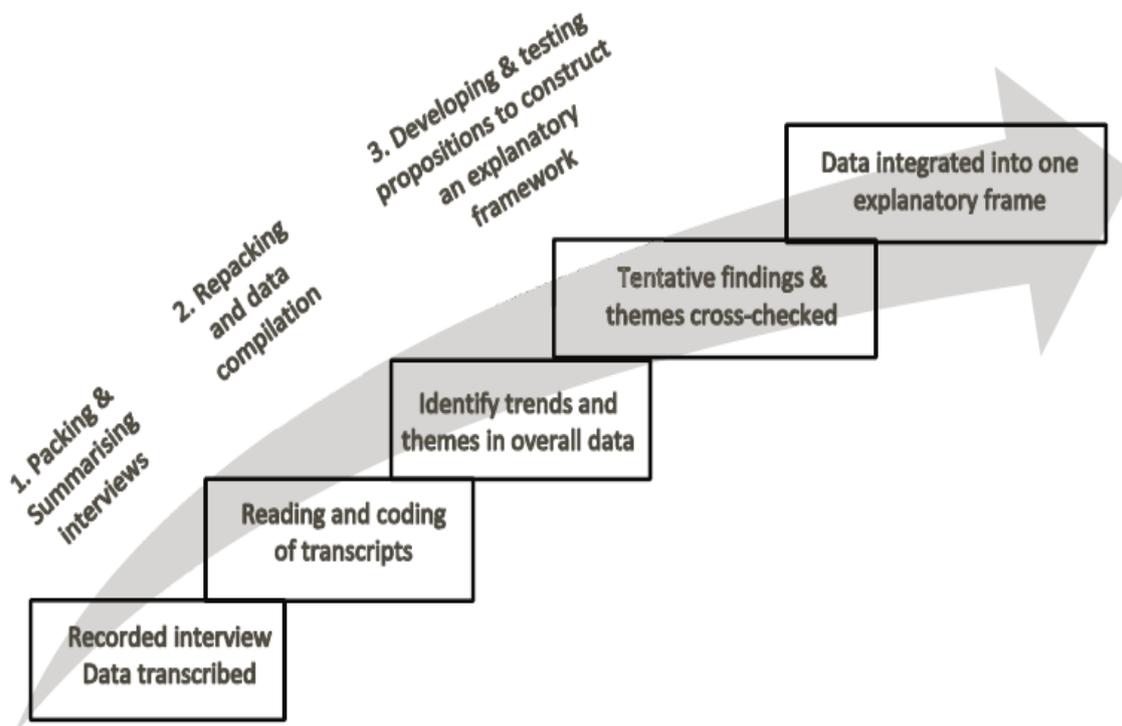
Figure 5.7: Adapted analytical ladder of Miles and Huberman (1994:92)

Three levels of data analysis were used to analyse the generated narrative data. At the first analytical level the packing and summarising of the interviews were done and the narrative data were prepared in text format. The researcher received the electronically recorded transcribed responses of the participants to the open-ended questions from the transcriptionist with dates, participant codes and numbers. Each transcript was printed and manually analysed and coded by reading three times through it. While reading, the researcher reflected and thought about the data to obtain a general sense of what the data meant. This was done to identify and assign labels as well as grouping similar codes into themes (Creswell, 2014:195; Maree, 2007:265; Plowright, 2011:122; Saldanha, 2016:10). The data reduction, identification of core concepts and the meaning of the data – known as content analysis – of each of these transcripts were coded manually in three different colours (Patton, 2002:453). Analytical notes were made during the content analysis of each transcript to indicate the connection between the different contexts of interpretation (Miles & Huberman, 1994:92).

The content analysis, the repacking and the data compilation at the second analytical level were conducted with an analytical framework approach. The coding took place in order to organise and sort the generated data. During the structural coding of the data analysis process, the researcher repeatedly read carefully through the transcripts after which the data were arranged and analysed into meaningful categories and subcategories (De Vos *et al.*, 2005:33; Saldanha, 2013:84). These identified categories and subcategories were then used as an analytical framework (Miles & Huberman, 1994:92). The researcher used as co-coder the independent competent researcher, who did the individual and focus group interviews, to assist with the coding of the data.

Developing an explanatory frame was done on the third analytical level. On this level the tentative findings and themes were cross-checked for three reasons. Firstly, to ensure the accuracy of the data; secondly, to identify overlapping categories and, in the third place, to reduce and order the bulk of data into identified trends and themes (cf. Ch. 6 sect. 6.2) (Miles & Huberman, 1994:92). Data integration into one explanatory frame was subsequently done with the findings obtained from the different data generation methods to address the research questions.

5.4.3.3   Analysis of data from the Delphi survey

The data generated on the teaching, clinical, research and service activities of nurse educators from their workload diaries were analysed to identify the content items of the Delphi survey. The numerical data from the Delphi were analysed with statistical analyses and the interpretation of these results were presented in tables (Creswell, 2009:152). The Delphi survey was employed to complement the narrative data generated by the individual and focus group interviews.

The Delphi survey data were analysed by using the EvaSys survey automation suite to check between rounds for the consistency of the responses of the experts (Ab Latif *et al*., 2016:89). These authors draw attention to the favoured use of the mean and median score based on Likert-type scale measures as used in the Delphi survey. The measures of central tendency were used in the statistical analysis of the Dephi data to present information on the collective judgement of the panel of experts (Hasson *et al*., 2000:1010). In the present study the experts achieved consensus on the data by calculating the mean and median scores in each of the three rounds.

5.5   DATA QUALITY

Data quality measures related to aspects of validity, reliability and trustworthiness of the data are discussed in this section.

5.5.1   Validity

In this study, electronic workload diaries, interview guides and Delphi questionnaires were used for generating data. The data validity measures for each of these data methods are briefly discussed below.

5.5.1.1   Validity measures for workload diary data

Data validity was enhanced by ensuring the face validity of the workload items on the electronic workload diaries to determine whether each item measured what it was supposed to measure (Brink *et al*., 2012:165; Polit & Beck, 2012:728). The researcher ensured the workload activities listed on the electronic workload diaries were directly and

realistically related to the workload of the nurse educators. Before the pilot study, a statistician at Stellenbosch University assisted with and reviewed the data generation tool for face and content validity before it was implemented (Brink *et al.*, 2012:168; Creswell, 2009:149).

The electronic workload diaries (artefact analysis) were piloted by two higher education and training managers at the corporate office of the identified private higher education institution and one nurse educator at one of the nursing education sites. Their nursing education experience varied between eight to 15 years. This pilot was done to determine the clarity of the instructions, the time it took to complete the activities, how often it should be done and to find out whether any activities had been missed. Feedback from the pilot exercise indicated the instructions were clear, it took approximately 15 to 20 minutes per day to complete the workload activities of the day and all workload activities were included in the workload diary (Durand & Chantler, 2014:118 & 195). A few changes were made to the dropdown boxes with the aim to make it more user-friendly. The workload diaries were completed by the nurse educators in their real work environment to reflect their daily activities and real time spent on each workload activity. The natural setting of nurse educators was thus the principle context for data generation.

5.5.1.2   Validity measures for interview data

The interview schedule used with nurse educator participants was based on relevant literature in the field of nursing education. The content validity of the interview items was enhanced by ensuring that the interview questions corresponded with real life workload issues (Brink *et al.*, 2012:165). Before the pilot study, a highly skilled external consultant (with a PhD degree) assisted with and reviewed the data generation tool for face and content validity before it was implemented (Brink *et al.*, 2012:168). Transcriptions and translations were cross-checked for accuracy by the same external consultant who also conducted the individual and focus group interviews. The same consultant was also contracted to externally cross-check the coding and themes to ensure the codes for the same passages of text were similar (Creswell, 2009:149).

The interview guide was piloted by an external consultant during an individual (face-to-face) interview with a nurse educator who was in retirement after 10 years as a nurse

educator at one of the nursing education institutions of the private higher education institution. The pilot interview took 40 minutes and was audio-recorded. The focus of the researcher was to pay attention to some specific features of data collection via interview sessions. These included listening to the clarity of the questions and answers, considering whether the depth of information was sufficiently probed, the time spent on the interview and determining the audibility of the recordings. Also, the sending of the tape to the transcribed, how long it would take to receive the transcribed data and the quality of the transcript for interpretation and data analysis purposes (Durand & Chantler, 2014:118 & 195). On feedback the time allocated per individual interview and focus group interview was changed to 60 minutes. The recordings were clear and audible with rich data generation. The audiotape was loaded successfully on the web at www.wetranfer.com. An email was sent to notify the transcriber of the audiotape on which a return email from the transcriber verified the receipt thereof. The transcript received was of a good quality which promoted coding and data analysis. It was not necessary to make any changes to the interview guide or the rest of the process.

5.5.1.3   Validity measures for Delphi data

The researcher enhanced the validity of the data generated by the Delphi survey by ensuring that the questions asked in the Delphi questionnaires were simple, clear, logical and directly related to the workload of nurse educators (Polit & Beck, 2012:745). Before the pilot study, two research specialists – one a skilled research supervisor and the other a skilled external consultant (with a PhD degree) – assisted with and reviewed the Delphi tool for face and content validity before it was implemented (Brink *et al.*, 2012:168; Creswell, 2009:149). Adjustments that were made based on the feedback included the reformulation of some instructions and questions to make it more clear and appropriate so that the relevant information could be obtained.

The Delphi questionnaire was piloted by two nurse educators. One was employed at one of the nursing education sites of the private higher education institution in the Northern region and the other was employed at the private higher education institution corporate office (Hasson *et al.*, 2000:1010). These participants and the results were not used in the main research study. The purpose of the pilot run was to ensure that the instructions and questions were clearly worded and appropriate to elicit relevant data (Durand & Chantler,

2014:118 & 195). The necessary changes were made. One was to increase the number of years' experience as a nurse educator and the other was to add the number of hours spent on two activities that were not indicated.

5.5.2   Reliability

Reliability (of instrumentation and data) is not in question in narrative/qualitative data because in this type of data the concern is about validity. Reliability refers to quantitative data which in this study pertained to the workload diaries and the Delphi instrument and data. Section 5.5.2.1 and section 5.5.2.2 provide an overview of the measures that were taken in this study to enhance the reliability of the workload diaries and the Delphi instrument and data.

5.5.2.1   Reliability measures for workload diary data

The numerical/quantitative generated data from the work life situation of the nurse educators on the electronic workload diaries were codified before being captured on a Microsoft Excel spreadsheet developed by the consultant statistician. The data on the spreadsheet was observed by the researcher for any obvious patterns, dynamics and phenomena that were active within the data. The reliability of the workload diaries was enhanced by (1) all participants used a standardised workload diary sheet during the nine months (2) the application of simple principles to ensure accurate data from the workload diaries, e.g., capturing the data on an Excel spreadsheet, and (3) a statistical descriptive analysis made by a consultant statistician of the statistical consultation service and using the STATISTICA 13.2 software computer program. Variables were presented graphically in the form of histograms and frequency tables allowing for visual interpretation of the nature of the distribution of the particular variable and to be able to identify possible outliers. The data generated from the workload diaries were analysed to identify the content items for the Delphi survey.

5.5.2.2   Reliability measures for Delphi data

The reliability of the Delphi questionnaires was enhanced by using the same measuring tools with all the participants. Also, the data were analysed by EvaSys survey automation suite to check between rounds for the consistency of the responses of the experts

(Creswell, 2014:203). Reliability of the study was further enhanced statistically by the high rate of responses in each round of the Delphi. During the Delphi exercise, the participants saw their feedback and the percentages of individual topic rankings. The data obtained through the workload diaries were used in the Delphi questionnaires which the panellists had to rate during various rounds.

5.5.3 Trustworthiness

The methods for establishing reliability and validity in quantitative research are not the same as those used in qualitative research (Brink, Van der Walt & Van Rensburg, 2018:110 & 158). The terms 'reliability' and 'validity' are rejected by qualitative researchers in favour of trustworthiness to ensure data quality based on credibility, dependability, confirmability and transferability (Miles, Huberman & Saldana, 2013:198; Polit & Beck, 2012:582-585) Trustworthiness refers to qualitative data (in this study the interview data). Section 5.5.2.2 provides an overview of the measures that were taken in this study to enhance the trustworthiness of the interview data.

5.5.3.1 Trustworthiness measures for interview data

Trustworthiness in narrative/qualitative data are about establishing credible, transferable, confirmable and dependable findings. In terms of credibility, the empirical data generated in Chapter 6 of the study originated from participants who were specially selected from a group of highly experienced and qualified nurse educators. All selected participants experienced this high workload on a daily basis at the identified private higher education institution where they were employed. Therefore, it was expected to be the true nature of the workload of the nurse educators. Concerning transferable, Chapter 1 (section 1.2) and Chapter 3 (section 3.7) provide sufficient information on the study location. The study environment described enables the reader to determine whether the environment and findings of this study may be applied in a similar but another environment. Although it is difficult to proof dependability, according to the researcher, this study can be repeated by other researchers in the future, although methods of data collection with respect to the extent of the institution and population may differ. This may lead to different methods of data analysis. In the case of confirmability, the findings produced and reported in Chapter 6 reflect the participants' actual voices. The findings were based exclusively on the data generated during the interviews as well as on its comparability with the key concepts,

contextualisation and theoretical context of the study as well as with the conclusions and implications presented in Chapter 8 (Brink *et al.*, 2018:158-159; Polit & Beck, 2012:584-585; Shenton, 2004:64-72). Considering the aforementioned, the study can be considered as trustworthy.

5.6   WARRANTABILITY OF THE RESEARCH

Warrantable research is considered to be research resulting in valid conclusions to assist the researcher in answering the research questions (Plowright, 2011:146). The research warrant provides credibility and a way in which the data supports the claims made. This is why Thomson (2017) refers to the warrant as the glue holding the argument together because it links the reason (facts) to the claim (statement). Only sufficient data and hard facts will be a valid reason to support a claim or statement made by a researcher in order to persuade the reader (Shepard, 2018). To achieve warrantable research, Breault and Breault (2012:73-77) set three important conditions, namely justification, belief and truth. When applied to this study, justification was obtained with the meaningful data generated by using the mixed methods of the FraIM.

Other aspects that also contributed to the warrantability of this study were the researchers' own experience and insights in nursing education, the history of educator workload at the private and relatively young institution, and the assurance that the current workload dispensation is not fair and productive and thus requires a new/amended dispensation. Warrantability was especially high because of the findings from the data generated and the statement thereof was the most accurate available.

This meaningful data were made even more meaningful by investigating the data in terms of a theoretical framework to achieve the condition of belief. The study revealed the truth in the form of the first-hand experience nurse educators had of their workload which formed the empirical basis of the study (Yates, 2003:223-232). In the present study warrantability emerged as the researcher made assumptions about the relationship between the produced facts and the claims about the cases which, in turn, lead the researcher to arrive at valid and credible conclusions in answering the research question(s) (Plowright, 2011:142). In the closing chapter the issue of research warrantability is referred to again (cf. Ch. 8 sect. 8.2).

5.7   ETHICAL CONSIDERATIONS

Ethical issues in social research are mainly participant-centred (Plowright, 2011:150). It includes participant protection from harm, allows for participant decision-making, emphasises informed consent, addresses important issues such as the right to privacy, equity, honesty between colleagues and professional codes of conduct which must be consistently applied when people are involved in research studies.

Approval to conduct the study was obtained from the Research Ethics Committee: Social and Human Sciences at Stellenbosch University (see Addendum A). The study adhered to the ethics requirements of the university as well as those of the private higher education institution where the data were generated (see Addendums B & C). The participants were fully notified and informed concerning the reasons for the study as well as the conditions of participation and their rights regarding participation (Cohen *et al.*, 2011:75-104; Creswell, 2014:98; Plowright, 2011:155-158; Polit & Beck, 2012:150-170).

Confidentiality of information was ensured by assuring each participant that any information shared by them would be kept confidential and their anonymity would be protected as their names would not appear anywhere or would not be used at any time during the interview process. All participants gave their voluntary consent and participated of their own free will in all the phases of the research study. In Phase 1 informed consent was obtained from all participants (see Addendums F & G). In Phase 2 informed consent was given at the beginning of each individual and focus group interview as reflected in the digital recordings. Informed consent forms were also signed by all participants (see Addendum F). Confidentiality was further guaranteed in that it was explained to each participant that their names would remain confidential and that all digital records would be kept locked in a safe place and would be destroyed after the data analysis had been completed.

Built into the declarations of consent was the right of participants to withdraw at any time from the study without penalty (Cohen *et al.*, 2011:78; Plowright, 2011:155; Polit & Beck 2012:158). The researcher ensured that no participants were harmed or experienced discomfort during participation. She also made sure that her position as training manager

did not in any way influence the decisions of nurse educators in the private higher education institution to participate or decline participation in the study.

Clarity, privacy and voice are advantages of the Delphi technique which contribute towards the issues of confidentiality, anonymity and disclosure of relevant information. At the same time it protects the participants' right to privacy (Cohen *et al.*, 2014:358). Panel members present their ideas and react to the ideas of others unbiased because they do not meet face-to-face and thus remain largely anonymous (Hasson et al., 2000:1012). In this study, each participant of the expert panel was invited by email to participate in the Delphi survey (see Addendums H, I & J). Attached was an explanation about the study process, approximate time it would take to complete the questionnaire and what was expected from them in each round of the Delphi. The panelists were further assured that anonymity and confidentiality would be strictly adhered to as would their unique access to the Delphi survey (Keeney *et al.*, 2011:106). A cover letter was also sent with each new questionnaire containing the feedback from the previous completed questionnaire of the previous round. Consent to participate was managed electronically for the Delphi survey.

5.8   SYNTHESIS

A pragmatic worldview as a philosophical stance was adopted in support of a mixed methodology design which was employed in this study. The Framework for an Integrated Methodology (FraIM) was used as a design type to generate data from nurse educator workload diaries and individual and focus group interviews with nurse educators. Finally, a modified Delphi exercise was employed for further investigating the workload activities of nurse educators. The overall aim of the study was to inquire into an existing needs-based workload model for nurse educators within a conceptual framework which included the systems theory and the expectancy theory. In this study, electronic workload diaries, interview guides and Delphi questionnaires were used for generating data. Thus, the importance of data quality measures related to the aspects of validity, reliability and trustworthiness of the data were thoroughly addressed. The necessary ethical clearance was obtained. The main participant protection ethical issues against harm as well as voluntary participation, informed consent, the right to privacy, equity and honesty between colleagues and professional codes of ethics were consistently applied and adhered to

during this study process. Chapter 6 reports on the empirical findings based on the narrative data generated by the study and a discussion thereof.

CHAPTER 6

FINDINGS FROM THE NARRATIVE DATA AND DISCUSSION

## 6.1.	INTRODUCTION

Chapter 5 dealt with the research methodology and design for this study. This chapter focuses on the findings and discussion of the narrative data generated through individual and focus group interviews conducted with a group of nurse educators. Chapter 7 addresses the numerical data revealed by the nurse educators' workload diaries as well as the results from the Delphi survey.

The data generated in the empirical part of the study continued to address the main research question:

> "*What constitutes a suitable workload model related to productivity and job satisfaction of nurse educators?*"

Answering this question may contribute to addressing the workload problem of nurse educators within a private higher education institution context (Wellington, Bathmaker, Hunt, McCulloch & Sikes, 2005:177).

## 6.2.	DESCRIPTION OF NARRATIVE DATA

Thirty-seven (n=37) nurse educators were selected to participate in the individual and focus group interviews based on the criteria as set out in section 5.3.1.2. This represented over 80% of the 44 permanently employed nurse educators at seven nursing education sites of the identified private higher education institution. More than 78% (n=29) of the selected employed nurse educators finally participated in these interviews. Ten nurse educators in individual interviews and nineteen nurse educators in group interviews.

The interview guide used (Addendum E) consisted of eight questions and was divided into three sections, namely (a) workload, (b) job satisfaction and (c) productivity. Where appropriate, the most relevant and important quotes are included to explain the findings. Participants were allocated codes (e.g., NEFGD1 NOR NE2 P4 L8) for the sake of

anonymity. The codes only reflected specific group/individual interview session (NEFGD1), the nursing education site (NOR – North), the specific educator interviewed (NE2), the page number of the transcript (P4) and the line number of the verbatim quote (L8). In other words:

NEFGD1	=	Nurse educator focus group number D1
NOR	=	Northern
NE2	=	Nurse educator no. 2
P4	=	Page 4 of the educator no. 2's transcribed recording
L8	=	Line eight of page four of nurse educator no. 2's transcribed recording

The nine identified categories and 39 subcategories that emerged from the analysis of the data obtained from the individual and focus group interviews are summarised in Table 6.1. It provides a summary of the nursing education sites, number of nurse educators per nursing education site, selected number of nurse educators per nursing education site, number of individual interviews, number of focus group interviews and number of participants per focus group.

Table 6.1: Summary of the nursing education sites, number of nurse educators per nursing education site, selected number of nurse educators per nursing education site, number of individual interviews, number of focus group interviews and number of participants per focus group

Nursing education site	Number of nurse educators	Selected number of nurse educators	Number of individual interviews	Number of focus group interviews	Number of participants per focus group
Cape Town	12	10	2	2	Group 1 x 4 Group 2 x 3
Bloemfontein	9	8	5	0	0
Polokwane	2	0	0	0	0
Nelspruit	3	2	2	0	0
Kimberley	1	0	0	0	0
Sandton	8	8	0	1	Group 1 x 4

Nursing education site (continue)	Number of nurse educators	Selected number of nurse educators	Number of individual interviews	Number of focus group interviews	Number of participants per focus group
Pretoria	9	9	1	2	Group 1 x 4 Group 2 x 4
Total	**44**	**37**	**10**	**5**	**19**

6.2.1. Category 1: Workload experience

The interviewees were asked to explain how they, as nurse educators, experience their current workload. Three subcategories: 'overwhelming', 'work to take home' and 'different student groups in different courses and programmes' were identified. The subcategories are addressed individually throughout the discussions.

6.2.1.1 Subcategory 1: Overwhelming

Twenty-two (88%) of the nurse educators experienced their workload as overwhelming, double overtime, a lot of work, high workload, a challenge and hectic. Some of the verbatim responses of the participants are shown in Table 6.2.

Table 6.2: Participants' verbatim responses related to their current workload experience

Participant	Verbatim quotes
NE2 CEN P1 L15	"*I experience my current workload as overwhelming.*"
NEFGD1 NOR NE2 P4 L8-12	"*I am overwhelmed at this stage … one of my colleagues left … I am all alone with all the courses, extra added on responsibilities … I see students only once a month in a specialise unit.*"
NEFGD1 NOR NE3 P11 L17 & P12 L7	"*… overwhelmed … we experienced it like that, yes...*"
NE1 TSH P1 L16 & 17 & P4 L13-15	"*… I feel overwhelmed because of the two intakes of the second-year enrolled nurse course per year … the fact that I am coping … keeping to the due date does not mean that I do not feel overwhelmed.*"
NEFGD2 TSH NE1 P1 L10-12	"*Overwhelming … since I've started at the learning centre, the groups of students grown tremendously and the amount of educators did not necessarily match the growth in students.*"

NEFGD2 TSH NE2 P2 L10-12	"*Since I've started … my workload doubles each year … student numbers do increase and our additional workload increases.*"
NEFGD2 TSH NE1, NE2, NE3 & NE4 P4 L13-18	"*Overwhelming … you feel you pouring in and pouring some of yourself, your family and of your own without getting back.*"
NE1 CAP P9 L10-11	"*I think my workload now is the maximum I can handle. If I did not give up the Pen 2, it would not be manageable.*" (translated from Afrikaans)
NEFGD1 CAP NE1 P2 L6-8	"*… in nursing language, you're on a triage basis every day, so you have to assess what is the most important and what you think are the things that can wait…*"
NEFGD1 CAP NE2 P9 L17-19	"*The big word in my life is overwhelming. You literally fall from one deadline to the next deadline.*" (translated from Afrikaans)
NEFGD2 CAP NE1, NE2 & NE3 P16 L30-35	"*… often overwhelming…*" (translated from Afrikaans)
NE1 CAP P1 L12 & NEFGD2 CAP NE3 P14 L13	"*… workload a lot with pressure sometimes…*" (translated from Afrikaans)
NE4 CEN P1 L18 &19 & P5 L7 17 &18	"*Current workload quite hectic because we have a lot of different programs running …heavy… feels like things falling on the ground with some courses in the second half of the year*" (translated from Afrikaans)
NE 5 CEN P1 L16-19	"*I do feel the workload is heavy … make use of crisis management … have to facilitate a class tomorrow I have two hours to prepare but … work I need to prepare requires more.*"
NE1 TSH P3 L23-27	"*If we started the new courses this year, while we were phasing out older ones, it would have been chaos … I am selfish enough to say it makes my workload just manageable.*"
NE2 CAP P1 L17	"*Regarding my workload … to say on a scale of one nine to ten, ten being the most it are ten…*"
NE5 CEN P2 L22 & 23	"*It feels I am constantly racing to complete my work.*"

Looking at the response from an overall respective, it seemed the nurse educators' work life was experienced by them as 'running on a treadmill' and 'almost speeding out of control', with them barely being able to hold on. They were apparently almost not wholly

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able to cope even with their daily workload. They constantly had to readjust and consider what activity was most important – being in class or performing administrative tasks. Although they seemed to attempt all activities within office hours, they still took home a substantial volume of work in order to achieve all role expectations and get the work done (also see Ellis, 2013:304).

A combination of the different activities related to teaching, clinical practice, research and administrative workload indicated in the conceptual framework (see Figure 4.5) determines the daily workload of a nurse educator as mentioned. A critical factor dictating the work life of nurse educators is the time spent on these activities (Rosser & Tabata, 2010:456; Zibrowski, Weston & Goldszmidt, 2008:873). Therefore, nurse educators' workloads need to be addressed to promote optimal productivity and job satisfaction of nurse educators to enhance the provision of high quality nursing education (Vardi, 2009:500). However, excessive workloads may promote faculty helplessness which may lead to demoralised faculty members (Maharjan, 2012: 47; Sohail *et.al.,* 2014: 67).

As mentioned in section 1.3, nurse educators at the identified private higher education institution have to face a range of different educational workload activities as well as extensive additional tasks to perform in the tightly regulated South African higher education health environment. Nurse educators have to cope with escalating volumes of administrative tasks, travelling between clinical facilities and accommodate an increasing level of demands with regard to academic and clinical duties. At the same time, they have to respond to culturally diverse nursing student groups which, in turn, demand more dedicated effort, higher levels of motivation and effort to remain effective and productive within a competitive business environment.

Table 6.3 illustrates the different courses and programmes nurse educators are involved in so that the above mentioned verbatim responses of the participants can be better understood.

Table 6.3: Summary of programmes and courses presented at the nursing education sites of the private higher education institution

Basic programmes	Training period Years – Months		Month programme/course commences	
1. Certificate: Enrolled Nurse	1		January	June
2. Diploma in General Nursing Science	2		January	June
3. Diploma in Operating Department Assistance	3		January	
Post-basic Diploma programmes				
1. Diploma in Critical Care Nursing Science	1-2		January	
2. Diploma in Operating Theatre Nursing Science	1-2		January	
3. Diploma in Emergency Nursing Science	1-2		January	
4. Diploma in Paediatric Nursing Science	1-2		January	
5. Diploma in Midwifery	1		January	
Short courses				
1. Anaesthetic and Recovery Room: EN		6	April	
2. Anaesthetic and Recovery Room: RN		6	April	
3. Cardio-thoracic Critical Care: RN		6	April	
4. Critical Care Nursing Science: RN		6	April	
5. Diagnostic and Therapeutic Cardiac Interventions		6	April	
6. Emergency Nursing Science: RN		6	April	
7. Haematology, Advanced: RN		6	April	
8. Neonatal Nursing Science: RN		6	April	
9. Oncology/Haematology Nursing Science: RN		6	April	
10. Operating Theatre Nursing Science: RN		6	April	
11. Orthopaedic Nursing: RN		6	April	
12. Paediatric Nursing Science: RN		6	April	

In-house courses	Training period Years – Months		Month programme/course commences	
1. Operating Theatre Nursing: EN		10	January	
2. Infection Control for Specialists & CRM		10	January	
CPD courses for nurses				
1. Anaesthetic & Recovery Room Nursing: RN & EN		4		August
2. Anaesthetic Nursing: ENA		4		August
3. Back-to-Practice for Midwives: RN		4		August
4. Cardio and Thoracic Surgical Nursing: RN		4		August
5. Circulating Nurse: EN & ENA		4		August
6. Clinical Risk Management Course: RN & CRM		4	April	
7. Critical Care Nursing: ENA		4		August
8. Critical Care Nursing: RN & EN		4	April	
9. Diagnostic and Therapeutic Cardiac Intervention		4		August
10. Emergency Care Nursing: RN & EN		4	April	
11. Endoscopic Course: Flexible & Rigid: RN, EN, ORP, ODA		4		August
12. Forensic Nursing		4	April	
13. Gynaecological Nursing: RN & EN		4	April	
14. Infection Prevention & Control on-line course for Healthcare Staff		4	April	August
15. Health Service Management and Leadership		4		August
16. Maternity Nursing: RN & EN		4	April	
17. Medical and Geriatric Nursing: RN, EN & ENA		4	April	
18. Neonatal Nursing Critical Care Nursing: RN & EN		4		August
19. New Born Care: RN, EN & ENA		4	April	
20. Oncology Nursing: RN, EN & ENA		4	April	
21. Operating Theatre Nursing: RN & EN		4	April	

CPD courses for nurses (continue)	Training period Years – Months		Month programme/course commences	
22. Orthopaedic Nursing: RN & EN		4		August
23. Paediatric Critical Care: RN & EN		4		August
24. Paediatric Emergency Care Nursing: RN & EN		4		August
25. Paediatric Nursing: RN & EN		4		August
26. Pain Management: Basic RN & EN		4	April	
27. Pain Management: Epidural & Spinal RN		4		August
28. Pain Management: Childhood RN & EN		4	April	
29. Pharmacology: Advanced RN		4		August
30. Pharmacology: Basic RN & EN		4	April	
31. Post-anaesthetic Care Unit Nursing: RN		4		August
32. Professional Practice for Nurses		4		August
33. Psychiatric Nursing: RN		4	April	
34. Rehabilitation: RN & EN		4	April	
35. Scrub Course for Midwives		4		August
36. Anaesthetic & Recovery Room Assistance: ORP/OTPs		4		August
37. CSSD Course for all Categories of Theatre/CSSD/TSSD Personnel		4	April	
38. CSSD Course for Supervisors		4		August
39. Cardio & Thoracic Surgery: ORP & ODA		4		August

Table 6.3 indicates a total of three basic programmes, 53 courses and the clinical accompaniment of five post-basic programmes are offered at the seven nursing education sites of the private higher education institution. The workload distribution of nurse educators at the different nursing education sites for these programmes and courses are indicated in Tables 3.1 to Table 3.7. Ten of these programmes and courses commence in January, 29 start in April, two in June and 23 in August. Except for the clinical accompaniment of the five post-basic diplomas, the nurse educators of the nursing education sites are also responsible for the theoretical and clinical components of the

programmes and courses, which include contact sessions, tests, assignments, and clinical accompaniment, the evaluation of procedures and coordinating programmes and courses at regional and/or national level.

This information confirms the complexity and multidimensionality of nurse educators' workload at the private higher education institution pose a challenge for nurse educators to stay highly effective and efficient considering all the learning areas that have to be covered. Underlying this complex and multidimensional workload of nurse educators are the main tasks of teaching, clinical practice and administrative components as illustrated in the conceptual framework (see Figure 4.5). Table 6.4 gives a more detailed breakdown of the number of contact sessions, tests, assignments, portfolios, clinical procedures and examinations per programme and per course.

Table 6.4: Summary of the number of contact sessions, tests, assignments, portfolios, clinical procedures and examinations per individual programme or course

Basic programmes	Contact sessions	Tests	Assignments	Clinical procedures	Portfolio	Examination Theory/Practical	
1. Certificate: Enrolled Nurse	60	5	1	24	1	-	1
2. Diploma in General Nursing Science:							
Year 1	50	8	-	7	-	-	1
Year 2	50	8	-	6	2	-	1
3. Diploma in Operating Department Assistance:							
Year 1	80	17	1	20	1	5	1
Year 2	55	16	1	18	1	5	1
Year 3	45	7	1	13	2	3	2
Total	**340**	**61**	**4**	**88**	**7**	**13**	**7**
Short courses							
1. Anaesthetic and Recovery Room: EN	6	2	1	15	1	1	1
2. Anaesthetic and Recovery Room: RN	6	2	1	15	1	1	1

Short courses (continue)	Contact sessions	Tests	*Assignments*	Clinical procedures	Portfolio	Examination Theory Practical	
3. Cardio-thoracic Critical Care: RN	6	2	1	16	1	1	1
4. Critical Care Nursing Science: RN	10	2	1	21	1	1	1
5. Diagnostic and Therapeutic Cardiac Interventions	6	2	1	16	1	1	1
6. Emergency Nursing Science: RN	6	2	1	22	1	1	1
7. Haematology, Advanced: RN	6	2	1	23	1	1	1
8. Neonatal Nursing Science: RN	6	2	1	15	1	1	1
9. Oncology/Haematology Nursing Science: RN	6	2	1	23	1	1	1
10. Operating Theatre Nursing Science: RN	6	2	1	20	1	1	1
11. Orthopaedic Nursing: RN	6	2	1	13	1	1	1
12. Paediatric Nursing Science: RN	6	2	1	10	1	1	1
Total	**76**	**24**	**12**	**209**	**12**	**12**	**12**

In-house courses	Contact sessions	Tests	Assignments	Clinical procedures	Portfolio	Examination Theory Practical	
1. Operating Theatre Nursing: EN	10	3	-	14	1	1	1
2. Infection Control for Specialists & CRM	3	3	-	-	1	1	-
Total	**13**	**6**	**-**	**14**	**2**	**2**	**1**
CPD courses for nurses							
1. Anaesthetic & Recovery Room Nursing: RN & EN	4	2	-	11	1	-	-
2. Anaesthetic Nursing: ENA	4	2	-	9	1	-	-
3. Back-to-Practice for Midwives: RN		2	-	12	1	-	-
4. Cardio and Thoracic Surgical Nursing: RN	2	2	-	6	1	-	-
5. Circulating Nurse: EN & ENA	4	2	-	35	1	-	-
6. Clinical Risk Management Course: RN & CRM	2	2	-	-	1	-	-
7. Critical Care Nursing: ENA	3	2	-	13	1	-	-
8. Critical Care Nursing: RN & EN	3	2	-	18	1	-	-

CPD courses for nurses (continue)	Contact sessions	Tests	Assignments	Clinical procedures	Portfolio	Examination Theory Practical	
9. Diagnostic and Therapeutic Cardiac Intervention	3	2	-	20	1	-	-
10. Emergency Care Nursing: RN & EN	3	2	-	11	1	-	-
11. Endoscopic Course: Flexible & Rigid: RN, EN, ORP, ODA	-	1	-	2	-	-	-
12. Forensic Nursing	-	2	-	2	1	-	-
13. Gynaecological Nursing: RN & EN	-	2	-	2	1	-	-
14. Infection Prevention & Control on-line course for Healthcare staff	-	2	-	-	1	-	-
15. Health Service Management and Leadership	-	-	1	-	1	-	-
16. Maternity Nursing: RN & EN	-	2	-	14	1	-	-
17. Medical and Geriatric Nursing: RN, EN & ENA	-	2	-	16	1	-	-
18. Neonatal Nursing Critical Care Nursing: RN & EN	2	2	-	13	1	-	-

CPD courses for nurses (continue)	Contact sessions	Tests	Assignments	Clinical procedures	Portfolio	Examination Theory Practical	
19. New Born Care: RN, EN & ENA	-	2	-	14	-	-	-
20. Oncology Nursing: RN, EN & ENA	-	2	-	9	-	-	-
21. Operating Theatre Nursing: RN & EN	3	2	-	14	1	-	-
22. Orthopaedic Nursing: RN & EN	2	2	-	13	1	-	-
23. Paediatric Critical Care: RN & EN	-	2	-	16	1	-	-
24. Paediatric Emergency Care Nursing: RN & EN	-	2	-	9	1	-	-
25. Paediatric Nursing: RN & EN	-	2	-	12	1	-	-
26. Pain Management: Basic RN & EN	-	2	-	3	-	-	-
27. Pain Management: Epidural & Spinal RN	-	2	-	4	-	-	-
28. Pain Management: Childhood: RN & EN	-	2	-	6	-	-	-
29. Pharmacology: Advanced RN	-	4	-	3	1	-	-

CPD courses for nurses (continue)	Contact sessions	Tests	Assignments	Clinical procedures	Portfolio	Examination Theory Practical	
30. Pharmacology: Basic RN & EN	-	2	-	4	-	-	-
31. Post Anaesthetic Care Unit Nursing: RN	3	2	-	12	1	-	-
32. Professional Practice for Nurses	-	2	-	-	1	-	-
33. Psychiatric Nursing: RN	-	2	-	3	1	-	-
34. Rehabilitation: RN & EN	-	2	-	20	1	-	-
35. Scrub Course for Midwives	2	2	-	5	1	-	-
36. Anaesthetic & Recovery Room Assistance: ORP/OTPs	4	2	-	10	1	-	-
37. CSSD Course for all Categories of Theatre/CSSD/TSSD Personnel	-	2	-	5	1	-	-
38. CSSD Course for Supervisors	2	1	-	8	1	-	-
39. Cardio & Thoracic Surgery: ORP & ODA	3	-	-	6	-	-	-
Total	**49**	**74**	**1**	**360**	**31**	**-**	**-**
Grand Total	**478**	**165**	**17**	**671**	**52**	**27**	**20**

A nurse educator is normally responsible for a programme and at least two courses. From Table 6.4 it is clear that over and above the travelling between the clinical facilities and related administrative activities, the nurse educator is responsible for the preparation and presentation of the number of contact sessions of a particular programme or course. The nurse educator further sets the required number of test papers for that programme or course; mark the number of tests per student; guide each student in the clinical practice environment and find each student competent/not competent in the number of procedures indicated in Table 6.4. He/she in addition sets the examination paper and supplementary examination paper; mark each student's examination and supplementary examination script and do the practical examination of each student. It needs to be explained that although students are responsible for practice procedures, which are occasionally done with the assistance of mentors, the nurse educator in this institution remains responsible for the student's competence before the programme or course can be successfully completed.

All of these time-consuming activities directly relate to the teaching, clinical practice and administrative workload components of the nurse educator. Teaching activities constitute the most intensive time activities of nurse educators as it involves more than time spent in the classroom (Collins, 2006:20; Dennison, 2012:301; Kaufman, 2007:296; Naidoo & Mthembu, 2015: 216)). Similarly, clinical practice activities are crucially important to close theory-practice gap and the supply of knowledgeable skilled nurse practitioners (Premji *et al*., 2011:876; SANC, 1992:7). Currently, the primary barrier to nurse educators in the clinical practice component is the lack of time for such activities (also see Shuttleworth *et al*., 2008:704). The time factor involved in the different activities is in depth together with the results of the Delphi survey as presented in Chapter 7.

6.2.1.2   Subcategory 2: Work taken home

Time spent on work related-activities after hours were apparently the norm as it was part and parcel of the nurse educator's position. However, from the individual and focus group interviews it became clear that the participants did not share the same view on taking work home. Their opinions are reflected in Table 6.5.

Table 6.5: Opinions of nurse educators on work taken home

Participant	Verbatim quotes
NEFGD1 CAP NE4 P6 L5-33	"*Time is very limited ... take work home ... marking tasks and tests ... setting up tests is a lot ... must organised properly to not take work home but stress because there is a lot of due date ... class preparation .... doing research ... takes time to look … not always access at work ... block some website ... then you will do research at home.*" (translated from Afrikaans)
NEFGD1 CAP NE2 P9 L1-6	"*When I start a new course ... lectures are prepared at home ... it does not happen at work because you do not have time ... work two hours at home every night.*" (translated from Afrikaans)
NE1 CAP P5 L1-6	"*… open-plan ... try concentrate ... set tests and mark tests over weekends…*" (translated from Afrikaans)
NEFGD2 CAP NE2 P6 L12-14	"*I do marking of tests and preparation for class at home ... tries to do it at work, but sometimes admin is so much you cannot do preparation as well…*" (translated from Afrikaans)
NEFGD2 CAP NE3 P11 L33 & 34 & P12 L3	"*What I regularly do is take tests home and do the admin... at least every week.*" (translated from Afrikaans)
NE1 CEN P8 L5 & P11 L14	"*…take work home like class preparation ... it really takes more energy to work out those activities for class.*" (translated from Afrikaans)
NE2 CEN P11 L14	"*… if you don't get it done within the work time, … take it home because they expect you to do markings within two weeks.*"
NE4 CEN P6 L11	"*… lots of class preparation ... you do not really get time at work ... you need to prepare for class after hours at home.*" (translated from Afrikaans)
NEFGD1 NOR NE4 P18 L2 & 3	"*… at night or over weekends … set tests, moderating…*"
NEFGD1 TSH NE2 P3 L26-31	"*… I sat at home and marked the tests … frustrating it took me four hours to mark nineteen papers … although you start at six in the morning … you still have to take work home…*"

NEFGD 2CAP NE1 P3 L35 & P4 L4-14	"… *do my research … class preparation … at home due to … limited internet access at work.*"
NE5 CEN P3 L17	"*The workload is such that you find it difficult to manage not working at home.*"
NE2 CAP P3 L11-17	"*I work at least in the evenings two hours … some time the whole weekend just to get up to date …*"
NEFGD2 TSH NE4 P9 L6-13	"… *lecture weeks I take my work home because I can't mark my tests when lecturing … take practical books home to mark* "

From the sample verbatim quotes in Table 6.5 it is evident that four participants did their preparation for class at home and eight participants did their setting and marking of tests at home due to limited internet access at home and their busy schedule at work. Most participants spent two hours a day, five hours a week or three to eight hours a month on work-related activities such as setting tests, marking tests, doing research and class preparation at home. This was mainly due to their workload being of such a nature they could not complete it during working hours. One participant commented during an individual interview as follows: "*I stopped to do work at home because my husband complained. He said this is his time so he is going to send the [private healthcare company] an invoice…*" (NE5 CEN P3 L7-9) This husband feels strong about his time his wife had to spend on work-related activities at home, because in his perspective the company was misusing their family time.

If the company wants to be the employer of choice as reflected in its vision, family time of nurse educators should be taken into consideration when employee workloads are designed. In accordance with the expectancy theory (cf. Ch. 4 sect. 4.3) nurse educators seem to believe that there is a connection between the effort they put in by working after hours at home and what they achieve from these efforts (e.g., better student results); thus the reward they will achieve from the effort performed (Lunenburg, 2011:1 & 2). To give a visual picture of the current workload of the nurse educators at this private higher education institution, the total numbers of contact sessions, tests, assignments, clinical procedures, portfolios, theoretical examinations and practical examinations generated per academic year by all the

programmes and courses of the private higher education institution are summarised in Table 6.6.

Table 6.6: Summary of the total numbers of contact session, tests, assignments, portfolios, clinical procedures and examinations

Basic programmes	Contact sessions	Tests	Assignments	Clinical procedures	Portfolio	Examination Theory/Practical	
Basic programmes	330	61	4	88	7	13	7
Short courses	76	24	12	209	12	12	12
In-house courses	13	6	-	14	2	2	1
CPD courses	49	74	1	360	31	-	-
Total	**468**	**165**	**17**	**671**	**52**	**27**	**20**

Table 6.6 is self-explanatory regarding the substantial number of tests (165 per year) and supplementary tests (165 per year), the moderation of each set of 165 tests and marking the tests as well as additional 17 assignments and the evaluation of 671 procedures – all part of the teaching and clinical practice workload components of the nurse educator (see Figure 4.5). This probably explains why a participant, during a focus group interview, made the following comment: "*It's an enormous amount of setting tests, supplementary tests, marking it, moderating it … that is over and above the clinical support that you feel you don't get to* [but] *that you so desperately want to get to…*" (NEFGD1 NOR NE3 P17 L18-22). The enormity of the theory-related amount of work obviously complicates allocating of 20% of a nurse educator's time to practical guidance even further (AACN, 2005:2; Premji *et al.*, 2011:880-881; Williams & Taylor, 2008:900). The time factor involved in each of these workload activities is discussed in more detail with the results of the Delphi survey discussed in Chapter 7.

6.2.1.3   Subcategory 3: A variety of student groups in different courses and programmes

The different programmes and courses offered at the various nursing education sites of the private higher education institution (see Table 6.3), the teaching and clinical practice workload activities of each programme and course (see Table 6.4) and the total number of teaching and clinical workload activities (see Table 6.6) reflect the complexity of the nurse educator's role. Key abstracts taken from the verbatim quotes of the participants are recorded in Table 6.7 which demonstrates how they experience the different programmes and courses.

Table 6.7: How nurse educators experience the different programmes and courses

Participant	Verbatim quotes
NE2 CAP P2 L16-21 & L30-33	"*… two hundred students in one group is one thing but being involved in five or six different courses with two students is something different because your preparation is still the same.*" "*… different courses at different levels is a challenge.*"
NEFGD1 NOR NE1 P2 L25	"*In class I see different student groups therefore the workload is obviously different.*"

NE2 CAP P5 L26-34	"*Currently twenty-five students in five different courses. One group of students in two different hospital*[s] *and the post basic course students are in the hospitals of Windhoek, Swakop, Upington and George.*"
NEFGD1 NOR NE1 P2 L3-15	"*I have collectively thirty-three students of which some are first-years bridging, some second-year bridging and some Pen 2 students in different hospitals therefore I* *actually offer three different courses.*"
NEFGD1 NOR NE1 P2 L3-15	"*... it dilutes your focus with your primary students.*"

The above verbatim quotes clearly reveal that the wide range of different nurse training programmes and courses divide the attention of nurse educators. This may result in possibilities towards insufficient training due to the specific learning theoretical and/or clinical outcomes per programme or per course not being successfully achieved.

6.2.2.   Category 2: Factors impacting on workload

The question, "please explain the issues that currently affect your workload as a nurse educator" resulted in a range of factors that were divided into 'institutional-related factors', 'operational-related factors', student-related factors and 'educator-related factors'.

6.2.2.1   Institutional-related factors

There are different peak times during the academic year due to students completing courses or programmes and starting new ones. Specifically the four-, six- and ten-month courses (April to July; August to November; April to October; January to October as shown in Table 6.3) result in heavy workloads. This situation also escalates into peaks in the workload activities of nurse educators such as preparation for class and setting and marking practical and theoretical examinations. One participant commented as follows during a focus group interview: "… *at this time of the year, our students started to get ready or come to a place where you can assess them … it is also difficult with the CPD students starting … planning is difficult … get the student numbers one August … have to book venues and visit the CPD students … I have two CPD student groups and one short course*…" (NEFGD2 CAP NE1 P4 L23-30 & P5 L1-10) (translated from Afrikaans).

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In another focus group interview a nurse educator described her responsibilities as "… *travel a lot … have to give class, have to see students … have to do administration stuff … have to train people to present these different courses … running fundamental critical care* [4 months] *short course critical care* [6 months], *assist* [with] *diploma* [in] *critical care, monitor basic life support instructors, renew the instructor status, present ACLS for hospital staff at regional level*…" (NEFGD1 NOR NE2 P4 L10-32 & P5 L1-6). In Figure 6.2 these responsibilities of a nurse educator as stipulated in their work profile are illustrated (Private healthcare provider, 2014:1-3). It is posited that the myriad responsibilities of nurse educators may relate to academic staff burnout and be connected to insufficient training – thus compromising the values of the company.

Regional or national coordination of a programme or course add additional responsibilities to the workload of nurse educators and existing demanding schedule. One participant expressed this as follows: "… *editing of tests and examination papers, distribution of test papers, sending examination papers to external moderator … giving back marks to nurse educators and so on*…" (NE5 CEN P7 L17-22).

The workload of a nurse educator is loaded even more when expectations such as the preparation of a teaching methodology that enhances the critical thinking skills of students requires additional preparation time from them – especially with regard to the activities. The typical responsibilities of a nurse educator are set out in Figure 6.1.
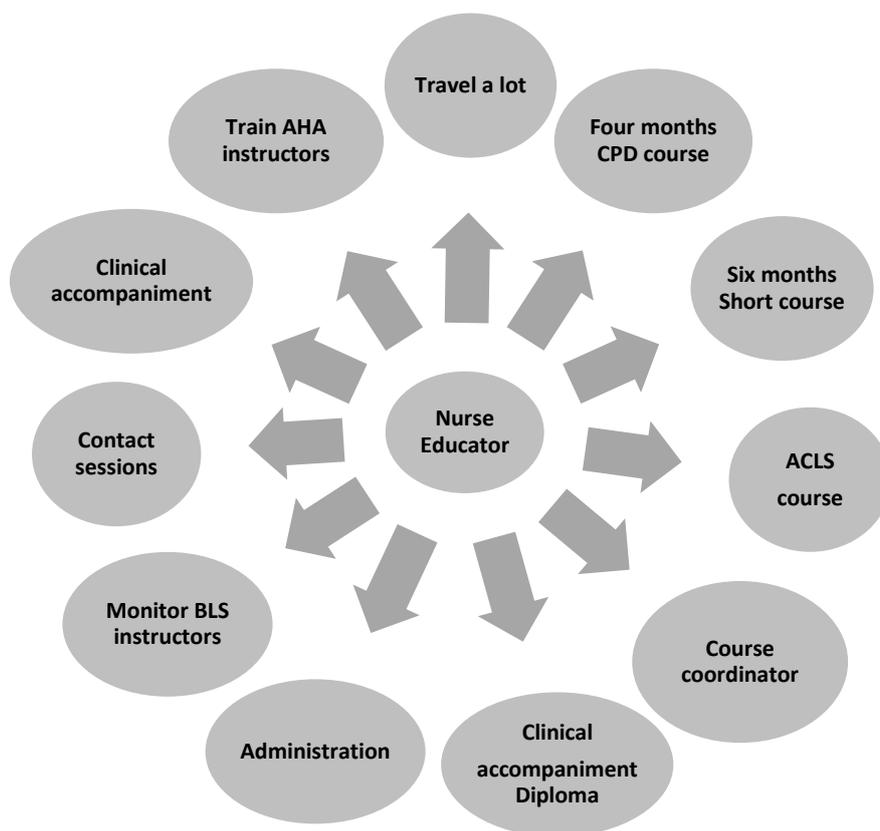
Figure 6.1: Typical responsibilities of a nurse educator (Private healthcare provider, 2014:1-3)

The following additional teaching activities, considered to be extremely time-consuming, were highlighted by the participants during individual and focus group interviews:

- preparation time for Basic Life Support for Healthcare Providers (BLS) and Advanced Cardiovascular Life Support (ACLS) workshops.

- Preparation of equipment for BLS and ACLS before the workshops.

- Cleaning of BLS and ACLS equipment after the workshops.

- If broken, fixing of the BLS and ACLS equipment.

- Remediation of students who are not competent in BLS and ACLS.

- Setting of tests for all the different courses and programmes.

- More time is required for the preparation of the contact sessions of the Short courses and CPD courses.

All teaching workload activities of the participating nurse educators also generated administrative activities which were part of their administrative workload. It is therefore not surprising for those educators to share that they experienced an excessive administrative load as shown in their verbatim quotes summarised in Table 6.8.

Table 6.8: Some views of the nurse educators on their excessive administrative load

Participant	Verbatim quotes
NE4 CEN P12 L12-16	"*Kronos management of students can take you on a Monday to three hours, which will make workload even bigger.*" (translated from Afrikaans)
NEFGD1 CAP NE1 P1 L19-20	"… *a lot of admin* [administrative work] *involved with whatever you do, whether it's being in class or whether it's seeing students.*"
NEFGD1 CAP NE2 P11 L32-34 & P12 L1	"… *a lot of time goes in admin ... thirty per cent*" (translated from Afrikaans)
NEFGD1 CAP NE3 P12 L3-6	"… *lectures you offer have a lot of admin ... clinical accompaniment of students has a lot of admin ... admin at work only your emails and request ... look at study guides then we talk from admin.*" (translated from Afrikaans)
NEFGD1 CAP NE4 P13 L16	"… *admin is a lot of time then you have not even come to loading test marks ... take many hours because you have to go into each student's file.*" (translated from Afrikaans)
NEFGD2 CAP NE1 P1 L19	"*My problem is administration … the loading of periods, the scanning of documents that takes up time…*"
NEFGD2 CAP NE2 P6 L14-19	"… *there is sometimes so much admin ... student admin ... loading of classes and everything you write on GPL* [what is this – write out in square brackets!] *records.*" (translated from Afrikaans)
NEFGD2 CAP NE3 P10 L28-30	"… *I am involved in the development of the new staff nurse course study material ... which is quite a lot of admin work, theoretical work…*"
NEFGD1 NOR NE2 P10 L13-16	"… *you've got administrative duties … have a secretary at the school … when it comes to student records and our files … do it all on our own.*"
NEFGD1 NOR NE3 P17 L1-4	"*The admin is quite a lot … there is a lot of duplications … same information in four places which is frustrating…*"

NE1 TSH P2 L16-23	"*If I will ever be disciplined it will be about admin … it is time-consuming … I recognise the value of it but when it comes to must I go to practice to see a learner … or must I fill in admin then the admin is the last choice…*"
NEFGD2 TSH NE2 P2 L19-25	"*Admin work takes a lot of time … we have a heap load of paperwork to do … takes more than fifty per cent of our time.*"

Clearly, from the sample quotes it is obvious that the administrative workload of nurse educators at the private higher education institution is a problematic issue. These activities may involve a significant portion, between 30% and 50%, of a nurse educator's time at work. It had a major impact on the participating nurse educators' workload. Williams-Utz (2009:630) states these workload activities should be part of any workload model and according to Ellis (2013:305), two hours per week should be provided for the administrative activities of a nurse educator. In fact, the author further points out that an additional 10 hours a week is necessary if the nurse educators are expected to maintain their clinical skills.

In South Africa, the current nursing qualifications of all the categories of nurses are in a phasing out process (SANC, 2014:1-2; SANC, 2016:1-2). Meanwhile, the SANC is at present involved with the implementation process of the new nursing programmes. The identified private higher education institution has submitted curricula of two of these new nursing programmes to the SANC for accreditation (SANC, 2013c:4). In the interim, the nurse educators employed by the mentioned private higher education institution are developing the study material for these programmes so that when the private higher education institution receives accreditation, these programmes can be implemented. The views of two participants, one in the individual interviews and one in the focus group interviews, saw the time allocated to new study material as follows:

- "*I have to prepare the study material... I feel you need to, we have the opportunity to create study material that is interactive and addresses what the clinical setting wants and that takes time. I don't think it is something that my colleagues always understand.*" (NE1 TSH P3 L28-30).

- "*… also help with developing new study materials ... need to make time somewhere ... feel at this stage you only do what you can where you can if you had more time you could have*

produced a better quality product ... where now it is done hastily ... rushed." (NEFGD2 CAP NE3 P17 L23-27) (translated from Afrikaans).

These participants seemed to be positive about the development of new nursing programmes, but it impacted negatively on their overall workload. At the same time, if nurse educators do not have sufficient time to update and develop new study materials the quality of teaching and learning may suffer (Ellis, 2013:305). In accordance with the systems theory (cf. Ch. 4 sect. 4.2), nurse educators receive the input (information) of the private higher education institution (internal environment) to deliver an output (study material). Job satisfaction is thus not experienced as the ruling perception that a better quality product can be delivered with a more reasonable workload. However, as illustrated in Figure 4.5 (cf. Ch. 4) workload activities depend on one another for survival of the educator (Smit *et al.*, 2011:62). Some authors are of the opinion that the job satisfaction of nurse educators can be improved when institutions consider their employed educators' feelings of self-worth, satisfaction and dissatisfaction regarding their workload (Booyens, 2016:323; Candela, Gutirrez & Keating, 2012:855; Nel *et al.* (2011:14).

Participants further experienced problems with the workload at nursing education sites by having to mentor and nurture newly appointed nurse educators. This was verbalised as follows by a newly appointed nurse educator who had started working just over a year prior to the interviews: *"… it just takes longer to prepare because I am still adjusting … things like setting a test … eight hours … to prepare for a week block in class take me two weekends to just prepare … the corrections on test after moderation takes me four hours therefore I describe my workload as challenging…"* (NEFGD2 TSH NE3 P5 L26-33 & P6 L20-23 & P7 L6). In this respect, this new employee's appointed mentor said: "*I mentor our junior colleague that started … I try to assist … she finds it difficult and challenging to adapt. She is very willing and eager, but I do realise the reality shock … so I sometimes go with her to class and then we do a few things together…*" (NE 1TSH P10 L20-27). Murray (2008:107) reminds us that if the expectations of new employees are met, they will experience increased job satisfaction and it will therefore be more likely for them to perform better.

The foregoing scenario indicates mentoring as another important workload activity of the nurse educator. The expectancy theory's perspective is to connect the performance of the nurse educators with what is valuable to them (such as a reward). As a mentor, the nurse

educator will receive job satisfaction as soon as the new nurse educator is familiar with the workload activities and can take over her/his workload duties. On the other hand, the newly appointed nurse educator will receive job satisfaction as a result of her continued development and independent functioning (Smit *et al.*, 2016:413).

Due dates were highlighted as challenging to nurse educators. In Table 6.8 a sample of quotes confirm the participants were constantly focused on meeting due dates.

Table 6.9: Sample quotes of how the participants experienced their challenges to meet due dates

Participant	Verbatim quotes
NE1 CAP P11 L28-29	"… [the] *workload has many deadlines for setting tests, marking tests and moderation of tests.*"
NEFGD1 CAP NE2 P9 L21	"… *you literally fall from the one deadline to the next deadline ... you prioritise all the time just to keep to deadlines*…" (translated from Afrikaans)
NE2 CEN P11 L17-28	"… *sometimes the students wrote a test and you are one or two weeks in the region … by the time you get back it is already the due date … it put you under a great deal of stress*…"
NE1 TSH P2 L6 & 7	"*Sometimes I feel overwhelmed especially if there is a due date and I know I am not going to make the due date.*"
NEFGD2 CAP NE3 P12 L32 & P13 L4 & P14 L3-5	"… *short notice deadlines ... on Friday announced to have completions ready for Monday … and missing due dates due to slow internal mail.*" (translated from Afrikaans)

Relevant literature indicates that deadlines have an effect on the performance of tasks. For instance, if there is a limited time frame in which a task has to be completed, employees appear to be more focused and less wasteful, which also increases productivity (Kelly & Loving, 2004:186; Mullainathan & Shafir, 2013:19-27). Deadlines also serve as a buffer to prevent postponement or to forget tasks (Zamir, Lewinsohn-Zamir & Ritov, 2017:769). Some disadvantages of deadlines include the intense concentration on a task due to time pressures centres the attention of employees on the particular task, sometimes at the expense of other important tasks (Mullainathan & Shafir, 2013:27-38). Deadlines can also affect the quality of decision making due to the issue of urgency (Carpenter, Zucker &

Avorn, 2008:1355). All these mentioned issues may be relevant to the position of nurse educator overload as some of the quotes in Table 6.8 illustrate.

Another challenging factor that has an impact on the workload of nurse educators is the open-plan office environment made available to them at the nursing education sites of the private higher education institution (see Figure 4.5). The verbatim responses of some participants regarding this matter are indicated in Table 6.9.

Table 6.10: Sample quotes pertaining to the matter of open-plan offices

Participant	Verbatim quotes
NE1 CAP P5 L1-2	"… *and we are open-plan you try to concentrate, but you hear everything that's going on*…" (translated from Afrikaans)
NE2 CEN P39 L14-21	"… *you are sharing offices so there is frequent interruptions and frequent talking with other people … and people talking to my colleague or people talking loud on the phone and you hear that*…"

Although open-plan offices are considered a cost-effective arrangement regarding the allocation of space, some employees experience such open spaces as a menace interfering with their work. It is clear from the above quotes that not all nurse educators can function optimally in open-plan offices. Sharing of office space with colleagues appears to reduce nurse educators' productivity due to frequent interruptions and breaks in concentration. Various studies on open-plan offices for academics confirm it is experienced as an elemental problematic. Colleagues talking and having conversations over the telephone are some of the many problems associated with in an open-plan work environment. An open-plan work environment has been found as an undesirable to work in. Office space in particular have a detrimental effect on productivity, job satisfaction, employees' ability to concentrate and their emotional well-being (Jahncke, Hygge, Halin, Green & Dimberg, 2011:373; Kok, Meyer, Titus, Hollis-Turner & Bruwer, 2015:51; World Green Building Council, 2014). The expectancy theory addresses the interrelationships between workload, motivation and productivity – motivated employees experience job satisfaction when their needs are met thus allowing for an increase in productivity (see also Figure 4.5) (Dugguh, 2014:22; Kim *et al.*, 2011:724).

What also emerged from the interviews were the frequent changes in the work programmes of nurse educators at the nursing education sites. Some participants voiced changes were experienced as challenges which they highlighted as follows:

- "*We were asked to assist with all the other training in the department ... now we've got to participate in all training with all different groups of stu*dents." (NE2 CAP P1 L26 & P2 L3)

- "*… a lot of student outcomes on a yearly basis change ... fifty per cent remains, but there is this constant changing of the goal posts that you have to keep in mind the whole time...*" (NEFGD1 CAP NE2 P16 L12-17)

Changes during the implementation of new training programmes are inevitable. Some nurse educators find change difficult and need assistance to understand why these changes are necessary and how it will be to the benefit of all. To achieve this, communication is required as one of the principles of the systems theory, namely to exchange the relevant information between systems such as the nurse educator and the internal institutional environment (cf. ch. 4 sect. 4.2.1) (Germain, 2015:15; Kissen, 1980:31-33; Stichweh, 2017).

Vehicle constraints were also seen as an institutional-related factor impacting on nurse educator workload. The participants in a focus group interview at one of the nursing education sites referred to this aspect as follows:

- "*… the vehicle has to be used for ACLS or BLS equipment, for hospital staff and informal students…*" (NEFGD NOR NE3 P26 L31-33)

- "*… we are training hospital staff from the school and that impacts on our workload and it impacts on our ability to do clinical accompaniment … only one vehicle for nine educators*." (NEFGD NOR NE2 P27 L2-11)

These participants shared one vehicle for nine nurse educators was insufficient because it was often used to transport the life support training equipment to the hospitals for BLS and ACLS training. The frequent unavailability of the vehicle had a dire impact on their ability to plan ahead for clinical accompaniment.

6.2.2.2 *Factors related to the clinical environment in the private hospitals of the private healthcare group*

Accidental obstruction in the clinical development of students due to work pressure in the private hospitals of a private healthcare group was singled out by the participants as a major dilemma. Accidental obstructions may lead to insufficient training of nursing students which could result in students not being rounded off clinically as indicated in the verbatim quotes of the participants in Table 6.11.

Table 6.11: Sample quotes pertaining to 'accidental obstruction' of clinical development of students

Participant	Verbatim quotes
NEFGD1 CAP NE4 P7 L14-20	"… *clinical guidance especially with the type of students I'm accompanying, you allocate a certain amount of time ... their support at the hospital in this particular procedure is not so much thus they are dependent on our guidance ... some students need more time for clinical guidance than others*…" (translated from Afrikaans)
NE4 CEN P2 L19-33	"*With the second part of the year where we have a lot of theatre CPD courses … we just manage to present the contact sessions … we don't see those students in practice … we only rely on the mentors in the hospitals because we do not have the capacity to get to the hospitals*…"
NEFGD1 NOR NE1 P2 L26-34	"*Students that I manage in the field are thirty-three at the moment … I see them maybe once a month during GPL if possible, each one of these students are seen between one to three hours depending on the number of students in a group per hospital which is not six hours per individual learner.*"
NEFGD1 NOR NE2 P4 L11-13	"*I see two different courses of students and I also see them only once a month in the specialised units … sometimes I cannot even see them for an hour because it's difficult in a critical environment*…"
NEFGD1 NOR NE3 P4 L24-26	"… *I feel the students' clinical development is obstructed by the structure of our work*…"
NEFGD 1NOR NE1 P7 L11-14	"*Poor students only get clinical guidance when we see them once a month because you can only go so many times a month.*"

NEFGD1 CAP NE2 P4 L22 & NEFGD1 CAP NE3 P5 L1-2	"*There is not a lot of help from the practical side, hospital environment, so it takes more time.*"
NEFGD2 TSH NE2 P12 L28	"*The support in the clinical setting is non-existent…*"
NEFGD1 NOR NE3 P6 L18-21	"*In this region in theatre we have very undeveloped mentorship and we have very underdeveloped clinical facilitation and in addition it's extremely busy … so nobody has the time to teach.*"
NEFGD1 NOR NE3 P14 L27-34 & P15 L1-12 & L21-24	"*… in the Northern region we had a huge leadership turnover … a lot of brand new leaders coming from other companies … teeny weeny [very small] little hospitals there in Eastern Cape … resulted in new inexperienced very young leaders … it takes a long time for them to be orientated to the student situation … you almost find yourself in the situation where you guide the leader … places stress on the educators because you know there is nobody to organise the students…*"

The narrative data indicated that students and nurse educators were not always available at the same times in the clinical environment. Students were therefore oftentimes viewed by the human resources department in the private hospitals of the private hospital group as part of the workforce and their programmes were scheduled accordingly. Changes in the work environment of the nursing units resulted in students not being available for clinical facilitation, even if these were scheduled well in advance.

Nursing students spent a long periods of their training in the clinical environment of the private hospitals with little or no clinical mentorship. According to the narrative data, it appears that ineffective clinical mentoring greatly contributed to the 'accidental obstructive clinical development' of students. Consequently, it did make a vital contribution to the insufficient training of nursing students.

Table 6.12: Sample quotes regarding clinical mentorship

Participant	Verbatim quotes
NEFGD1 CAP NE3 P5 L13-19	"*In the practical setting there is mentors that are supposed to be assisting students in a clinical setting but they've also got their workload, shortages and time issues … they don't get to assist the students … so it falls back on us.*"
NEFGD2 CAP NE3 P40 L28-31	"*… mentors have their own activities ... mentoring is an additional responsibility to that person…*" (translated from Afrikaans)
NE1 CEN P5 L20-22	"*... this hospital stipulates that the clinical supervisors are only available for their own staff...*" (translated from Afrikaans)
NEFGD 1TSH NE2 P9 L8-12	"*There are mentors ... you have to guide your student but the person who is actually in charge of the unit is not working according to policy... You have to stop and rectify her and guided her ... it is a big fight because you are from the learning centre ... you've read the policies ... and so you spend time with her before you actually get to your student...*"
NEFGD2 TSH NE2 P13 L21-23	"*... mentoring even if you have mentors, they are unable to mentor because they don't have the support in the clinical setting or the time...*"
NEFGD1 CAP NE1 P20 L25-34 & P21 L8-11	"*We find a lot of mentors in the unit aren't up to date with the recent procedures ... when it comes to assessment of procedures they just mark it off ... there is no synergy between you and the clinical setting in terms of mentoring ... and assessment of the students...*"
NEFGD1 TSH NE3 P10 L2-13	"*... you teach them the correct method ... they do it correct when you assess them ... in practice the mentor shows the student the short cut ... which is not according to procedure...*"
NEFGD1 NOR NE1 P9 L34 & P10 L9 & 10	"*... some of our units don't have any mentorship ... there is no support ... in our clinical units we don't have ... it is expected from us as educators ... unfortunately we can't keep up hundred per cent because you see so many at a time...*"

From the data reflected in Table 6.12 nursing students apparently lacked role model guiding in the clinical environment; they had little mentoring and guidance on how to go about executing tasks in a clinically correct way. Ineffective clinical mentorship undoubtedly added considerably to the workload burden of nurse educators. Support from the private hospitals of this private healthcare group was one of the factors related to the

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operations in the private hospitals of the private healthcare group that were experienced negatively by nurse educators. Sample quotes to this effect are recorded in Table 6.13.

Table 6.13: Sample quotes of nurse educators pertaining to operational support

Participant	Verbatim quotes
NEFGD1 TSH NE2 P10 L25 & 30-34 & P11 L1-6	"… *train the bridging students in their final year as mentors … we're putting in the effort to train these people to be competent mentors … but at hospital level there is no support to these mentors…*"
NEFGD2 CAP NE1 P2 L2 & 3	"… *my student ratio is a little bit higher … at the moment I'm coping with that because I have very good help from the hospital…*"
NEFGD1 TSH NE2 P11 L19-22	"*In the clinical setting with your theory … you find that you hit a rock … there is a disconnect* [no link] *between the theory part at the learning centre and the clinical part.*"
NEFGD2 TSH NE3 P11 L24 & 25	"… *learning and development facilitators and management of the hospitals … can be very critical instead of supportive to the students.*"
NE3 CEN P9 L1-3 & L25-28	"… *the fact that the clinical setting doesn't support the theory … the learning centre setting' sister would say to the student, 'now remember you are not doing your assessment today, you can't take as long as you do with the assessment in real life'*"

Only one verbatim quote seemed to reflect a positive experience with regard to support from the hospital environment. The clinical environment-related factors (discussed in section 6.2.2.2) signified that the clinical environment appears to have a major impact on the input side of a nurse educator's workload. Thus, approaching it from systems theory perspective, the interaction between nurse educators and their institutional/hospital/clinical training environment creates tensions that have the potential to negatively or positively change the stability of the system (Cordon, 2013:14). It is therefore important to manage the workload input side of nurse educators well for the benefit of both the educators' productivity and job satisfaction.

6.2.2.3   *Student-related factors*

The narrative data reflecting the views of some interview participants regarding nursing students who are treated as part of the workforce are summarised in Table 6.14.

Table 6.14: Sample views of nurse educators regarding student-related factors

Student related factor	Participants' verbatim quotes
Student as part of workforce	"… *you have scheduled two hours of clinical guidance for him and then you realise two hours are not enough ... you cannot hold him longer than you planned because he is part of the workforce ... so he must go back to his unit ...*" (NEFGD1 CAP NE4 P7 L24-28) (translated from Afrikaans)
	"… *so even though according to the books … it would appear that the formal students are over and above the workforce; because of the shortages they are often drawn in as part of the workforce.*" (NEFGD1 CAP NE3 P5 L27-30)
	"…*when they are at work they are seen as workforce and then one does not reach the goals or to provide effective guidance.*" (NE1 CEN P7 L11) (translated from Afrikaans)
	"*They are being used as workforce … some of them don't even get orientated on time…*" (NE2 NEL P20 L3-6)
	"... *students are part of workforce ... even on a pracitical day even though we ask the hospitals, they are still not allocated as a student ... they have to look after a patient, while you are trying to teach them...*" (NEFGD1 NOR NE1 P7 L17-22)
	"... *in the clinical setting you don't get support ... you find the students are not supernumeri, they are actually part of the workforce...*" (NEFGD2 TSH NE2 P12 L34 & P13 L1)
	"*The student can't scrub with me … the student is workforce … I must circulate and he must scrub and I must teach him from the side-line.*" (NEFGD1 NOR NE3 P6 L23-26)
	"… *if the patient needs urgent attention … you assist the student trying to stabilise the patient as soon as possible … but if you've set out an hour for the student and forty minutes have passed only twenty minutes is left for the student appointment.*" (NE2 CAP P17 L1-6)
Expectations of students	"… *expect the educator to go the extra mile for them … which also add to workload.*" (NEFGD1 CAP NE1 P1 L13)
	"*… to have extra additional support … but there is just not time.*" (NE2 CEN P6 L1-4)

	"… *a student who cancels an appointment has a knock-on effect ... once again you have programme changes to accommodate that student.*" (NEFGD2 CAP NE2 P27 L17-24)
Undoing of clinical shortcuts	"*In the clinical field really it is stressful, lately … you want to insist and confirm and instill the correct methodology and the short cuts in practice almost like overrides what you know is the right way to do things.*" (NEFGD 1TSH NE2 P10 L20-23)
	"… *that adds obviously a lot of hours to your work unintentionally … because you have to repeat assessments … you have to sometimes even re-demonstrate procedures…*" (NE3 CEN P10 L18-23)
	"*… often the student would be encouraged to do short cuts…*" (NEFGD1 CAP NE2 P30 L32-34)
Reiterating informatioin	"… *the patient presentation I do with the students is that you need to build them up. You need to guide them in steps … people do not learn at the same pace…*" (NEFGD1 TSH NE2 P7 L15-28 & P16 L30)
	"*Academic support is extra and not a thing that is planned a year ahead.*" (NEFGD2 CAP NE3 P24 L2) (translated from Afrikaans)
Extensive social problems	"*As a nursing educator, you are almost emotionally socially involved with these students … on a weekly basis two to three hours of progress counselling…*" (NE1 CEN P22 L15-18 & P24 L7 & P25 L21) (translated from Afrikaans)
	"*We've got students as well that they've got lots of social issues ... fifty per cent of my current student group...*" (NE2 NEL P11 L2-11)
	"*... then you are the social worker because you're the person they trust ... a lot of our learners have got extensive social problems ... it is realy bad ... I feel like a social worker and then an educator.*" (NE1 TSH P1 L21 & P2 L30)

The reported student-related factors as well as the diversity of the student complement seemed to complicate the nurse education context. Student diversity, for instance, relates to age, ethnicity, gender, values and previous learning experiences – all factors that place much pressure on nurse educators as it requires additional time of the educator to use innovative and applicable teaching strategies (Gappa *et al*., 2007:11; Mangold, 2007:22). Furthermore, additional time is often needed to support students with extensive social

problems. These 'external' factors are obviously interdependent and interrelated and influence nurse educator workload when taking into account the basic principles of the systems theory (cf. ch. 4 sect. 4.2.1) (Covington, 1998:11).

6.2.2.4   *Educator-related factors*

Nurse educator workload is not only influenced by student-related factors but also by educator-related factors. These include sometimes feeling neglected, weak communication channels, a lack of self-development, extensive travelling challenges and pressures to acquire specialised qualifications. Table 6.15 contains sample quotes of some of the interviewees on why they often experience feeling neglected.

Table 6.15: Sample quotes why nurse educators experience neglect

Participant	Verbatim quotes
NEFGD2 TSH NE1 P4 L13-20	*"… you feel you're pouring in and pouring some of yourself, of you family, of your own without getting back…"*
NEFGD2 CAP NE3 P15 L1-3	*"I'll never say my workload is too much, because I make it achievable or manageable ... I'll get out of my way, I'll work late, I'll work at home…"* (translated from Afrikaans)
NEFGD1 CAP NE4 P6 L8 & 9	*"… it puts a lot of stress on you because there are so many due dates ... you have to keep everyone's due dates and then your work stay behind..."* (translated from Afrikaans)
NE1 TSH P4 L25-33	*"… I am always stressed at work and at home … it keeps me awake at night because I know I have to catch up…"*
NEFGD 1CAP NE1 P10 L33-34 & P11 L7	*"… at the end of the day you blame yourself because you did not do it right or you did not plan well enough ... many times it's beyond your control ... you want to be proud of the product you have finished…"* (translated from Afrikaans)
NEFGD1 CAP NE3 P11 L9-17	*"Sleepless nights, stress on yourself and very strong guilt feelings when a student fail…"* (translated from Afrikaans)
NE2 CEN P1 L29 & 30 & P17 L18-22	*"No recognition for doing additional things … it would be nice to be specifically recognised and not only with Nurses day."*

NEFGD1 CAP NE2 P16 L21-23 & P17 L6 & 27	"*A lot of bitterness … if you want people's input then the input must be acknowledged or validated … that does not happen … you feel excluded and vulnerable.*"
NE5 CEN P10 L28 & P11 L2 & 3	"*… taken away an afternoon off per week … that was me time … I feel so strong about it that I am willing to give up a percentage of my incentive every year if I can have my afternoon back.*"
NEFGD 1TSH NE2 P13 L13-17	"*You as a nurse educator don't feel valued in the clinical setting and your input in your teaching are not necessarily supported in the clinical setting and you aren't getting the necessary respect as educator.*"
NEFGD NOR NE3 P24 L23-28	"*Instructions come from corporate office wanting to involve you … but you feel they don't really they take notes but not note because you don't see that it has an effect on you, feel it just takes more of my already limited time because they've decided what is right.*"
NEFGD2 TSH NE3 P19 L23	"*I feel in a way that I find myself becoming stagnated…*"
NE2 CEN P38 L32-33	"*I am not valued, my opinion does not count, no recognition, I feel overloaded.*"

The expectancy theory suggests motivation should be the driving force behind job satisfaction and productivity (Parijat & Bagga, 2014:1). It appeared important for nurse educators that the work and outcomes rewards relationship results in the desired behaviour in order to improve their job satisfaction and productivity and to prevent experiencing neglect (Tomey, 2009:104). Relevant literature also indicates there may be strong links between workload, motivation and productivity because motivated employees experience job satisfaction when their needs are met; hence their productivity increases (Dugguh, 2014:22; Kim *et al.*, 2011:724).

Another educator-related factor referred to was communication which is an integral part of all the functions of a nurse educator. Besides breathing, nurse educators spend most of the time in their working days on communication with management, students, colleagues and other healthcare workers. The following sample quotes indicate why communication as an educator-related factor has so much impact on nurse educator workload:

- "*New instrucions or procedures are being given through at clinical level but not to the learning centre, so your students inform you rather than you informing them of best practices ... I try to communicate with out specialist, she never even answered my email.*" (NEFGD 1NOR NE3 P25 L6-15)

- "*We first get the number of CPD students by August 1st ... I have two CPD courses and a short course started in April already. ... it complicates time management.*" (NEFGD2 CAP NE2 P5 L3-8) (translated from Afrikaans)

- "*Proper communication prior by end May, for instance*, *for course intakes … and additional CPD courses … and expectations thereof.*" (NE2 CEN P13 L19-33)

- "*From corporate office new stuff is not being communicated to us ... you come in the clinical field ... the student knows more that you about a new procedure...*" (NEFGD1 NOR NE2 P24 L30-34)

Smit *et al.*, (2011:412-415) highlight the importance of effective communication systems as one of the most powerful determinants and significant contributors toward an organisation's success. Clear communication identifies communication problems and encourages solutions to problems, spontaneity, empathy and respect in support of productive employees and team work (Rousell & Swansburg, 2009:153 & 419; Yoder-Wise, 2011:346-347). Rousell and Swansburg (2009) continue to explain that poor communication is a major source of job dissatisfaction. Employees can and will be motivated by sharing information about the organisation and its activities.

Nurse educators must be both teachers and clinical experts as suggested by Schuster *et al.* (1997:154). Therefore, the lack of self-development as an educator-related factor requires commitment from the institution to provide opportunities for the support and development of the nurse educator as a whole person (Potgieter, 2017:216). The sample quotes in Table 6.16 show how some of the interview participants perceive their lack of self-development.

Table 6.16: Sample quotes relating to a perceived lack of self-development

Participant	Verbatim quotes
NE1 CEN P11 L14 & P12 L6 & 14-16	"*… it really takes extra energy to eliminate class activities and also to know that you are still up to date with what you need to learn to the student … no time to reflect on the class of the day.*" (translated from Afrikaans)

NE1 CAP P7 L19-22	"… *the workload I had or what I would have taken if they were Pen1 students and also the responsibility for Pen 2 students.... I would not be able to continue my studies.*" (translated from Afrikaans)
NE2 CAP P9 L31-34 & P19 L1-6	"… *I run on oil that I poured in nine years ago ... one person can go to a congress once a year specifically a specialty which means you get there every second year ... I would love to do my masters* [Master's degree] *... I do not see the possibility in doing it with my current workload...*"
NE2 CEN P35 L20-22 & P36 L21-25	"… *I am allowed to do one congress in every four years regarding a specific specialisation … it is actually every two years but I am involved in more than one specialty … it is a bit frustrating not being able to have the time for self-development.*"
NE1 TSH P15 L13-15 & P14 L33-34 & P15 L1-5	"*Self-development and self-enrichment is sort of put on the backburner … you are so busy … you have to fit it in to keep abreast of the development as an educator is quite a challenge within the workload … they* [Management] *do give us an opportunity ... as educator I'm not convinced that is enough because not all of us get to the conference … then they* [nurse educators who attend the conference] *had to bring back the knowledge for the rest plus eighteen hours is not really a lot if you want to keep up to date with your profession … they've* [management] *given us twelve days for research…*"
NEFGD2 TSH NE3 P19 L28-31	"… *my workload is of such a nature that I can't really embark on a study post-grad like a masters* [Master's degree] *after hours because after hours you try to come with your current workload.*"
NE3 CEN P17 L10-13	"… *your reading to keep abreast … you actually need to do* [it] *in private time at home … there isn't time within the academic time at all*."

It is not only expected from nurse educators to keep up with clinical expertise, but also to update their existing knowledge in nursing and in their specialist field. The principles of nursing do not change, but nursing practices change as a result of improved medical therapies and advanced technology (Potgieter, 2017:219). These authors further point out that healthcare service (public and private) expect professional nurses to possess the necessary skills and knowledge from day one after completing their course as well as to be up-to-date with the current information and practice situations locally and internationally. This can only be achieved if the development of nurse educators includes

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hands-on nursing practice, conducting research and publishing articles. Clinically skilled nurse educators, according to Beres (2006:145), are not only role models to students, but they produce graduates who keep abreast with recent research to stay informed and knowledgeable and who have sufficient clinical practice experience. The high workload of nurse educators results in little time available for the critical clinical guidance of students in the clinical practice environment. To keep abreast of new innovations and change, it is imperative that nurse educators spend a fair amount of hours in clinical practice on a regular basis (Potgieter, 2017:219). It is the responsibility of management to support the nurse educator in making time available for the development of clinical experience and participation in continuing education because both the institution and the nurse educator benefit from it. As rightly stated by Levett-Jones (2005:231), institutions must have a strategic plan for continuing education due to its positive impact on the quality of work performance.

What further appeared to be educator-related factors associated with the workload of nurse educators involved in the study was the extensive travelling and concerns about safety issues when travelling – specifically early in the morning and after hours. Nurse educators travel between nursing education sites and the clinical facilities where the students are placed for their clinical practice. The nurse educators at one of the seven nursing education sites are in the fortunate position to travel not more than 50 metres one-way whereas nurse educators of other nursing education sites have to travel a much longer distance to the clinical facilities in their region. To get a better picture of the distances, Table 6.17 reveals the travelling distances from each nursing education site to the different private hospitals of the private healthcare group in their region where the nursing students who need clinical accompaniment on a regular basis are located.

Table 6.17: Travelling distances between nursing education sites and affiliated private hospitals

From nursing education site	To clinical facility	Travelling distance (one-way)
Cape Town	Cape Gate	10 km
	Cape Town	27 km
	Constantiaberg	32 km
	Durbanville	9 km
	George	416 km
	Hermanus	115 km
	Louis Leipoldt	5 km
	Milnerton	17 km
	Paarl	49 km
	Panorama	7 km
	Stellenbosch	33 km
	Swakopmund	1840 km
	Vergelegen	40 km
	Worcester	89 km
	Windhoek	1 479 km
Bloemfontein	Bloemfontein	50 m
	Hoogland	251 km
	Howick	536 km
	Newcastle	500 km
	Pietermaritzburg	565 km
	Victoria	760 km
	Welkom	250 km
Polokwane	Limpopo	600 m
	Tzaneen	100 km
Nelspruit	Nelspruit	50 m
Kimberley	Gariep	5 km
	Kimberley	45 m

From nursing education site (continue)	To clinical facility	Travelling distance (one-way)
Sandton	Emfuleni	91 km
	Highveldt	156 km
	Morningside	8 km
	Potchefstroom	141 km
	Sandton	50 m
	Vereeniging	96 km
	Wits Donald Gordon Medical Centre	15 km
Pretoria	Brits	56 km
	Kloof	12 km
	Legae	40 km
	Medforum	2 km
	Muelmed	2 km
	Midstream	25 km
	Pretoria Heart	1 km
	Thabazimbi	198 km

These distances reflect those that educators referred to in their comments (see Table 6.18). Nurse educators who teach in specialist areas have to travel nationally to do clinical accompaniment and teach in contact sessions of postgraduate nursing students doing a four months' CPD or six months' short course. Nurse educators of the nursing education site the Cape region also have to travel to Windhoek and Swakopmund in Namibia to present life support courses.

Table 6.18: Sample quotes of nurse educators' experiences regarding extensive travelling

Participant	Verbatim quotes
NE1 CAP P3 L1-3	"*My one hospital is Paarl ... my trip is at least an hour there and an hour back, which means that I can see up to three students a day.*" (translated from Afrikaans)
NEFGD1 CAP NE4 P8 L1-3	"*I spend about four hours on travelling to and from one of my hospitals which significantly reduces the time to spend with students.*" (translated from Afrikaans)
NEFGD2 CAP NE2 P5 L17	"*Travel time is dead time and it means that your workload in the end is so much more.*" (translated from Afrikaans)
NEFGD2 CAP NE3 P11 L1-6	"*… I start at eight o'clock in Worcester ... three students are seen for two hours each before my return to the learning centre … arriving at the learning centre after four o'clock…*" (translated from Afrikaans)
NE2 CAP P5 L33 & 34	"*I travel for all the post-basic courses to Windhoek, Swakopmund, Upington and George.*"
NE2 CEN P11 L7; P30 L6 & 12-15	"*I travel a lot… Victoria 760 km, Newcastle 500 km, Bethlehem 250 km … sometimes I travel after hours…*"
NE4 CEN P12 L19-22 & 31	"*... the spreading of my student ... Victoria 800 km which is at least eight hours travelling time ... it deprives my students contact ... and impacts my workload."*
NEFGD1 NOR NE2 P4 L10 & P5 L9 & P6 L5	"*I travel a lot as far as Nelspruit … it takes you four to five hours drive one-way … since my colleague left I travel even more.*"
NEFGD1 NOR NE1 P6 L9	"*I also travel to Vereeniging, Potchefstroom and Secunda to see students…*"
NEFGD1 TSH NEM1 P16 L27	"*I travel from the nursing education site Tshwane region to Tzaneen … three to four hours' drive one-way.*"
NEFGD2 TSH NE2 P3 L31	"*I leave home at six o'clock to travel to Tzaneen from the nursing education site at Pretoria.*"
NEFGD2 TSH NE1 P1L14 & 15	"*… then there's travelling that takes out a long time of your day that you spend on the road.*"

NE4 CEN P10 L16-21	"… *our workload is affected by the distances we travel to see students ... many unproductive hours are spent on the road ... we are in the region for a week at a time ... two days are used for travelling and three productive days for student guidance ... therefore the quality time spent with the student is actually very little.*" (translated from Afrikaans)
NE2 CAP P8 L33 & P9 L5-7	"*My travelling is for Basic Life Support and Advanced Cardiac Life Support for the whole organisation ... I am standing in as national coordinator.*"

Participants described travelling time as 'unproductive' or 'dead' time because of the long distances that they had to travel (see Table 6.17). Travelling is part of the clinical practice component within the nurse educator workload system which does not function in isolation because of its interrelationship with the other components of the system. It is thus important to take into account such 'unproductive'/'dead' time because it is disadvantageous to the whole system as indicated by the quotes from the nurse educator interviews (also see Cordon, 2013:21; Huber, 2013:43; Van der Walt, 2016:690).

The final educator-related factor that emerged from the narrative data were the scarcity of graduate level nurse educators with specialised qualifications, especially in the outlying areas due to the new requirements of the SANC (2013a:20). These requirements prescribe a nurse educator must be a registered nurse and midwife with a bachelor's degree and be in possession of an academic qualification at least at a level higher than the level of the programme offered. Further, an additional qualification in nursing education and at least five years' clinical experience in the specialist field in which the nursing educator teaches are required. Such requirements relate to the external nurse educator environment (also see Figure 4.5) and, according to the systems theory, the input from the external environment contributes largely to the workload. In the case of nurse educators, it is often the case that when a nurse educator resigns, the current nurse educators have to cope with their own workload as well as with the additional workload of the person who resigned until a suitable candidate has been appointed. This obviously jeopardises the productivity of the nurse educators – the double workload becomes a catalyst increasing the workload excessively leading to enormous pressure on the already work-overloaded nurse educator (also see Shah *et al.*, 2011:257). It is not only the productivity of the nurse

educator that is at risk, but also their job satisfaction because the adding-on of the additional tasks of the person who resigned to the already overwhelming workload causes a reduction in job satisfaction   (also see Altaf & Awan, 2011:93; Hammen, 2006:466; Mustapha & Ghee, 2013:15).

Nurse educators who participated in interviews often referred to the term 'overwhelmed'. This term refers to them having to lecture on theory, run various courses, travel extensively, having to deal with large numbers of diverse students who need clinical mentoring and support due to the lack of mentors in the clinical space and students being seen as part of the workforce. Each of these work expectations and requirements has its own unique effects on the nurse educator workload. In Figure 6.3 a summary is provided on the factors that emerged from the interviews as having a direct impact on the nurse educator workload.

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                    ┌─────────────────────┐
                    │ Factors apparently  │
                    │ impacting workload  │
                    └─────────────────────┘
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Institutional-related factors	Hospital environment - related	Student-related factors	Educator-related factors
1. Peaks 2. Responsibilities of nurse educators 3. Teaching activities 4. Excessive administrative tasks 5. Preparation for new nursing programmes 6. Nurturing of newly appointed nurse educators 7. Due dates 8. Open-plan offices 9. Change in work programme 10. Vehicle constraints	1. Obstructed clinical development 2. Clinical mentorship 3. Lack of operational support	1. Student as part of workforce 2. Expectations 3. Undoing of clinical shortcuts 4. Reiterating information 5. Extensive social problems	1. Experience neglect 2. Communication 3. Lack of self-development 4. Extensive travelling 5. Specialisation qualifications

Figure 6.2: Factors impacting the workload of a nurse educator

The summary in Figure 6.2 is an actual reflection of the major real life factors apparently impacting the current workload of a nurse educator. These factors highlight the reasons why the expected outcomes, e.g., a mentor-per-shift are not always achieved. In order to succeed in the tackling of the workload issue of nurse educators, all institutional-related, hospital environment-related, student-related and educator-related factors urgently need to be addressed (Pow & Wong, 2017:74). These factors affect each other at various levels. For example, clinical practice in the hospital is a complex entity that influences students' learning outcomes in the clinical practice environment. As indicated by Lekalakala-

Mokgele and Caka (2015:1), the clinical practice environment can be experienced by students as obstructive to their learning. Students who are part of the workforce may experience stress, fear and anxiety because their clinical accompaniment with the nurse educator may be cancelled on short notice due to change in the daily schedules at nursing unit level. This affects the nurse educator's already limited time because she/he has to reschedule her/his student. Sometimes it has cost implications if the nurse educator travelled far to the clinical facility and only upon arrival discovers the student had been rescheduled and the clinical appointment cancelled.

Furthermore, the hospital environment can fruitfully enhance student learning and assist with lessening nurse educators' workload by making students' experience in the learning environment positive. This is possible only and especially when management provides support to students in the form of being prepared for students' clinical accompaniment and making provision for his/her clinical accompaniment in the student's work schedule for the day. Another problem permeating the relationship between the factors affecting the workload of the nurse educator and hospital environment is when clinical staff on hospital level is unaware of the major impact of clinical shortcuts on student learning. This factor sometimes leads to the re-demonstration of clinical procedures which requires additional time from the nurse educator's already full schedule (Lekalakala-Mokgele & Caka, 2015:1).

6.2.3. Category 3: Management support required to review current workload

The interview question, "what do you think may be helpful to better manage your current workload?" was asked during the individual and focus group interviews. Twelve subcategories emerged from the analysis of the narrative data. These subcategories were: assistance with selected administrative tasks; one intake per programme per year; review of meeting structures; in-house learning centre communication; accessibility of electronic student files; distribution of workload; role of clinical facilitators; management of CPD and short courses; human resource support; availability of a lecture and test bank and vacant nurse educator positions.

Assistance with selected administrative tasks was at the top of the list of the interview data (see Table 6.19 for sample quotes).

Table 6.19: Sample quotes regarding assistance with selected administrative tasks

Participant	Verbatim quotes
NE1 CAP P12 L7, 23-32 & P13 L23	"… *we spend a lot of time in administration especially scanning student reports ... you do not have to be an educator to do it ... loading of student marks in more than one place ... administrative help for the things that matter*…" (translated from Afrikaans)
NEFGD1CAP NE1 P12 L12-24	"… *if there is someone who can do the admin, for example, loading of class attendance, scan tasks, monthly reports ... help with tasks I do not have to do.*" (translated from Afrikaans)
NEFGD1 CAP NE4 P 12 L30-34 & P13 L16	"… *there are also a lot of students hours to load ... if you can give it to someone to do ... administrative tasks rob us of our time … then do not even come loading tests marks.*" (translated from Afrikaans)
NEFGD2 CAP NE2 P21 L11-14	"… *something that takes a lot of time is admin ... I understand I have to do the three-monthly reports, but now it has to be scanned and loaded on every individual student's file.*" (translated from Afrikaans)
NEFGD 2CAP NE1 P21 L15	"… *admin takes a lot of time … you need to save documents in your file before you can load it onto the student's file* ..." (translated from Afrikaans)
NEFGD2 CAP NE3 P21 L17 & P22 L11	"… *admin takes time ... I can set papers but the formatting takes a lot of time ... it sometimes take me forever to get two lines across each other … it must be an administrative person who is computer literate.*" (translated from Afrikaans)
NE1 TSH P7 L33-34 & P8 L1-3	"*I think the core function of the educator is the theory and the practice and the support of the learner in theory and in practice … I feel my role is the teaching and the research … I hate admin … you don't need a twelve year experienced educator to sit and type in clinical hours for three days.*"
NEFGD2 TSH NE2 P18 L22-24	"*A lot of our administrative tasks can be done by a proper administrative person and that in itself will actually relieve a lot of our time spent on updating student records regarding things that can be done by an administrative person.*"

From the sample quotes it was clear doing administrative tasks brought on a lot of frustration. The nurse educators understood it was essential, but they perceived it as an administrative task which could be allocated to an administrative employee which would

lessen this burden and give them more time to concentrate on what they were actually appointed to do – teaching and preparing student nurses to be competent, skilled and knowledgeable when they entered the outside world. There was a clear need for the appointment of an administrative person capable to perform specific duties, e.g., accurate data capturing of results that requires no reviewing and correction by the nurse educator.

The second subcategory that emerged from the interview data pertained to the one intake per year per programme. A prominent quote illustrated the effect it had on the workload of nurse educators: "… *so the ideal situation for me if I have to create a wish list would be to say* [I] *can go on with the status quo now … give class, accompany the students in practice, be the emotional support for the students or the first stop in emotional support, but then each educator must have one group of students per year.*" (NE1 TSH P12 L2-5)

Table 6.3 shows the different programmes and courses that have two intakes per year. This was not the ideal situation, as the nurse educators were the same people who had to manage the students of both intakes. Although the student numbers per intake were small, it did not change the amount of work involved per student intake. In fact, generally the teaching, clinical practice, research and administrative activities involved in the preparation for each group invariably take the same amount of time. In this case, where the nurse educator resources were already stretched, another factor which was a challenge for the nurse educator was the culturally diverse student populations (Paewai *et al.*, 2007:385). This means more dedicated effort and higher levels of motivation from the nurse educator to remain effective and productive within a competitive environment as confirmed by Mngomezulu and Geyer (2017:21-25).

Review of meeting structures was the third emerging subcategory from the interview data. Some participants shared their views about the structure of meetings at the nursing education sites as follows:

- "... *we spend a lot of time at meetings ... every Friday at two o'clock we have a meeting ... the fact that I have to have a meeting at two o'clock every Friday day here at the learning centre break my day.*" (NE1 CAP P12 L8-22) (translated from Afrikaans)

- "*You've got to do the work and you've got to meet the deadlines but also must attend the meeting at awkward times, which could be awkward to you today because your deadline is*

four o'clock this afternoon but also the meeting is on today at two o'clock...” (NE 2 CAP P7 L24-27)

- “*Meetings is a big problem in the sense of sometimes you will hear something and then suddenly there will be a meeting and then for six months there are no meetings at all*...” (NE1 Nel P15 L7-11)

Meetings are a medium of communication, but if needed the structure and objectives thereof have to be reviewed as many meetings end up in problem-solving sessions and not serving the core objective. Electronic media such as emails should be used more effectively. Yoder-Wise (2011:549) confirms poorly managed, unfocused meetings are a time waste of valuable time and a frustration to personnel.

In-house learning centre communication was identified as the fourth subcategory from the narrative data. The general opinions of the participants are reflected in the sample quotes in Table 6.20.

Table 6.20: Sample quotes pertaining to communication at the nursing education site level

Participant	Verbatim quotes
NE1 NEL P15 L21-34	“… *you get an agenda, minutes of the meeting on the table, read and sign. If there is a problem you can come and discuss it*…”
NE1 CEN P15 L25-28	“… *you have to be familiar with what is expected of you ... a year back when I came here, I found this surprise box ... which made it more stressful* ...” (translated from Afrikaans)
NE2 CEN P14 L14-16 & P15 L25-28	“… *it would help if line management is aware of everybody's workload and what it actually entails … the whole plate*…”
NEFGD1 CAP NE2 P18 L29-32	“*A lot of time and emails to make a decision and two months later you receive an email to say we go back to the previous way of doing things.*”

NE2 CAP P9 L20-23	"… *affecting my workload is there would seems a lack of understanding of all the work that goes into being a proper nurse educator or effective nurse educator.*"
NEFGD1 TSH NE2 P8 L20-31	"… *there would seem to be management being unaware of the time involved to actually stand next to the student to get the student competent.*"

Communication, whether written or electronic, forms an important component of daily activities in the workplace. It must be done for the right reasons, because it is the first impression of communication that usually lasts. With this in mind, communication must be facilitated in such a way that a positive outcome is achieved (Yoder-Wise, 2011:346-348).

The accessibility of electronic student files was the fifth subcategory from the narrative data. Sample quotes are illustrated in Table 6.21.

Table 6.21: Sample quotes on the accessibility of electronic files

Participant	Verbatim quotes
NE1 CAP P13 L15-17	"*It's a technological thing … if someone has left a student file to have it automatically give others access after a certain time ... and marks of students must be loaded in one place and then have to pull through to all students files…*" (translated from Afrikaans)
NEFGD1 TSH NE3 P5 L19-33	"… *when the whole group of students is booked out by the course coordinator … it is a great frustration in your workload to load student results.*"
NEFGD 1TSH NE2 P20 L7	"… *more user-friendly intranet specifically the time component…*"
NE4 CEN P11 L7-16	"*I am national coordinator of the post basic courses ... I do not have access to my laptop when I'm in the region ... it will help me to have access to the system when I drive in the region ... then I do not have to do catch up when I am back…*" (translated from Afrikaans)

The automation check-in of electronic student files after the scheduled period of time can prevent the types of frustration mentioned in Table 6.21. The advantage of electronic systems is to store, organise and retrieve digital data in a quick and accurate manner.

These systems must be effective and user-friendly in order to decrease the workload of an employee (Yoder-Wise, 2011:197 & 200). Currently, nurse educators spend a lot of time on trying to access electronic student files. Changes in the current practice can be made to assist in the improvement of time management.

The sixth subcategory from the narrative data, namely the distribution of workload, was highlighted by the following three quotes:

- "*The work distribution seems unfair … so I think the management can be better … I think some people are favourable [favoured]… you feel more and more work come on to you*." (NE2 CEN P16 L6-11)
- "*There is an uneven spread of workload and now with the new courses it seems as if people don't hear what I try to communicate ... those that are already busy will be given more*." (NE1 NEL P5 L35 & P6 L1-5)
- "*There should be some sort of formula that can see how many days you offer class, how many students you accompany, how many CPD or BLS courses you offer so that there is a more even distribution of work*." (NE1 CAP P16 L19-22).

This is one of the many indications for the need for a realistic work model for the nursing educators of this private higher education institution. Nurse educators have a growing dissatisfaction with the unfair division of workload (Vardi, 2009:505). Contributing factors that influence the role of the nursing educator such as budget constraints and the increasing expectations of legislators, also contribute to an increase in workload (cf. ch. 2 sect. 2.2 & sect. 2.3; also see Wilborn *et al.*, 2013:9).

Structured revision of study material was identified from the narrative data as the seventh subcategory related to management support required to review the current workload. Table 6.22 illustrates some of the sample quotes of participants on their experience of the revision of study material.

Table 6.22: Sample quotes related to how the revision of study material is experienced

Participant	Verbatim quotes
NEFGD1 CAP NE2 P16 L25-31	"*The previous year we revised all our study guides … we understood a lot of what was going on … I think we would do this on a yearly basis.*"
NEFGD1 CAP NE2 P19 L9-11	"*Continual change of the student outcomes … you find really unsetting and time consuming.*"
NEFGD1 CAP NE1 P19 L11-15	"*Every year the text books change … so your lesson plans change and the things you have on your mind on how you teach needs to change all the time … these small things got a huge impact at the end of the day…*"

In the nursing higher education environment there are many reasons why the content of study material should be adjusted. One example would be that it has to be aligned with legislation. The study material of the private higher education institution where this study took place is revised every three years according to the policy or more often as needed, e.g., if changes in textbooks or technology necessitates it. These annual changes in study content have a spin-off effect that unsettles the nurse educators because they have to schedule additional time in their already overloaded schedules to adjust the study material beyond the standard timeframes so that it is available on time for ordering by the new intakes of students. When study material is revised, it has a ripple effect because changes need to be done, e.g., to lesson plans, PowerPoint presentations and so forth to accommodate the new adjustments. From the point of view of the expectancy theory, the relationship between the work effort, performance and outcome of performance will determine the employee's motivation which, together with management support, will lead to more efficiency, improvement of productivity and job satisfaction of the employee (Quinn, Faerman, Thompson & McGarth, 2002:261).

The role and availability of clinical facilitators was subcategory number eight. It emerged from the interview participants who expressed their views on this issue as summarised in Table 6.23.

Table 6.23: Sample quotes regarding the role and availability of clinical facilitators

Participant	Verbatim quotes
NE3 CEN P6 L17-20 & P7 L1	"*If we had more clinical facilitators involved in the lecturing and not just working in the hospital, the learning centre will be in a position accompanying their own students in the clinical setting … that would be much more helpful.*"
NE2 NEL P7 L21-23	"*If you had a clinical preceptor … someone that you know from the school that is in the hospital who is busy with the students…*"
NEFGD1 NOR NE2 P20 L3-11	"*… have people who do mostly the clinical follow-up … obviously come in for meetings and give limited lectures … that would imply employing more people … a clinical expert fully qualified.*"
NEFGD1 TSH NEM1 P16 L10 & 11	"*I would like somebody to help me with the CPD students to see them more in the clinical field.*"
NEFGD2 CAP NE3 P28 L13	"*An additional assessor for the times you are in class.*" (translated from Afrikaans)
NEFGD2 CAP NE1 P28 L18	"*… clinical facilitators in hospitals who specifically focus on the students…*" (translated from Afrikaans)
NE1 NEL P12 L12-14	"*… permanent practical facilitator for us in the wards so that we got someone permanent on the floor for the practical side and that will ease the job much, much more.*"
NEFGD1 NOR NE2 P28 L8	"*… a clinical facilitator to help us around clinical…*"
NEFGD1 TSH NE2 P20 L12 & 19	"*… there need to be clinical facilitators per year group that is managed from the school and that you and the clinical facilitator work together … so that there can be a better chance of a student getting clinical accompaniment.*"

Three additional participants in the focus group interviews indicated they agreed with their colleague who commented on the need for a "clinical facilitator per year group that is managed from the school" so that the nurse educator and clinical facilitator can work together to promote students' clinical accompaniment. (see Table 6.22). Also, 10 interviewees highlighted more than once the need for clinical facilitators to work with nurse educators and being managed by the learning centre manager of a nursing education site. The new nursing education and training standards (SANC, 2013a:39) stipulate that a

nurse educator should guide the student in both class and practice, but the request of the nursing educators for clinical assistance does not take away their responsibility to comply with the set standards. From the systems theory perspective, the workload (cf. ch. 2 sect. 2.2.1 & sect. 2.2.2) of the nursing educator as a system is influenced by legislation from the external environment (see Figure 4.5) which affects the output of the nursing educator directly or indirectly (Sullivan & Decker, 2009:14).

Subcategory nine related to the need for CPD and short courses and were addressed in the interviews as follows:

- "*I think the CPD courses for sure can go out of our hands … so we will be more involved in the formative support of the students … the CPD and informal in-house courses takes so much time of us setting tests, marking tests, facilitating session … it is just basic knowledge that can be taught on hospital level.*" (NE2 CEN P27 L4-10)
- "*The CPD courses must be offered by the hospitals and completely managed by them so that we can focus on the correct formal education for which the people receive a qualification.*" (NE4 CEN P7 L9 &12) (translated from Afrikaans)
- "*I think, for instance, let's look at the short courses ... why not do the contact session for all ... distribute the ten contact session between nurse educators to facilitate for all ... each nurse educator will still see their own students in the region for clinical accompaniment and assessment as we are doing.*" (NE 2CEN P29 L10-18).

These opinions carry weight and can be taken into account when reviewing the workload of the nurse educator. When management focuses on the needs of the employee and shows concern in their well-being, it provides a caring environment in the workplace. Nurse educators are highly experienced employees therefore the supportive behaviour of management will be very effective in this situation (Sullivan & Decker, 2009:52).

Human resources support from the narrative data were the tenth subcategory indicated as being in need of management support. Sample quotes illustrated in Table 6.24 some of the points suggested by interviewees about this issue.

Table 6.24: Sample quotes related to human resource support

Participant	Verbatim quotes
NE3 CEN P14 L21-33	"*At the moment we have quite a lot of issues with human resources … perhaps if the learning centres had a dedicated HR person which at the moment we don't have…*"
NEFGD1 NOR NE1 P19 L31-34	"*A way to cope with it is to actually allow you to work from home … it goes about I have still achieved and completed my work … output driven.*"
NEFGD1 CAP NE2 P14 L30-33	"*Acknowledgement of what you do with your time ... travel time that does not become acknowledge ... so at the end of the day you do something and it's part of your workload but you do not get the acknowledgment for it.*" (translated from Afrikaans)
NEFGD1 CAP NE4 P15 L4-7	"*I have a place to sleep therefore I stay over to spend more time with the students otherwise I have to travel two days in a row which take eight hours out of my time ... which is not necessarily counted or accommodated in Kronos.*" (translated from Afrikaans)
NEFGD1 NOR NE3 P12 L34	"*There is so many days that you work more hours and I think that is part of my frustration, is that when you work extra, we don't get overtime…it is not added.*"

Supportive human resources in such a challenging environment as private higher education in nursing is of utmost importance as they contribute to the effective satisfaction of the needs of the nurse educator so that she/he can experience the best possible job satisfaction. The motivation of the nurse educator is the power from which energy, thinking and other work flow which greatly influences the workload of the nurse educator as is the case with intrinsic job satisfaction (Swanepoel et al., 2016:14-18).

A number of interviewees referred to proposals to address the eleventh identified subcategory, namely the availability of a central lecture and test bank as confirmed in the following sample quotes:

- "*I think we can collaborate between us it may help, especially new people coming in who don't have lessons … like a bank to share PowerPoints and things countrywide … if we could share knowledge and information … sometimes we are on little islands and*

everyone is struggling, everyone is sinking but we don't have confidence in asking…"
(NEFGD1 CAP NE3 P21 L23-29)

- "*The availability of generic standard lectures*" (NEFGD1 CAP NE4 P22 L31)
  (translated from Afrikaans)

- "*Nurse educator guidelines with each study guide*" (NEFGD1 CAP NE2 P23 L19)

- "*If we could share lectures ... that would help as well ... if we had a lecture bank where you
  could go and draw from*" (NE3 CEN P23 L1 & 2).

The participants felt a properly structured PowerPoint bank and test bank would directly benefit the workload of a nurse educator in that it will reduce time in compiling a PowerPoint presentation or the setting of tests. The believed it would provide a mechanism to ensure the quality and standard of each PowerPoint presentation and questions. It will not only enhance quality but also productivity because as Quinn *et al.* (2002: 147) put it, the important thing is to design processes around the limitations.

The twelfth and last subcategory which emerged from the narrative data were the issue of how vacant nurse educator positions need to be handled. This was highlighted in particular by the following quote: "*I am currently the only one in the whole country with an emergency qualification … so that also adds to your workload.*" (NEFGD1 NOR NE4 P23 L8).

In summary, it can be posited that a number of management support issues emerged from the narrative interview data. What participants in this category indicated may assist them with their heavy workloads included: competent administrative support, a more user-friendly database for loading student marks and doing the administrative tasks, a clinical facilitator working alongside the nurse educator, a central test and basic lectures bank and the national filling of all nurse educator vacancies. All of these subcategories seemed to be directly or indirectly related to the teaching, clinical practice and administrative workload of nurse educators. As illustrated by the conceptual frame for this study (see Figure 4.5) and from a systems theory perspective, the issues highlighted in this category may be utilised to alleviate the problems related to nurse educator workload and their productivity as well as job satisfaction within the context of a private higher education institution (also see Covington, 1998:14-15).

6.2.4. Category 4: Tasks suggested to be delegated

The question, "in your opinion, what tasks currently performed by nurse educators could be delegated to other categories of staff?" was asked during both the individual and the focus group interviews. Two subcategories, namely 'administrative assistance' and 'selected assessments' emerged from the analysis of the interview data. Table 6.25 shows sample quotes indicating possible tasks from narrative data that may be delegated to provide administrative assistance.

Table 6.25 Sample quotes indicating tasks that can be delegated to provide administrative assistance

Participant	Verbatim quotes
NE1 CAP P12 L23-27	"…*documents that I have to scan and save on student records…*" (translated from Afrikaans)
NE2 CAP P6 L17-21	"*Every three months we've got three monthly reports … that need to be scanned in on the students' files … I feel something that an admin person can do for me.*"
NEFGD2 CAP NE2 P22 L6 & P28 L12	"*… a person who can help with the scanning of admin documents.*" (translated from Afrikaans)
NE1 CEN P27 L33-35	"*… those administrative tasks ... the capturing of marks…*"
NE5 CEN P8 L11	"*The only thing that we can really delegate is the admin work.*"
NE2 NEL P10 L8 &11	"*Admin … like completions can be done by the admin person.*"
NEFGD1 NOR NE3 P28 18	"*… loading test marks, capturing working hours, does students' leave…*"
NEFGD1 NOR NE1 P28 L24 & L26	"*… administrative tasks and ACLS administration … follow-up on cards…*"
NE1 TSH P13 L13-15	"*The time-consuming tasks in following up leave, quotes, whatever you still say that a very well developed and equipped competent admin person would be of ideal support.*"
NEFGD1 TSH NEM1 P6 L29	"*… capture our data and our hours…*"

At least 10 interviewees indicated that some general administrative tasks of nurse educators may be delegated to other staff. The delegation of general administrative tasks

is considered as a wise allocation of organisational resources. The distribution of administrative work will benefit the nurse educator by releasing him/her from some of the workload giving him/her more time to devote to those tasks that cannot be delegated such as the clinical accompaniment of students (Quinn *et al.,* 2002:241; Sullivan & Decker, 2009:146). Nurse educators' job satisfaction will be increased and goals will be achieved more efficiently (Sullivan, s.a.:132). Subsequently, productivity will increase. Delegation will not only be a critical component of self-management for the nurse educator but will also serve as a way to reduce stress as well as a time management strategy (Yoder-Wise, 2011:551).

Table 6.26 contains sample quotes of interviewees who indicated that selected assessments which are part of their clinical practice workload component may be delegated.

Table 6.26: Sample quotes related to assessments that may be delegated

Participant	Verbatim quotes
NE2 CAP P8 L26-29	"… *some of the procedures that we need to do with students who are on post-basic courses could be delegated to assessors or mentors in practice*…"
NEFGD2 CAP NE1 P28 L6	"… *clinical guidance and accompaniment by clinical facilitator*…" (translated from Afrikaans)
NE3 CEN P11 L20-21	"*Definitely a part of the practice, the clinical skills could be done by a facilitator.*"

Nurse educators need to work effectively; therefore, the delegation of non-critical assessments to skilled trained assessors can significantly lighten the workload of nurse educators. Although some nurse educators are often not comfortable with delegating assessments to other assessors, for example if there is a big difference in the results of the students evaluated by the nurse educator and those evaluated by an assessor, it will be to their own advantage. Assessments can be delegated to skilled trained assessors who meet the set criteria of the private higher education institution (Private healthcare provider, 2017:7-8). From a the systems theory perspective, the data generated from the individual and focus group interviews with nurse educators will lead to an improvement in the productivity of the nurse educators in terms of their administrative and clinical practice

workload components (also see Covington, 1998:14-15). Based on the expectancy theory, the nurse educators clearly expressed work-related expectations, goals and needs within private higher health education. On the other hand, the private higher education institution also has certain expectations of its nurse educators such as an excellent pass rates in order to reach shared goals (Nel *et al.*, 2011:14).

In summary, from the verbatim quotes shown in Table 6.25 and Table 6.26 it is obvious that the delegation of general administrative tasks and selected assessments would not only be a wise use of human resources but will also improve nurse educator performance (Mullins & Christy, 2010:185). It may significantly reduce the workload of nurse educators affording them the opportunity to make profitable use of time to concentrate on the clinical accompaniment of students in the clinical environment (Quinn *et al.*, 2002:241; Sullivan & Decker, 2009:146). Nurse educators will also experience an increase in job satisfaction and goals will be achieved more efficiently (Sullivan, s.a.:132). Subsequently, productivity will increase and delegation will not only be a critical component of self-management for the nurse educators but will also serve as a way to reduce stress. Delegation is an ideal time management strategy (Yoder-Wise, 2011:551).

6.2.5. Category 5: Level of educator job satisfaction

The interviewees were requested think about and give their honest perceptions with regard to the following question, 'tell me how you currently experience your job satisfaction?'

As illustrated in Tables 6.27 and Table 6.28, there were different feelings among nurse educators concerning their job satisfaction. The sample quotes in Table 6.27 are representative of why some nurse educators perceived their job as satisfactory.

Table 6.27: Sample quotes of job satisfaction as a positive experience

Participant	Verbatim quotes
NE1 CAP P17 L21-25	"*That's where I want to be and I'm not looking for other work. This is the job I had in mind and when I decided to do education and to study further ... I see myself blessed to do a job I enjoy.*" (translated from Afrikaans)

NE2 CAP P1 L13	"*I enjoy my job. It is what I want to do. There are many positive things…*"
NEFGD2 CAP NE2 P30 L18 & 20	"*I'm satisfied if I can stick to deadlines ... then I feel that I've achieved what is expected of me.*" (translated from Afrikaans)
NEFGD2 CAP NE3 P31 L35	"*I enjoy what I am doing so everything I do is to me what I've achieved, but if you're so busy it's just as if you're just struggle more to make a success.*" (translated from Afrikaans)
NE1 CEN P31 L32-35 & P32 L22	"*I like what I do, I enjoy the students and the clinical part a lot.*" (translated from Afrikaans)
NE2 CEN P12 L22 & 29-32	"*What I do like about my job is I can plan my own courses … when you accomplish the planning as was planned initially then it is very satisfying for me to know I did the planning, we have reached the outcome the students grow and I feel satisfied to see that.*"
NE3 CEN P17 L21 & 32	"*I am always very happy when I finish a task ... but i think on the whole I am reasonably satisfied about my job.*"
NE4 CEN P17 L23	"*I'm happy with my job I like to see the growth of the students.*" (translated from Afrikaans)
NE5 CEN P9 L31-35 & P10 L10	"*I like my work although there are things that I don't like ... like this constant racing against time ... must say definitly more than ninety per cent I am satisfied with my job.*"
NE1 NEL P13 L33 & 34 & P14 L5	"*I'm happy because of the people we work with ... you have to make job satisfaction for yourself.*"
NE1 TSH P15 L33 & 34	"*The fact that I'm still here says that I enjoy it ... the company look after their staff...*"
NEFGD1 TSH NE1 P23 L20-24	"*The fact that I can go to practice and be with the patient and seeing the student grow ... gives me the pleasure of doing this job...*"
NEFGD1 TSH NE3 P23 L29-34	"*Like getting the news that they identified one of my students for a senior registered nurse position*"
NEFGD1 TSH NEM1 P24 L7-20	"*I love that gradual progress of the students ... that is what makes me tick and that is what gives you the pleasure of coming to work.*"
NEFGD2 TSH NE4 P9 L25-29	"*I love working with my students. I absolutely love what I'm doing... I love to see that wow moment when your in practice and they get it.*"

From the above sample quotes it was clear that despite the challenges of their workload, nurse educators experienced a high level of job satisfaction due to their personal desire to

be a nurse educator (see also section 4.3). It is well known and accepted that job satisfaction is an employee's emotional response to different work-related factors. Being satisfied and feeling fulfilled in the workplace result in finding pleasure in achievements, giving and receiving feedback and it enhances organisational support and recognition to name a few positive outcomes of experiencing job satisfaction (Temesgen, Aycheh & Leshargie, 2018:1). Furthermore, satisfied employees tend be more productive and performance driven (Mustapha, 2013:121). Job satisfaction as a positive contributor to an individual's performance and overall sense of having a quality life should never be questioned or overlooked. When nurse educators enjoy job satisfaction, this sense of feeling good and motivated can improve the teaching, clinical, service and research productivity of this private higher education institution (Maharjan, 2012:46; Sohail *et al*., 2014:66).

Obviously, not all nurse educators who participated in the interviews were positive about job satisfaction. Table 6.28 illustrates samples of participants' quotes relating to the reasons why they were dissatisfied with their job as nurse educators.

Table 6.28: Sample quotes of negative experiences of job satisfaction

Participant	Verbatim quotes
NE3 CEN P17 L24-30	"*It is not as satisfying not to be able to accompany a student to the end of a year, because you have got another intake of students … a double intake is extremely frustrating.*"
NE5 CEN P10 L12-15	"*There are things that puts negativity to our work … our work hours has been changed recently … that really was a negative impact on me… I enjoyed my afternoon off in a week … now I do not have 'me time' anymore.*"
NEFGD1 NOR NE1 P31 L27-30	"*Previously we actually used to be allowed to leave early on a Friday … when it was taken away from me I kind of felt very disheartened…*"
NEFGD1 NOR NE3 P31 L32	"*We all agree on that … to leave early on a Friday was more productive.*"
NEFGD1 NOR NE2 P32 L3	"*The afternoon off on a Friday was like an incentive to us.*"
NE2 CEN P39 L8	"*Our team work is not optimum … at the moment there is favouritism in the learning centre … so this is dissatisfying to me.*"

NE2 NEL P13 L9-11	"*You're forever working, you're marking, you are setting questions papers … so it's like you have to take work home … no job satisfaction.*"
NE1 TSH P16 L 20-23 & 30-34	"*It is very frustrating if you have learners that do not progress … and my greatest frustration is the fact that I feel my area of interest is not the [company's] area of interest … and that I am not really valued for that which in a sense is a bit of an isolation from the work therefore that is one thing that will make me leave.*"
NEFGD2 TSH NE4 P10 L3-6	"*I feel like a duck on water I look calm on the outside but underneath my legs are kicking like hell to get forward … I am this close to resigning I really do not feel like I can … I'm of no quality at home and I'm less quality here.*"
NEFGD2 TSH NE2 P23 L21-28	"*Currently I am like giving just enough to each course to make sure I do what is required of me in my work profile … I am not giving a hundred per cent ... I'm giving a bit here and a bit there, touching here, touching there … I had a finger in all of my course pies but no proper hand … that for me takes away my job satisfaction.*"
NEFGD2 TSH NE2 P24 L14-21	"*You feel you work very superficially which is very unsatisfactory … you will give three out of ten … you feel stagnated because of lack of time and finance to get yourself updated even though you are to teach a national speciality programme.*"
NEFGD2 TSH NE1 P24 L23-25	"*Satisfaction … at this stage I would agree with a three … it feels you are rushing through work to get it done and meet deadlines without actually enjoying what you are doing.*"
NEFGD2 TSH NE4 P25 L5-6	"*I give one out of ten because my students that keep me going … that is the actually the only thing make me come to work.*"

The verbatim quotes in Table 6.28 sketch the negative sentiment of some nurse educators on their job satisfaction which can result in reduced productivity and efficiency. From an economic point of view, job satisfaction improves the productivity of the private higher education institution due to the quality and quantity of output while from a behaviour point of view job satisfaction reduces boredom and stress (Mullins & Christy, 2010:286).

The participants were also asked, if applicable, what they would do to improve their current job satisfaction. Sample responses included the following:

- Interviewees suggested additional flexibility as confirmed with quotes such as the following:
    - "*Flexibility will improve your job satisfaction and you would be more willing to give overtime, because it is your choice.*" (NEFGD2 TSH NE2 P28 L12-14)
    - "*It also shows a better trust relationship; then you also feel like you are more valued and appreciated.*" (NEFGD1 NOR NE2 P30 L34)
    - "*I feel that the implementation of workforce management [Kronos] cause a form of micro-management ... we are not compensated for overtime hours ... so to improve my satisfaction and productivity the Kronos system may be adjusted to applied to nurse educators.*" (NEFGD 2 TSH NE2 P28 L29-34 & P29 L1-2).
    -
- Interviewees also suggested 'recognition' confirmed by quotes such as the following:
    - "*… to be treated like academics … and rather be evaluated on your output*." (NEFGD 2 TSH NE2 P32 L7 & 11)
    - "*… it's like applying a brake ... if you offer something, a new idea or initiative ... it does not necessarily be experienced with positivity and feedback is not given*." (NE 1CEN P35 L9-12) (translated from Afrikaans).

- Sample quotes related to 'effective teamwork' included the following:
    - "*We almost living past one another … we don't have to be best friends but there's just certain things that I think that if we can manage them we can actually become a force to reckon with.*" (NE2 NEL P14 L21-24)
    - "*We are a small group of educators together with very strong personalities, very different personalities, which leads to spectacular clashes … professional jealousy … that's not nice because we are not a team*." (NE 1TSH P17 L21-34 & P18 L1)

The above quotes reveal the job satisfaction of the nurse educators could be improved by additional flexibility, recognition and effective teamwork. The negative experiences of job satisfaction can be changed into a positive experience with the support of management by implementing additional flexibility, regular recognition of nurse educators' initiatives or a job well done. Promoting effective teamwork would also increase nurse educators' job satisfaction (Gui *et al.*, 2009:473; Wood, Zeffane, Fromholtz, Wiesner, Creed, Schermerhorn, Hunt & Osborne, 2010:56). The implementation of these requests may provide opportunities for employees to have more freedom and control over their work arrangements in order to achieve the desired performance as well as effective teamwork.

Effective teamwork is strengthened when the unique specialty of each team member complements each other (Wood *et al.,* 2010:56).

The interview participants (n=25) were also asked the following question: 'what do you think can be done differently to improve (1) teaching productivity; (2) administrative productivity and (3) clinical productivity?' The results from the narrative data are reported in the next section.

6.2.6. Category 6: Suggestions to enhance teaching productivity

In this section, three subcategories of narrative data were identified as illustrated in Table 6.29 together with sample quotes from interviewees.

Table 6.29: Sample quotes as suggestions how to enhance teaching productivity of nurse educators

Subcategory	Verbatim quotes of participants
Technology	"*Access to YouTube especially for physical representation of anatomy and physiology.*" (NE1 CAP P5 L27-30) (translated from Afrikaans) "*Teaching productivity can be enhanced if you are given a freedom to offer the lecture in a way that you want to experiment … and be trusted with the experi*ment." (NEFGD1 CAP NE2 P28 L3-15) "*One way is to attend courses like doing your masters and open access to medical journals.*" (NE2 CAP P14 L23 & 28 & 29) "*More access to certain products on the Internet and medical records so that you can stay the expert in your area.*" (NE1 CEN P39 L11-12) (translated from Afrikaans) "*Access to Wi-Fi … resources like the Intranet for updates and to refer the students to it … the library is not extensive enough at the moment.*" (NE3 CEN P20 L20-28) "*The students of today wants live; almost encounter for example a video clips.*" (NEFGD1 NOR NE2 P33 L1 &11) "*Free access to Wi-Fi … allow YouTube to show students anatomical videos.*" (NEFGD1 NOR NE3 P33 L5-7 24-25)

	"*Access to Wi-Fi to help the students with their assignments … teaching is not about lectures … it's about making it interest for the new generation … they want to see interesting things.*" (NEFGD1 NOR NE1 P33 L19 & 30-32)
	"*We have this wonderful Wi-Fi technology, but you have to pay for it … make it free for everybody during class because sometimes you want them to search for information.*" (NEFGD1 TSH NE3 P25 L26-31 & P26 L1-4)
	"*Access to more advanced technology like interactive boards.*" (NE1 CEN P39 L22) (translated from Afrikaans)
	"*Modern technology like smart boards to teach in class.*" (NEFGD1 NOR NE4 P32 L30-34)
	"*Advanced technology because the students of today wants more advanced technology like 3D projectors … they wants to see and know how it works.*" (NEFGD1 NOR NE3 P33 L12-13)
	"*Demonstrations and training to use electronic dolls optimal to their fullest extent.*" (NEFGD1 TSH NE2 P25 L14-24)
	"*Advanced technology like Skype and video for contact sessions.*" (NE2 CEN P21 L35)
	"*A virtual theatre or simulation laboratory and training to use it optimal.*" (NEFGD1 TSH NE1 P27 L1-5)
Lecturing	"Standard guidelines with each study guide." (NEFGD1 CAP NE4 P22 L31)
	"*I suggest that the nurse educators presenting the same subject, assemble heads and make sure they understand the same outcomes to the same depth and same level and that students are then prepared accordingly.*" (NEFGD 2CAP NE2 P37 L20-23) (translated from Afrikaans)
	"*Assistance with the preparation of the classroom before and after life support training.*" (NE 2CEN P43 L25-35)
	"*Giving nurse educators allocated module.*" (NE5 CEN P14 L23)
	"*To start with critical thinking … integrated of learning and critical thinking … opportunity in education time … teaching productivity goes beyond the focus area to the person … development the student … expose them … then the student nurse will see the patient as a whole.*" (NE1 TSH P19 L13-34)

	"Being given time to prepare properly for contact sessions" (NEFGD2 TSH NE4 P25 L29)
Official visits	"*Visits to specialist institutions, for example, radiology, oncology, laboratories and so forth so that the students' knowledge can be broadened and established.*" (NE1 CAP P19 L1-34) (translated from Afrikaans)
	"*Exposure of students to specific types of learning, for example, to nurse a patient with a stoma … we could have compensated if we were able to work with them in the clinical setting…*" (NE3 CEN P6 L20-27)

It seems clear that many participants were of the opinion that technology can improve teaching productivity. The participants of the Tshwane focus group interviews highlighted the importance of available time for the preparation of lectures and the development and growth of a nurse educator. This includes the prevention of 'stagnation' because this has a negative effect on teaching productivity. In education sites based the Cape participants focus group interviews emphasised a reduction in travel time, more time to prepare lectures and that nurse educators have to be competent and involved in the areas in which 'they are good' in order to improve teaching productivity. In a pharmacy education institution, which is similar to nursing education institutions, the integration of tablet technology has resulted in educators reported an increased productivity as well as it allowed educators to experiment with new teaching strategies in the classroom and experiential setting DiVall (2014:1). Technology according to Wong, Kuper, Robinson, Morra, Etchells, Wu, Shojania (2012:795) will assist educators to identify and create educational opportunities and protect the safety of the students during the training experience in the learning centers.

6.2.7. Category 7: Redraft administrative load

Four subcategories with regard to suggestions to redraft the administrative load of nurse educators were identified from the analysis of the narrative data as shown in Table 6.30. Verifying verbatim quotes are also given.

Table 6.30: Sample quotes with suggestions to redraft the administrative load of nurse educators

Subcategory	Verbatim quotes of participants
Electronic system	"*Must be able to load marks in one place so that it draws to all areas of interest.*" (NE1 CAP P13 L16) (translated from Afrikaans) "*Must be able to load the marks of thirty students in one place so that it draws through to all the other areas of interest ... more than one nurse educator must be able to work at the same student files.*" (NEFGD2 CAP NE3 P20 L9-35) (translated from Afrikaans) "*Some electronic system that can help capture the paperwork.*" (NE3 CEN P22 L24) "*An electronic record system that prevents the same thing from being repeated three times.*" (NE4 CEN P9 L20) (translated from Afrikaans) "*Our documentation can definitely be streamlined.*" (NE5 CEN P8 L16) "*Improve duplication of information which is a frustration.*" (NEFGD1 NOR NE3 P17 L8) "*A system pulling through all results to the final document of the student.*" (NEFGD1 TSH NE1 P6 L3-5) "*Off-site access to the system that we are working on students' files, when you have half an hour here, half an hour there … it is incredible what you can do in half an hour.*" (NE2 CAP P15 L3-7 & 14) "*… access to 3G cards so you can finish your administrative tasks when you are in the region.*" (NE2 CEN P45 L4&5) "*Access to the H-drive when I'm out for a week in the region.*" (NE4 CEN P11 L12-16) (translated from Afrikaans) "*Own laptops with access to the system when out of office.*" (NEFGD1 NOR NE1 P18 L5) "*Computers with 3G to take home and work at home…*" (NEFGD1 TSH NE2 P4 L14-15) "*Reduce the system off-time at the learning centre.*" (NEFGD1 TSH NE3 P4 L30) "*Tablet that synchronises with student's record ... student signs in practice with what you did with him ...*" (NE1 CEN P44 L29-32) (translated from Afrikaans)

	"*A big frustration is formatting ... we need to be equipped to apply it correctly.*" (NE1 CEN P49 L15 & 32)" (translated from Afrikaans) "*Computer literate administrative person who can do the formatting of tests.*" (NEFGD2 CAP NE2 P22 L11 & 21) (translated from Afrikaans)
Delegate selected tasks	"*If we can get help for those non-confidential things.*" (NE1 CAP P22 L21) "*Capturing of students' clinical hours, test marks and periods on class registers…*" (NEFGD1 CAP NE2 P12 L29 & 34 & NEFGD1 CAP NE4 P13 L21) "*Capture data and student hours.*" (NEFGD1 TSH NEM1 P6 L29) "*Help with things like scanning.*" (NE5 CEN P16 L21)
Training of current administrative assistants	"… *if she is sent or rather being taught how to do certain administrative tasks she would be able to assist us.*" (NE2 NEL P10 L 28-29) "… *if this secretary can be used more correct ... that she is being properly managed … that she does not go her own way … then we can use her to do some of our administrative work…*" (NE1 NEL P17 L16-19)
Break away area	"Working in quite environment like available class room or a break away area" (NE2 CAP P15 L28)

At the time of study the nurse educators felt administration had become a behemoth stealing their time. On average the nurse educators spent between 23% and 27% of their time monthly on administrative activities (see Table 7.3). A call for appropriate, updated and supportive technology was observed in the above verbatim quotes. A need for the necessary skills to format documents to ensure administrative productivity could be increased and the workload of nurse educators decreased. Today's nurse educators must operate effectively to achieve results and must use resources efficiently to reach their outcomes and goals. Therefore, the nurse educator should follow the credo: "Once you know you're spending time on the right things…focus on doing them right." (Stack, 2016:98).

6.2.8. Category 8: Enhancing clinical productivity

The narrative interview data also revealed four subcategories related to suggestions to enhance clinical productivity. Sample quotes are provided in Table 6.31.

Table 6.31: Sample quotes suggesting the enhancement of clinical productivity

Subcategory	Verbatim quotes of participants
Meetings	"*Review of meetings on Fridays.*" (NE1 CAP P25 L16)
Partnership arrangement with management in clinical environment	"*... if students get the opportunity to apply what you are teach them in practice you will spend less time on them because yes they have the opportunity to apply what they have learned… and if deemed and supported in the clinical area, this will increase clinical productivity.*" (NEFGD1 CAP NE4 P28 L29-30 & P29 L4) (translated from Afrikaans) "*Clinical productivity would only be addressed and I referring to a much deeper source and that management at hospital level hasn't bought into a teaching culture and doesn't cultivate that ongoingly. When you pop in there as a nurse educator and then you get also told to just be quick.*" (NEFGD1 CAP NE2 P30 L27-31) "*There isn't synergy between the clinical setting and the training setting and that needs to be in place because if that is in place supportive to each other it will.*" (NEFGD1 CAP NE1 P31 L14-17) "*Students are regarded as workforce that impacts on your clinical productivity as a nurse educator and the clinical productivity of the student … if a hospital has students, then the hospital is seen as a training hospital and they have to come to meet the students.*" (NEFGD2 CAP NE2 P42 L1-13) (translated from Afrikaans) "*Clinical productivity can improve with students' support … students being allocated to do tasks that they are not yet competent in so that they can become competent but under mentorship or direct supervision.*" (NEFGD2 CAP NE1 P42 L26-29) "*For the clinical part a student must be recognised as a student and there must be time for the clinical procedures you do with them ... the six hours a month ... which almost never happens ... because they are part of the workforce ... it is difficult for a student to do a procedure with you if the unit manager of the nursing unit is annoyed with the situation.*" (NEFGD CAP NE1 P29 L26-34) (translated from Afrikaans) "*To improve clinical productivity, the training centre and the clinical setting should see themselves as a unit towards equipping the student for the same company rather than two entities or forces working against each other.*" (NE3 CEN P22 L13-17)

	"*Clinical mentoring in the hospitals specifically for the students will make our workload more feasible.*" (NEFGD2 CAP NE3 P40 L32-34) (translated from Afrikaans) "*Clinical facilitator to work with student when you are not there…*"(NE1 NEL P9 L1-3 & L19-24) "*At this stage they can just assign mentors to the students … the students don't have mentors now … students don't get orientation in the wards on time … I wish I had much more time with them inside there because they're lost …*"(NE2 NEL P19 L11-12 & P20 L4-13) "*If we had good mentorship.*" (NEFGD1 NOR NE3 P6 L30)
Training unit	"*I would love to see a training ward where people go in and we give the nursing care that the patient needs … to give that holistic training for the student … not as a first or second year but as a nurse … to accompany them twenty four hours a day in a ward where we have patients that are allocated to us.*" (NE3 CEN P12 L1-7)
Clinical Preceptors	"*Clinical preceptors in the hospitals for all students … employed by the learning centre*" (NE2 NEL P16 L14-20) "*… the implementation of the nurse educator: student ratio 1:15 of SANC.*" (NEFGD1 CAP NE4 P28 L28) (translated from Afrikaans)

Clinical education is a component of nursing training that takes place within the clinical workplace environment. It provides the transfer of important essential knowledge for the production of work-ready nursing students. Underperformance by students in clinical practice education causes an increase in emotional fatigue and stress concomitant with an increase in workload for the nurse educator (Foo, Rivers, Ilic, Evans, Walsh, Haines, Paynter, Morgan, Lincke, Lambrou, Nethercote, & Malone, 2017:742).

This 'meeting' subcategory links to the subcategory 6.2.3, 'review of meetings structure'. A major influence on clinical productivity seems to be the fact that nursing students are seen as part of the hospital workforce. This misinterpretation of the student's role leads to a lack of mentorship and management support at hospital level. It is important to keep in mind that productivity does not take place in a vacuum and is influenced by cultural factors, interpersonal relationships and relations with authority (also see Allen, 1997:25; Americano & Bhugra, 2014:449-453).

The aforementioned feedback from the nurse educators (categories 6.2.5 to 6.2.8) can be redirected back into the workload system as new input and may serve as a guide to more effective performance (Ferreira & Bothma, 2015:55; Flood & Carson, 1993:6-8; Smit *et al.*, 2011:62). In the next section, the impact of the current workload of the nurse educator is pointed out as well as how it affects the nurse educator and nursing education in this private higher education institution.

6.2.9. Category 9: Impact of current workload

This is the ninth and an important data category which emerged from the narrative data. The subcategories 'possible insufficient training' and 'burnout' are illustrated individually in tables with some verbal sample quotes from the participants. Table 6.32 shows samples of quotes from the narrative data of some of the interviewees related to the possibility of 'insufficient training'.

Table 6.32: Sample quotes related to 'possibly insufficient training'

Participant	Verbatim quote
NE4 CEN P1 L18 &19 & P2 L7-10 & L 31-33 & P5 L17	"*My current workload is hectic because we have a lot of different programmes running … in total ten different courses and fifty-five students … the clinical component we rely on the mentors in the hospitals because we do not have the capacity to get to the hospitals in the second part of the year… Feels if 'things get dropped' with some courses … you just do not get to it.*"
NE2 CAP P5 L25-34; P8 L30 & 33	"*You've got five different courses and approximately in total a constant amount of twenty-five students in different hospital … one group of students I've got in two different hospitals, but all the other post-basic courses I go to hospitals in Windhoek, Swakop, Upington and George … I travel extensively for teach Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) and I coordinate it.*"
NEFGD1 NOR NE1 P1 L16-21	"*With fifty-eight students, can you realistically give them your utmost practical experience and be a hundred per cent committed to the practical with them? ... you are also giving lectures in class to them as well … so I think it's something to consider because you want people that are competent when they are qualified.*"

NEFGD1 CAP NE2 P10 L20-23	"*You would like to provide a quality service but it is not always possible because it's this time grip.*" (translated from Afrikaans)
NEFGD1 CAP NE1 P8 L22-30	"*… your time is spent on class-giving and practical guidance and it leaves no time for anything else ... a big reality is, you are sitting patiently for three hours sometime at the hospital and waiting for a student to start ... which is dead time.*" (translated from Afrikaans)
NE2 CEN P5 L16-20 & P32 L21-24	"*I feel with the work overloading that you drop standards to get through … you may not go in to the depth like you would have wanted … overwhelming workload actually compromises the quality of education.*"
NE3 CEN P10 L4-21	"*The double standards that we are living and that are being applied in practice caused this disregard to patients and patient care … when you get the student back … it takes again much time to unlearn the bad habit … you have to repeat assessments and sometimes even re-demonstrate procedures.*"
NEFGD1 NOR NE2 P8 L12-14 & P22 L6-12	"*You are so stressed for time that everything is very superficially covered … which makes you feel frustrated … at the moment we are only reaching minimal standards with these students … they are competent according to the criteria and the student passes … the minimum has become the standard.*"
NE2 CAP P12 L4-13	"*You know the a student from pre-qualification days … when you see them in a post-basic course their competency level is not as expected to enter the course … now you have to put in extra time.*"
NE5 CEN P1 L16-19	"*I do feel the workload is heavy and that I mostly make use of crisis management in the sense of if I have to facilitate a class tomorrow I have two hours to prepare but then the work I need to prepare requires more.*"
NE1 CAP P4 L 22-27 & P6 L25-29	"*At this stage I'm running because this is another busy time of the year with students who are getting ready ... and new ones that start again ... so many classes to be facilitated… I'm about fifty-eight days of the year in class which actually does not looks very much but the priority is to prepare each class ... plus setting and marking tests. If you are in class there is no time for something else.*" (translated from Afrikaans)
NEFGD1 CAP NE4 P6 L13-16	"*Superficially to sort of cover the bases ... you do not come to the depths of what you want because there is no time for preparation.*"

NE1 NEL P7 L31	"… *at the same time you fear that you do some things superficial.*"
NE1 TSH P10 L2	"*My research and preparation for class occurs in the class with the learners.*"
NEFGD2 TSH NE1 P5 L7-9	"*They withdraw the CPD students from class if the practice is busy … so you wonder why the test results are ten per cent for a test.*"
NEFGD1 NOR NE1 P2 L26-34	"*I manage in the field thirty-three students at the moment which I see once a month during GPL if possible, each one of these students are seen between one to three hours depending on the number of students in a group per hospital which is not six hours per individual learner.*"
NEFGD1 NOR NE2 P4 L10-13	"*I travel a lot … I see students of two different courses … I can only see them once a month in the specialised units … sometimes I cannot even see these students for an hour because it is difficult in the critical environment.*"
NEFGD1 NOR NE3 P4 L24-26	"*I feel the students' clinical development is obstructed by the structure of our work.*"
NEFGD 2 TSH NE2 P2 L22-25	"*Accompaniment is the most important factor here because you can always take the classroom to the clinical setting and we do not have enough time to spend with students in the clinical setting due to the fact that we have to be in class and we have a heap load of paper work to do … that takes more than fifty per cent of my time.*"

The sample quotes clearly indicate that the workload of nurse educators needs to be reconsidered and revised as current workloads may result in the 'possibility of insufficient training' of nursing students. Globalisation has an impact on the changes and developments in the South African higher education institutions which may also be true for the nurse educators as higher education practitioners (Du Toit 2000:275). Due to the complexity of the workload of nurse educators and the increasing demands for equity and fairness, it seems necessary for more formal approaches to the management of the nurse educator's workload (Barrett & Barrett, 2010:183). Academic staff works significantly more hours than the normal working time as indicated in the Basic Conditions of Employment Act 11 of 2002 (Kyvik, 2013:10; Republic of South Africa, 2002). It is important to recognise the education environment and its challenges in order to reconsider and revise the current workload of the nurse educator for the production of quality nursing education (Paewai *et al.*, 2007:385).

Although this study did not aim to investigate the issue of educator burnout in particular, Table 6.33 shows some sample quotes emerged from the narrative data related to this issue.

Table 6.33: Sample quotes from participants related to educator burnout

Participant	Verbatim quote
NEFGD1 NOR NE2 P4 L31 & P5 L1-3	"*I am running the four months CPD couses, I am running the six months short courses and the clinical accompaniment of the diploma critical care students ... have to monitor basic life support instructors ... and I have to present ACLS course for the hospital staff in the Northern region.*"
NE2 CAP P4 L4	"*I'd never thought about how often do I feel like that … I just live from day to day and I try to do my best and the best I can in the circumstances.*"
NE1 TSH P13 L27-33	"*Over and above you're your two intakes of students twice a year you have CPD and short course students nationally … as coordinator you have to compile tests, moderate tests, answer any questions, answer all problem queries, finalise the passing or failing of students on the system and do all the remaining administrative tasks.*"
NE4 CEN P1 L20-27 & P2 L7-13	"*I am responsible for the first and second year ODA students, theatre CPD courses with an intake in April and August (all nursing categories) and theatre Short courses for the region which, in total ten different courses … I have students in Kimberley, Welkom, Bloemfontein, Bethlehem, Newcastle, Howick, Pietermaritzburg and Tongaat.*"
NEFGD1 NOR NE3 P14 L27-34 & P15 L1-13 & L21-24	"*The huge leadership turnover in the theatres of the Northern region resulted in new inexperienced very young leaders from other companies and small hospitals who did not get the picture of managing a ten-theatre highly specialised unit and it takes a long time for them to be orientated to the student situation therefore you guide the leader … this creates stress on the educators because there is nobody except the educators to organise the students therefore the nurse educators have to be in theatre all the time to assist with the organisation of the students.*"
NE1 TSH P4 L25 & 32-33	"*I am always frustrated and stressed at work and at home it keeps me awake at night because I know I have to catch up.*"

NE2 CAP P3 L19-23;	"*It's a challenge … it makes you think, 'what can I do to make it do-able?' … plan how I can do things differently when I am extremely exhausted I put everything down … 'what happens tomorrow I will manage tomorrow' because I have to look at my own health.*"
NE2 CEN P6 L24-28	"*Heavy workload that you have to carry leads to you not being able to do what you want to do with the student … it affects you negatively.*"

From the narrative data it can be asserted that nurse educators of the identified private higher education institution experienced their workload as overwhelming. The work generated by the variety of programmes and courses with more than one student intake per academic year exacerbated their workload. The influence of a range of factors such as institutional-, operational-, student- and educator-related factors profoundly complicated the workload. As a consequence, it also had an influence on the job satisfaction and productivity of the nurse educators. Table 6.34 summarises categories three to nine and their subcategories which emerged from the interviews as having a direct impact on the nurse educators' workload.

Table 6.34: Summary of categories three to nine and their subcategories

Category	Subcategory
3: Management support required to review current workload	1. Assistance with selective administrative tasks
	2. One intake per year per programme and course
	3. Review meeting structures
	4. In-house learning centre communication
	5. The accessibility of electronic student files
	6. Distribution of workload
	7. Structured revision of study material
	8. Role and availability of clinical facilitators
	9. CPD and short courses
	10. Human resources support
	11. Availability of a central lecture and test bank
	12. Vacant nurse educator positions

4:Tasks suggested to be delegated	Administrative assistance
	Selected assessments
5: Level of educator Job satisfaction	Positive experience
	Negative experience
	Improve current job satisfaction
6: Suggestions to enhance teaching productivity	Technology
	Lecturing
	Official visits
7: Redraft administrative load	Electronic system
	Delegate selected tasks
	Training of current administrative assistance
	Break away area
8: Enhancing clinical productivity	Meetings
	Partnership arrangement with management in clinical environment
	Training unit
	Clinical preceptors
9: Impact of current workload	Possibly insufficient training
	Educator burn out

6.3.   SYNTHESIS

The focus in this chapter was on the interpretation of the findings from the narrative data generated by individual and group interviews with nurse educators. The goal was to obtain more insight and a better understanding of the current workload of nurse educators at a South African multi-campus private higher health education institution. The findings of the narrative data were accounted for by nine identified categories and 39 subcategories which emerged from the analysis of individual and group interviews.

A number of trends were revealed by the data. The most important being that nurse educators experienced their workload as overwhelming. They faced escalating volumes of administrative tasks, had to do extensive travelling between clinical facilities and accommodate increasing demands regarding academic and clinical duties. At the same time, nurse educators needed to respond to diverse nursing student groups with extensive social problems which, in turn, meant nurse educators had to heighten their dedication and

motivation to meet the varied and numerous demands from the students. Yet, no matter what challenges or obstacles they encountered, they had to remain effective and productive to keep up with the competitive health provision business environment. Nurse educators were compelled to take substantial amounts of work home in order to get their work done and achieve role expectations. At present, time spent on teaching, clinical practice, administrative and research workload activities dictates the working (and indeed private) life of nurse educators who are challenged with 56 programmes and courses commencing at different dates during the academic year and offered at seven nursing education sites all over the country.

Different institutional-, operational-, student- and educator-related factors also seemed to impact on the workload of the participants. Faculty-related factors that influenced nurse educators' workloads included different peak times during the academic year, excessive teaching responsibilities and activities, excessive administrative tasks, preparing for new nursing programmes and the mentoring of newly appointed nurse educators. Other factors found that were faculty-related included many due dates, open-plan offices not conducive to individual work, changes in work programmes at different nursing education sites and vehicle constraints.

Operational-related factors highlighted by the narrative data which may impact on nurse educator workload included 'obstructive' clinical development, ineffective clinical mentorship and lack of operational support. Another set of impacting factors related to the students. Students were seen as part of the workforce and not for what they were – students still being prepared to stand in the shoes of a registered nurse. Nurse educators had a difficult task to undo the clinical shortcuts that students learnt in the clinical practice environment. They also had to constantly repeat information to make sure the students remembered what they had learnt and in many instances the nurse educators had to deal with students' extensive social problems in a professional and emphatic manner. The last set of factors impacting on the workload of nurse educators included educator-related factors such as feeling neglected, coping with the communication gaps or the total lack of communication form clinical environments who cancelled students' practical accompaniment without informing the nurse educators. On a personal level, the nurse educators lacked self-development opportunities, they did extensive travelling and were pressurised into specialised qualifications.

Various supportive proposals were made by participant nurse educators to assist them in the management of their workload. At the top of the list was the request to be assisted with selected administrative tasks followed by the request for only one intake of students per academic year per programme. Other suggestions included a review of the meeting structure, more effective in-house learning centre communication, more user-friendly accessibility to electronic student files, better distribution of workload, a structured revision of study material, the use of clinical facilitators, the need for CPD courses to be offered by the hospitals, human resources support, a lecture and test bank and the appointment of nurse educators in the current vacant positions. The participants also indicated the general administrative and selected clinical assessments as tasks that needed to be delegated.

In general, diverse opinions were voiced by the nurse educator participants regarding job satisfaction. The majority indicated some positive experiences gave them some job satisfaction – the most important one was that they shared they loved their work with the students. The participants also saw additional flexibility, recognition and effective teamwork as potential positive issues that could improve their job satisfaction. Suggestions from participants to enhance teaching productivity included access to more advanced technology, sufficient time to prepare for lectures, reduction of travel time and student visits to specialist institutions.

Major calls for the revision of the nurse educator administrative workload and updating supportive electronic systems were made by the participants. These were accompanied by the need for skills to format documents for improving administrative productivity. For the enhancement of clinical productivity, partnership arrangements with management in the clinical environment and a training unit were suggested. It was also highlighted that the current impact of the increasing workload of nurse educators may lead to insufficient training of nursing students which may result in students not being rounded off clinically. Although it was not the researcher's intention to investigate burnout of the nurse educators, it surfaced in both individual and focus group interviews as an important issue. It was therefore included in the narratives.

When these trends are considered against the backdrop of relevant literature, it seems clear that concerns about the workload of a nurse educator are not new or unfounded

(Voignier *et al.*, 1998:35). The current higher education environment is complex and demanding (Campbell, 2013:886; Frenk *et al.*, 2010:1927; Zibrowski *et al.,* 2008:873 & 874). It is the responsibility of nurse educators to train novice nurse students to become professionals who will fit into a 21st century healthcare workforce characterised by technological advancements and high expectations from clients who are more knowledgeable than before due to unlimited access to information. Therefore, nurse educators have no option but to stay informed and keep up with current trends in healthcare technology and current knowledge. However, they also have to share knowledge. Access to knowledge and information and sharing thereof is done through research which implies reading, writing up articles and publishing them. This means on top of their already high workload, nurse educators have to become involved in research initiatives (Candela *et al.*, 2013:853; Du Plessis, 2005:1379). Traditionally, faculty workload is described as the teaching, research and service activities with teaching and research taking priority over service activities (Bentley & Kyvik, 2012:529; Colbeck, 2002:43; Duderstadt *et al.*, 2002:238; Ellis, 2013:303; Houston *et al.*, 2006:17; Seaberg 1998:7; Zabriskie *et al.*, 2002:4). In the context within which the research was conducted, it seems that teaching and clinical practice workload activities were prioritised followed by service workload activities and then research workload activities. This is to be expected, given the business aim of the institution.

It was evident from the qualitative findings and the relevant literature if nursing education institutions want to offer effective education and training programmes, they must be prepared to engage in both academic and clinical teaching (Pohl, Duderstadt, Tolve-Schoeneberg, Uphold & Hartig, 2002:238). Indeed, the South African National Strategic plan for nursing education, training and practice (Republic of South Africa, 2012) and the SANC (2013a:22) require clinical education components to be offered alongside the theoretical component; however, clinical education may not be well-supported by effective nursing education facilities. Theory-practice integration in the identified private higher education institution is crucial for the delivery of competent and highly skilled registered nurses to the 54 clinical facilities of this institution. Therefore, the clinical practice component is an essential part of the nurse educators' workload.

In accordance with the findings from the qualitative data in this study, the findings of Houston *et al.* (2006:27) indicated that academic staff generally works a considerable

number of hours even after hours to stretch their working capacity and accommodate the demands of their work. These authors are of the opinion that both managers and nurse educators should be actively involved in the management of nurse educator workload through the necessary advocacy of needed changes in institutional practices, programme delivery patterns and reconsideration of activities that could detract from the fundamental objectives of higher education.

Relevant literature also supports impact factors such as technology, students' higher expectations about the availability of their educators and constantly updating curricula on the workload of the nurse educators (Kyvik, 2013:3). Increased workloads may thus result in fewer deadlines being met, decreases in productivity and less job satisfaction (Timperley & Robinson, 2000:47; Rothman *et al.*, 2008:404-422). In the case of this private higher education institution it seems imperative to address the problem of workload in order to ensure optimal productivity and job satisfaction of its nurse educators to enhance high quality nursing education (Vardi, 2009:500).

Nurse educators who are dissatisfied with their workload and who experience it as overwhelming find themselves in a position where they cannot achieve good student results. As a consequence, both the students and the nurse educators suffer (Hinrichsen, Jackson, Jackson, Templeton, Flannigan, Lawrence, Modianos & Skaggs, 2002:13). These authors also highlight the immeasurable importance of the development of attractive creative course materials and individual attention to students by nurse educators as this promotes job satisfaction. The quality of higher education depends on the effectiveness of educators; hence the need for satisfied and sufficient nurses (Amstrong *et al.*, 2008:88).

Earlier, McInnis (2000:143) indicated that the workload and the levels of job satisfaction of nurse educators had reached a point where nothing less than radical reform would be sufficient to improve the quality of teaching and learning. In addition, Ntshoe *et al.* (2008:401) observe the need to redefine the workload and role of nurse educators in South Africa, particularly in a constantly changing higher education and private higher education environment. These issues were well underscored and supported by the qualitative data generated from the nurse educators in this study.

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The next chapter, Chapter 7, contains the findings from the numerical data of this study project. The discussion includes the findings and results from the Delphi exercise whereby a level of consensus was generated on a possible workload framework for nurse educators within the context of a private higher health education institution.

CHAPTER 7

FINDINGS FROM THE NUMERICAL DATA AND DISCUSSION

7.1   INTRODUCTION

Chapter 6 provided information on the findings and discussion of the data generated from the narrative part of this study. This chapter focuses on the findings and discussion of the numerical data as revealed by the nurse educators' workload diaries and the results from the Delphi survey.

A critical factor that dictates the workload of the nurse educator is the time spent on the different workload activities of each key concept, namely the teaching, clinical practice, research and administrative workload as indicated in the conceptual framework (cf. ch. 4 Fig. 4.5) (also see Rosser & Tabata, 2010:456; Seaberg, 1998:7). The purpose of the study was to determine the total workload of a nurse educator by calculating the total time spent on each activity (Soliman, 1999:3). A formal method of determining the workload of the nurse educator can assist to improve the perception of equal work distribution (Wilborn *et al.*, 2013:9) and with the compilation of a suitable workload model for the nurse educators at the multi-campus private higher education institution.

Time-based workload models are considered comprehensive because they cover the academic work directly related to human resources. Vardi (2009:506) and Soliman (1999:4) point out that a time-based model can assist in the analysis and planning of individual workloads as well as the development of academic workload profiles.

As explained in Chapter 5, data triangulation was achieved with the exploration of and analysis of data from nurse educator workload diaries, individual and focus group interviews with relevant respondents and a Delphi exercise to indicate the level of consensus on ideal workload allocations (also see Brink, 2012:99; Polit & Beck, 2012:745). This chapter highlights the notion that findings from the data can be linked which clearly points towards the advantage of Plowright's FraIM, namely that all phases of data generation are planned according to a predetermined, integrated approach (Plowright, 2011:7).

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7.2   DESCRIPTION OF NUMERICAL DATA

7.2.1 Workload diaries

As mentioned in Chapter 5 (cf. sect. 5.4) data were obtained from the electronic workload diaries (artefact analysis) received from 37 specially selected permanently employed nurse educators at the seven nursing education sites of the identified private higher education institution. The purpose of the workload diaries was to identify the time factor involved in the different teaching, clinical practice, administrative and research workload activities. A link enabling the respondents to submit their electronic workload diaries anonymously was sent to their email addresses. With the emphasis on high quality data only, 49% (N=18) of the 37 nurse educators initially selected were used for analysis purposes. They were from the Western Cape region, the Central region and Tshwane region nursing education sites respectively. Twenty-six key activities of a typical nurse educator were addressed in each workload diary (see Addendum D). Data were recorded on a monthly basis over a nine-month period and summarised on an Excel spreadsheet for analysis.

The majority (44%) of workload diaries were completed by respondents (N=8) from the Tshwane region followed by 39% (N=7) from the Western Cape region and 17 % (N=3) from the Central region. The distribution of the respondents is illustrated in Figure 6.4 below.
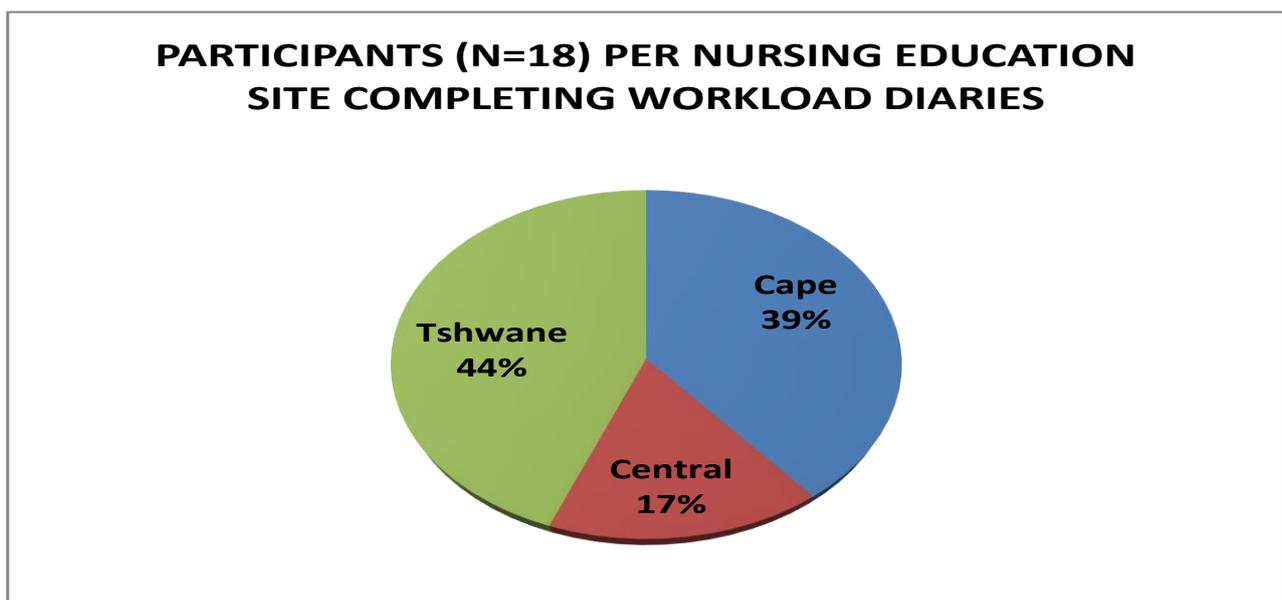
Figure 7.1: Respondents per nursing education site who completed workload diaries

The academic qualifications of nurse educators are particularly important (SANC, 2013a:20). Therefore, the respondents (n=18) had to indicate their highest qualification in the workload diaries. Forty-four per cent (n=8) of the respondents held a Masters containing a research component, 17% (n=3) held an honours degree, 28% (n=5) a degree and 11 % (n=2) a diploma as reflected in Figure 7.2.
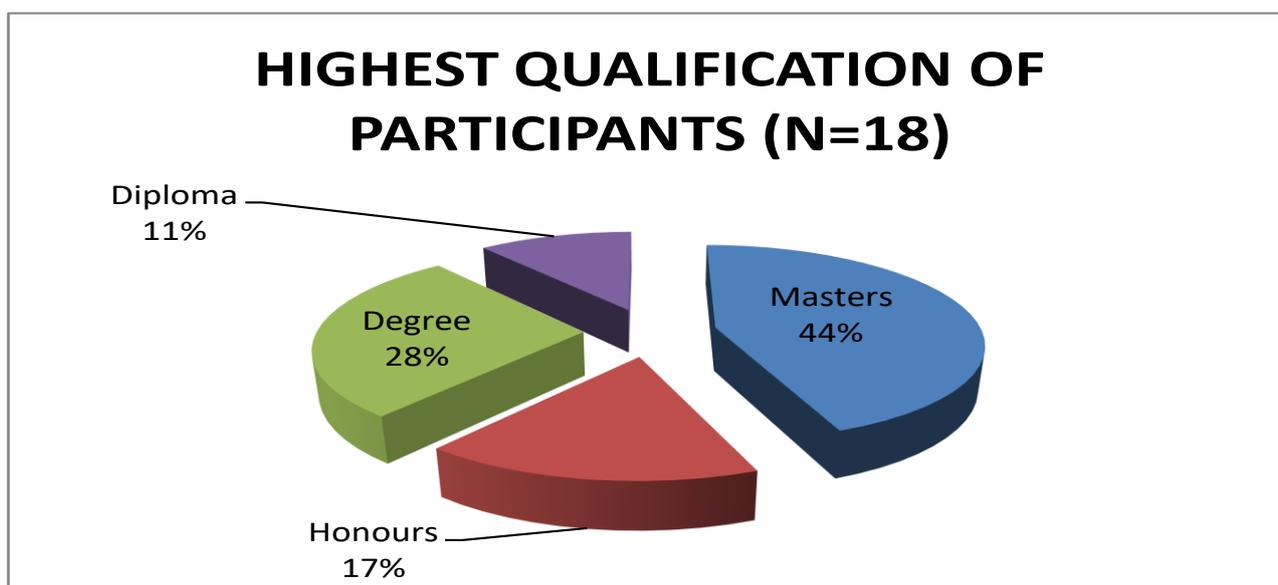
Figure 7.2: Highest qualification of respondents

It was encouraging that 89% of the respondents held a degree of which 68% held a postgraduate degree. It reflected not only the academic qualification criteria laid down by legislation, but also that the private higher education institution encourages nurse educators to improve their qualifications.

The respondents (N=18) were required to record their ages. Figure 7.3 indicates the age distribution of the respondents which ranged from a 20- to 30-year-old group (6%) to a 51- to 60-year-old group (17%) with the highest concentration of respondents in the 41- to 50-year-old group (39%). The age group that will have a huge impact on the workload of nurse educators in future is the 55- to 60-year-old group that made up 17% of the respondents older than 50 years. They are the older generation employees who will have to be replaced over the next 12 years due to the retirement age policy of the private higher education institution. This observation is of utmost importance when taking into account

the current critical nurse shortages of qualified experienced nurses in South Africa and worldwide as well as the shortage of skilled nurse educators (Bruce & Klopper, 2016:29).

AGE CATEGORIES OF PARTICIPANTS (N=18)

- 51-60 Years 17%
- 20-30 Years 6%
- 31-40 Years 38%
- 41-50 Years 39%
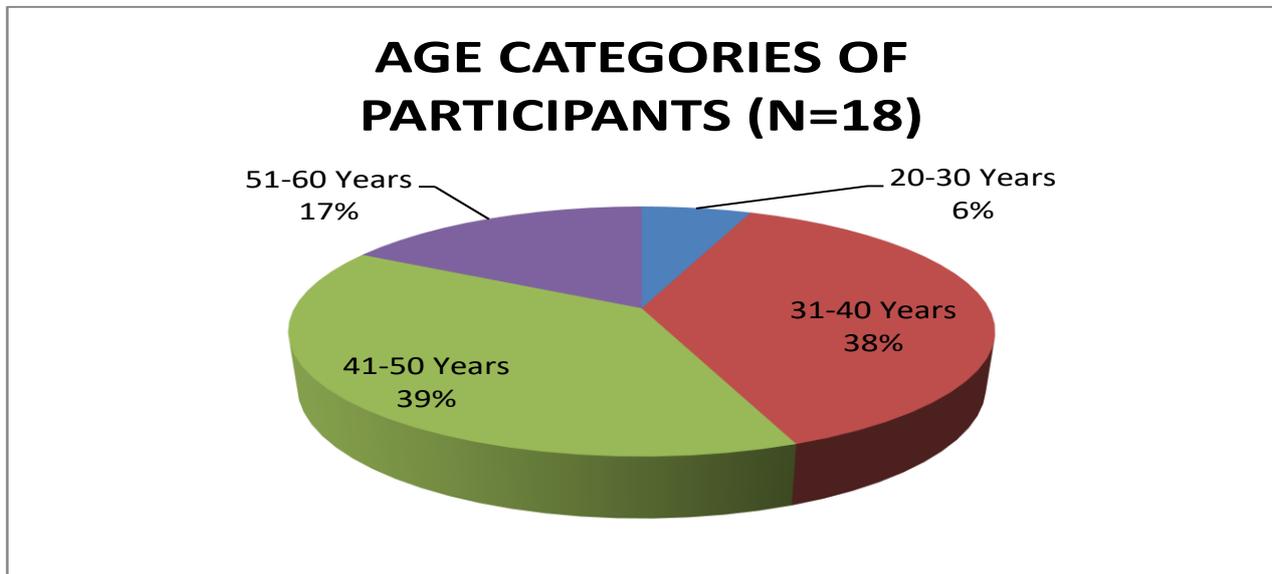
Figure 7.3: Age categories of respondents

The educational experience of the respondents ranged from one to 14 years (see Figure 7.4). The fact that 26% had less than five years' education experience implies they can be considered as 'inexperienced'. Potentially this may have had an impact on the time spent on the different workload activities of the nurse educators (Organisation for Economic Co-operation Development [OECD], 2012:476).

EDUCATION EXPERIENCE OF PARTICIPANTS (N=18)

- 10-14 Years 40%
- 1-4 Years 26%
- 5-9 Years 34%
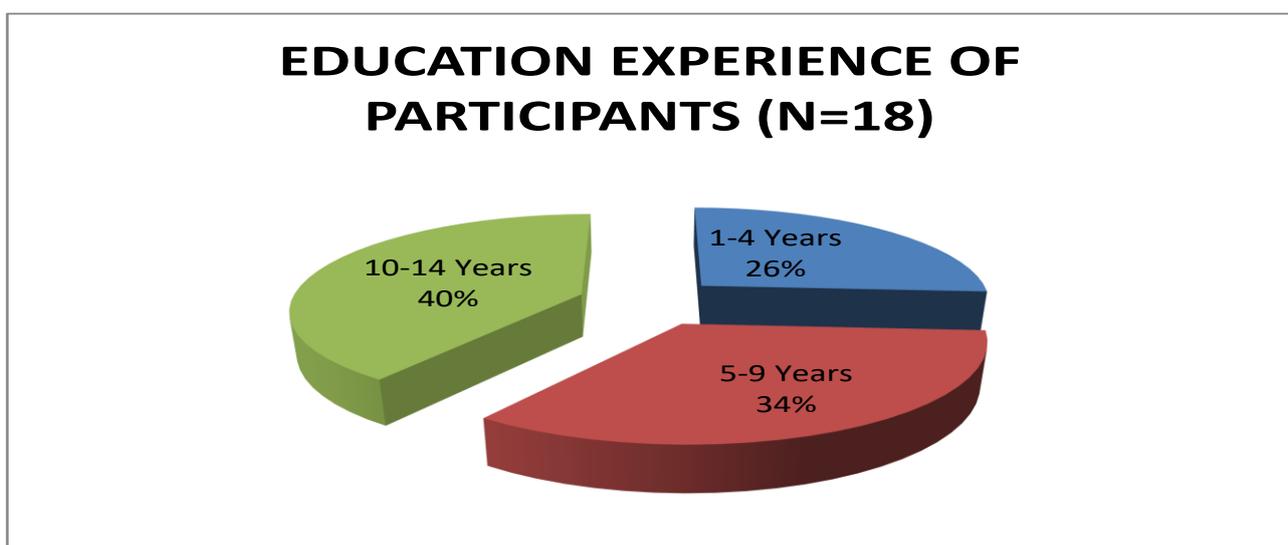
Figure 7.4: Educational experience of respondents

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The bar charts, histograms and tables that follow summarise the actual time spent by the respondents (N=18) on teaching, clinical and service activities and other activities as recorded over a period of nine months. Notwithstanding the fact that the respondents attempted their utmost to accurately record the time duration of each workload activity during the research period, the high day-to-day workload may have resulted in the occasional omission of some recordings. The findings of the numerical data represent the recorded 1 620 observations received from the respondents (N=18) for the nine-month period, from March 2016 to November 2016.

The recorded teaching activities of the respondents are presented in Figures 7.5 to 7.10. It includes the facilitation of contact sessions, teaching preparation, setting of tests, invigilation of tests and examinations, moderation of tests, examination papers and assignments, marking of tests, examination scripts, assignments and portfolio of evidence. Figure 7.5 illustrates the majority of recorded observations, 63% (n=60),

indicate between 11 and 40 hours per month were spent on the facilitation of contact sessions.
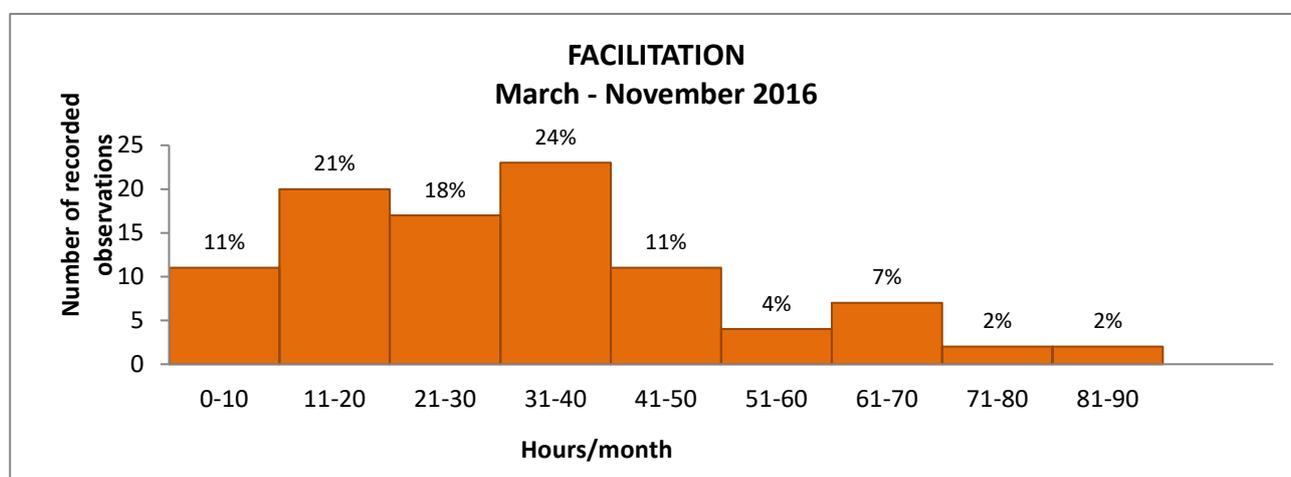
Figure 7.5: Hours spent on facilitation

The recorded facilitation hours also show an average (mean) of 33.69 hours per month for the Western Cape region with a standard deviation of 19.25 hours followed by Tshwane region with an average (mean) of 31.62 hours per month and a standard deviation of 19.71 hours. The Central region showed an average (mean) of 28.29 hours per month and a standard deviation of 21.55 hours. In total the average (mean) is 31.93 facilitation hours

per month with a standard deviation of 19.25 hours. The monthly average of Tshwane region is the closest to the overall monthly average while the monthly average of the Western Cape region is much higher than the overall monthly average and the monthly average of the Central region is much lower than the overall monthly average.

Sixty-one per cent (n=57) of the recorded observations indicate 10 hours per month of teaching preparation time over the nine-month period as shown in Figure 7.6.
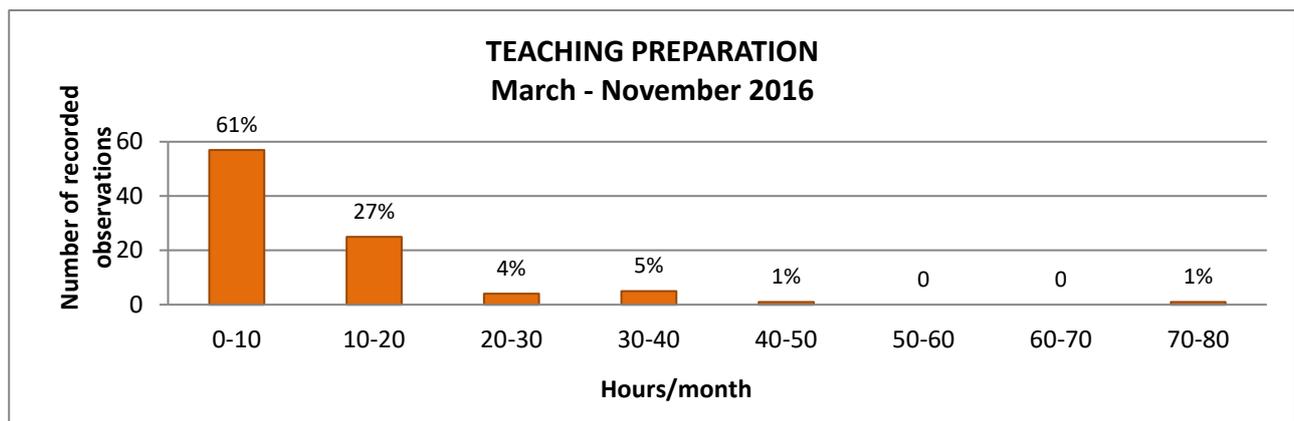
Figure 7.6: Hours spent on teaching preparation

The recorded teaching preparation hours show an average (mean) of 15.94 hours for the Central region with a standard deviation of 9.82 hours followed by Tshwane region with an average (mean) of 11.18 hours and a standard deviation of 13.59 hours and the Western Cape region with an average (mean) of 9.29 hours and a standard deviation of 5.23 hours. In total the average (mean) is 11.00 hours of teaching preparation per month with a standard deviation of 10.93 hours. The average of Tshwane region is the closest to the overall average while the average of the Central region is much higher than the overall average and the average of the Western Cape region is much lower than the overall average.

The setting of tests over the nine-month period took five to 10 hours monthly according to 35% (n=26) of the recorded observations as presented in Figure 7.7.

SETTING TESTS
March - November 2016
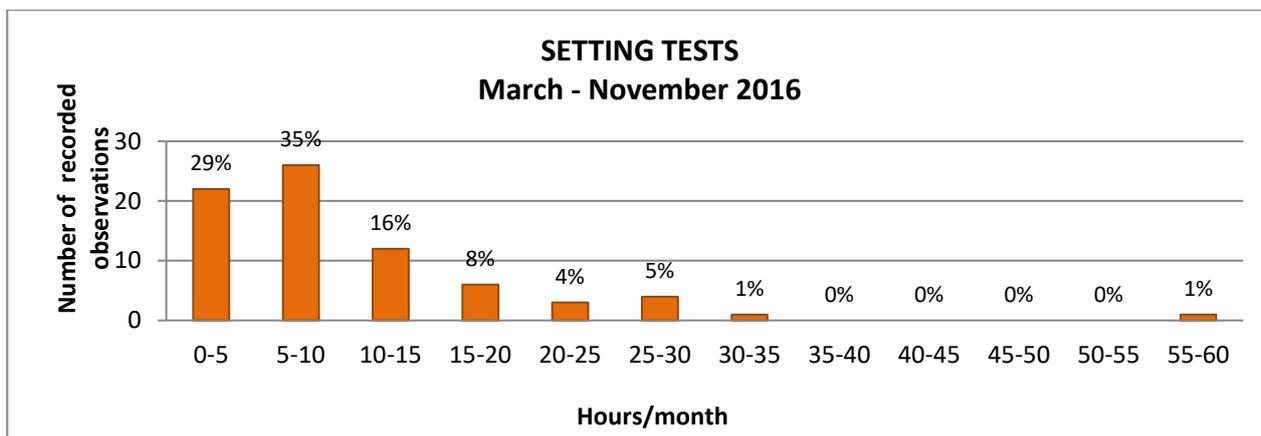
Figure 7.7: Hours spent on setting tests

The recorded setting tests hours show an average (mean) of 11.42 hours for the Western Cape region with a standard deviation of 7.93 hours followed by Tshwane region with an average (mean) of 10.51 hours and a standard deviation of 1.62 hours and the Central region with an average (mean) of 7.99 hours and a standard deviation of 2.66 hours. In total the average (mean) is 10.16 facilitation hours with a standard deviation of 9.46 hours. The average of Tshwane region is the closest to the overall average while the average of the Western Cape region is much higher than the overall average and the average of the Central region is much lower than the overall average.

Most of the time spent with invigilation of tests and examinations over the nine-month period were five to 10 hours per month as indicated by 35% (n=19) of the received observations in Figure 7.8.

INVIGILATION
March - November 2016
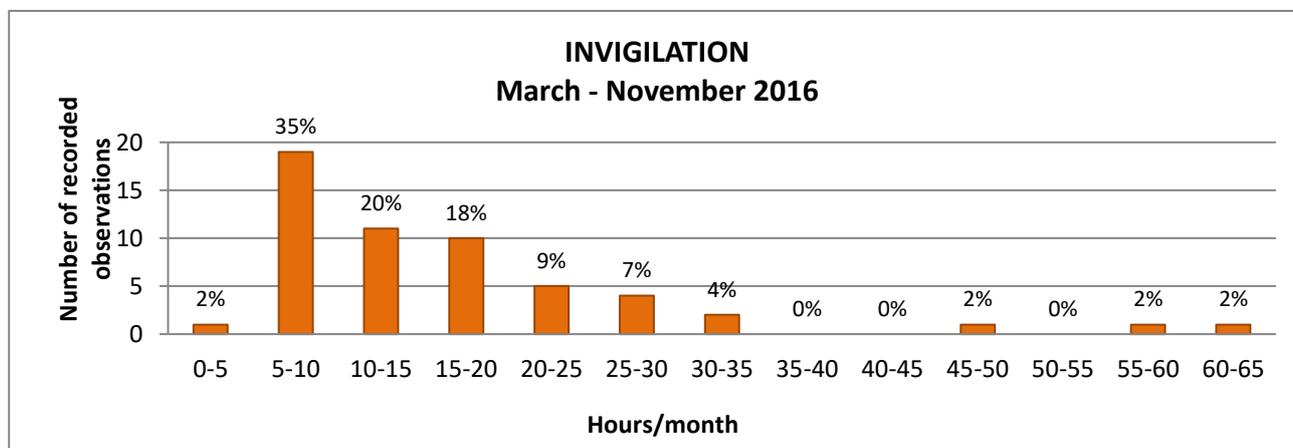
Figure 7.8: Hours spent on invigilation

The recorded invigilation hours indicate an average (mean) of 5.13 hours for the Central region with a standard deviation of 3.77 hours followed by Tshwane region with an average (mean) of 3.66 hours and a standard deviation of 2.27 hours and the Western Cape region with an average (mean) of 2.73 hours and a standard deviation of 1.16 hours. In total the average (mean) is 3.60 facilitation hours with a standard deviation of 2.39 hours. The average of Tshwane region is the closest to the overall average, while the average of the Central region is much higher than the overall average and the average of the Western Cape region is much lower than the overall average.

During the nine-month period, zero to five hours per month were spent on the moderating of tests, examination papers, examination scripts and assignments as indicated by 54% (n=28) of the recorded observations illustrated in Figure 7.9.
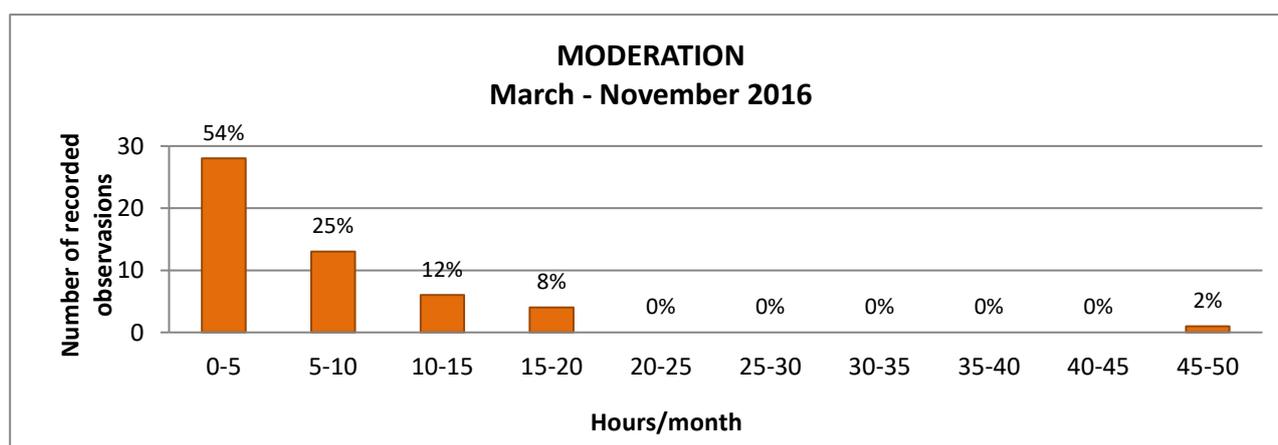
Figure 7.9: Hours spent on moderation

The recorded moderation hours show an average (mean) of 11.68 hours for the Central region with a standard deviation of 13.95 hours followed by the Western Cape region with an average (mean) of 6.95 hours and a standard deviation of 5.54 hours and Tshwane region with an average (mean) of 4.68 hours and a standard deviation of 4.28 hours. In total the average (mean) is 6.94 moderation hours with a standard deviation of 7.75 hours. The average of the Western Cape region is the closest to the overall average, while the average of the Central region is much higher than the overall average and the average of Tshwane region is much lower than the overall average.

During the nine-month period the highest percentage (65%) (n=55) of the recorded observations was for the marking of tests, examination scripts, assignments and portfolio of evidence over a period of zero to 10 hours per month as shown in Figure 7.10.

MARKING
March - November 2016
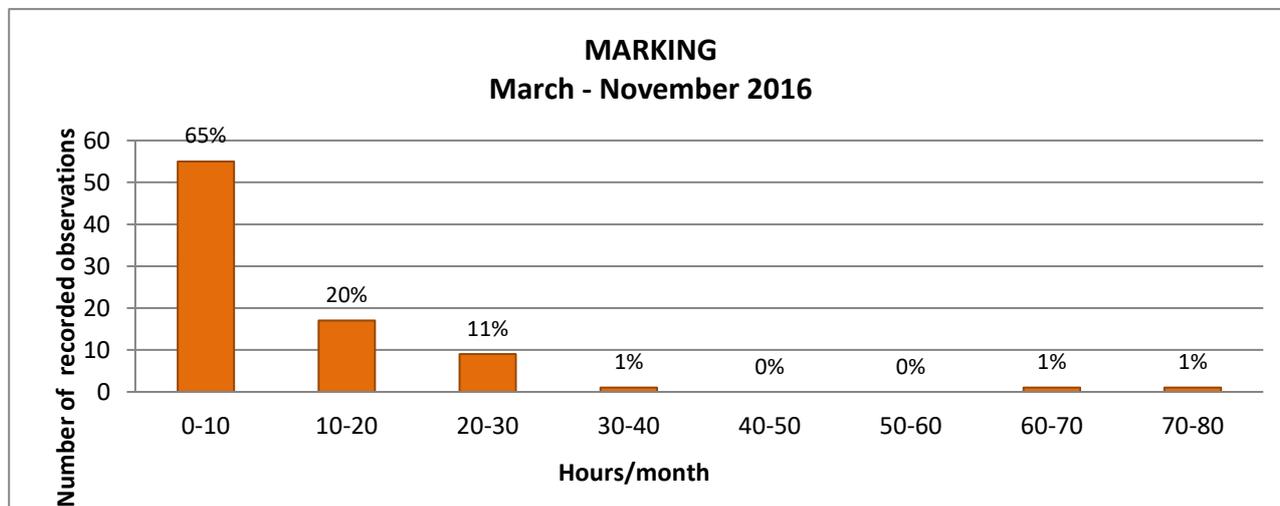
Figure 7.10: Hours spent on marking

The recorded marking hours indicate an average (mean) of 21.39 hours for the Central region with a standard deviation of 22.64 hours followed by the Western Cape region with an average (mean) of 9.52 hours and a standard deviation of 6.71 hours and Tshwane region with an average (mean) of 7.73 hours and a standard deviation of 6.12 hours. In total the average (mean) is 10.62 marking hours with a standard deviation of 11.73 hours. The average of the Western Cape region is the closest to the overall average, while the average of the Central region is much higher than the overall average and the average of Tshwane region is much lower than the overall average. Table 7.1 summarise the various teaching activities.

Table 7.1: Summary of the various teaching activities of the teaching workload

Teaching activities	Western Cape region average hours/month	Central region average hours/month	Tshwane region average hours/month	Average hours/month
Facilitation	33.69	28.29	31.62	31.93
Teaching preparation	9.29	15.94	11.18	11.00
Marking	9.52	21.39	7.73	10.62
Setting tests	11.42	7.99	10.51	10.16
Moderation	6.95	11.68	4.68	6.94
Invigilation	2.73	5.13	3.66	3.60
Total	**73.6**	**90.42**	**69.38**	**74.25**

An average of 74.25 hours were monthly spend on teaching activities which is 44% of the 168 hours a nurse educator works per 21 working days per month. The Central region spent an average of 90.42 hours (54%) on teaching activities followed by the Western Cape region with 73.6 hours (44%) and Tshwane region with an average of 69.38 hours (41%). According to literature as far back as 1994, nurse educators have to spend 40% of their time on teaching (American Association of University Professors, 2000:69; Mancing, 1994:32). It is not specified which activities were taken into account by these authors to arrive at this teaching workload percentage.

The findings of the clinical activities of the nurse educators are presented in Figures 7.11 to 7.17. These activities include clinical accompaniment of students, assessments of the skills of the students, demonstrations and the preparation thereof, practical examinations and the preparation thereof and clinical allocation of students. Clinical guidance is a very important variable in the workload of the nurse educator. Figure 7.11 shows a large and uneven distribution of the recorded observations (n= 88) over the nine-month period. It was indicated clinical accompaniment took up most of the time. Thirty-four per cent (34%) (n=30) required between zero to 10 hours, 20% (n=18) between 15 to 20 hours and 14% (n=12) between 25 to 30 hours per student per month.

CLINICAL ACCOMPANIMENT
March - November 2016

Figure 7.11 chart showing Number of recorded observations versus Hours/hours. Bars with percentage labels: 0-5: 16% (14), 5-10: 18% (16), 10-15: 9% (8), 15-20: 20% (18), 20-25: 8% (7), 25-30: 14% (12), 30-35: 2% (2), 35-40: 5% (4), 40-45: 5% (4), 45-50: 0%, 50-55: 1% (1), 55-60: 1% (1), 60-65: 1% (1).
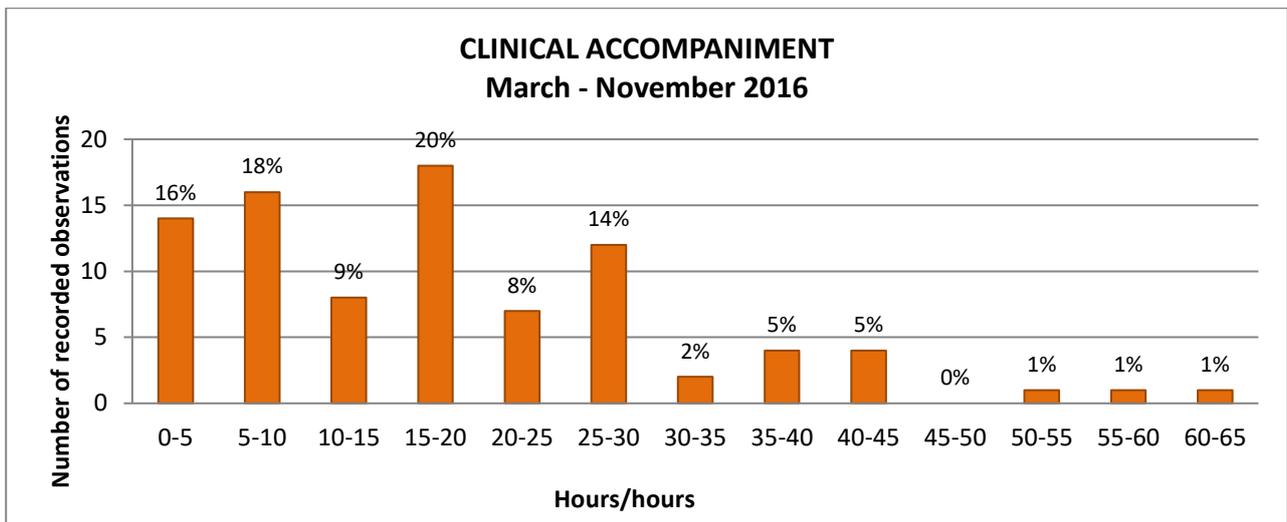
Figure 7.11: Hours spent on clinical accompaniment

The recorded clinical accompaniment hours show an average (mean) of 20.68 hours for Tshwane region with a standard deviation of 14.81 hours followed by the Western Cape region with an average (mean) of 19.04 hours and a standard deviation of 11.14 hours and the Central region with an average (mean) of 4.85 hours and a standard deviation of 5.17 hours. In total the average (mean) is 18.46 clinical accompaniment hours with a standard deviation of 13.58 hours. The average of both Tshwane region and the Western Cape region is higher than the overall average while the average of the Central region is much lower than the overall average.

Recordings collected on assessments reflected 64% of the observations made during the nine-month period indicated between zero and 10 hours per month were required to conduct assessments as indicated in Figure 7.12.

ASSESSMENTS
March - November 2016

Figure 7.12 chart showing Number of recorded observations versus Hours/month. Bars with percentage labels: 0-5: 39% (25), 5-10: 25% (16), 10-15: 6%, 15-20: 8% (5), 20-25: 6%, 25-30: 6%, 30-35: 3%, 35-40: 2%, 40-45: 2%, 45-50: 2%, 50-55: 0%, 55-60: 2%.
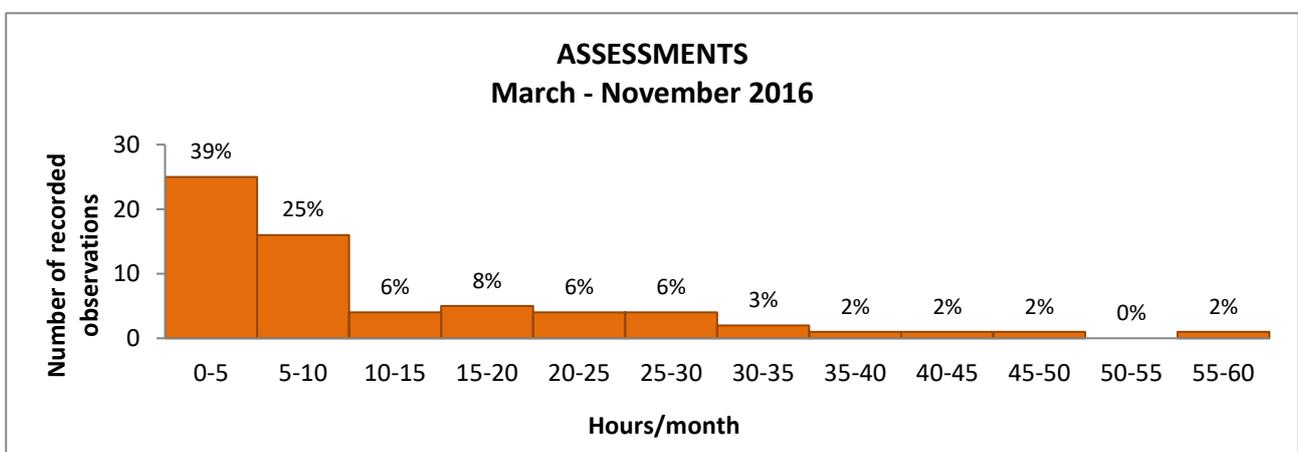
Figure 7.12: Hours spent on assessments

The recorded assessment hours show an average (mean) of 13.79 hours for the Central region with a standard deviation of 16.50 hours followed by the Western Cape region with an average (mean) of 13.78 hours and a standard deviation of 14.66 hours and Tshwane region with an average (mean) of 9.73 hours and a standard deviation of 9.14 hours. In total the average (mean) is 11.82 assessments hours with a standard deviation of 12.60 hours. Both the averages of the Western Cape region and the Central region are higher than the overall average while Tshwane region has a much lower average than the overall average.

The majority (72%) of the recorded observations (n=24) indicated a preparation for demonstration time between zero to three hours per month were required as illustrated in Figure 7.13.
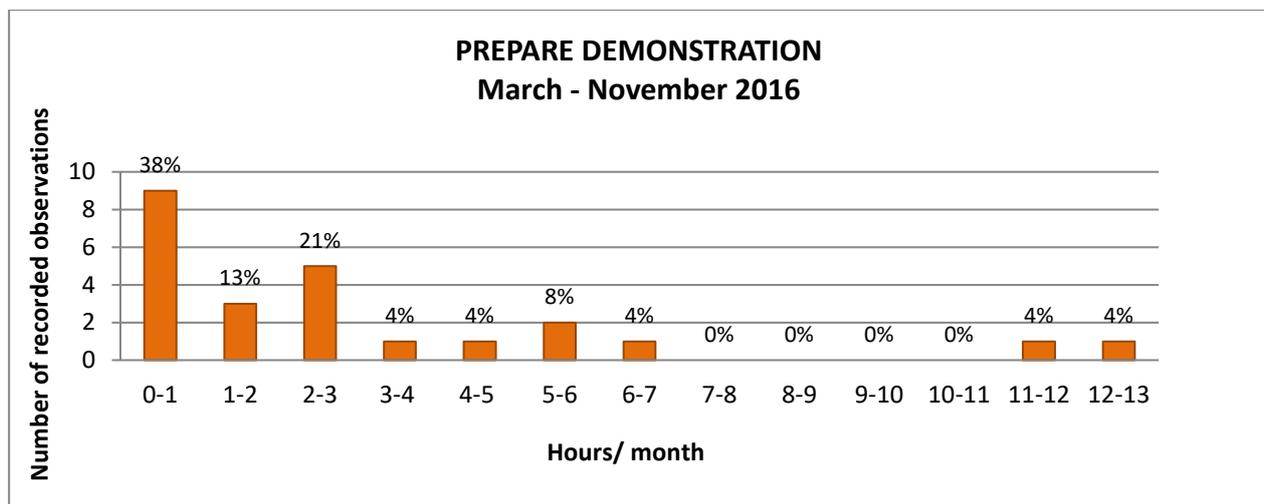
Figure 7.13: Hours spent on preparing for a demonstration

The recorded prepare demonstration hours show an average (mean) of 1.82 hours for the Western Cape region with a standard deviation of 1.82 hours followed by Tshwane region with an average (mean) of 1.61 hours and a standard deviation of 1.73 hours and the Central region with an average (mean) of 0.90 hours and a standard deviation of 0.84 hours. In total the average (mean) is 1.65 preparations for demonstration hours with a standard deviation of 1.68 hours. The average of Tshwane region is the closest followed by the average of the Western Cape region while the Central region's average is much lower than the overall average.

Figure 7.14 illustrates that half (78%) of the received observations (n=32) indicated between zero to four hours per month were spent on demonstrations.

DEMONSTRATIONS
March - November 2016
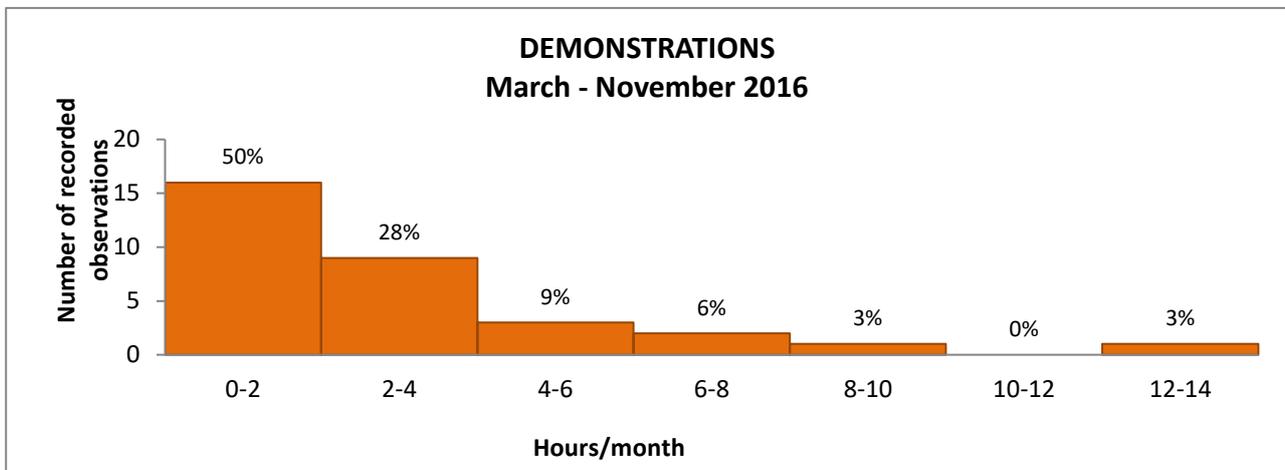
Figure 7.14: Hours spent on demonstrations

The recorded demonstration hours show an average (mean) of 3.58 hours for Tshwane region with a standard deviation of 3.32 hours followed by the Western Cape region with an average (mean) of 2.88 hours and a standard deviation of 1.81 hours and the Central region with an average (mean) of 1.03 hours and a standard deviation of 0.87 hours. In total the average (mean) is 3.16 demonstration hours with a standard deviation of 2.91 hours. The average of Tshwane region is the closest to the overall average while the Western Cape region has a lower average and the Central region has a much lower average than the overall average.

Preparation of practical examination took zero to two hours per month as indicated by 63% (n=24) of the received observations (n=38) over the nine-month period as indicated in Figure 7.15 below.
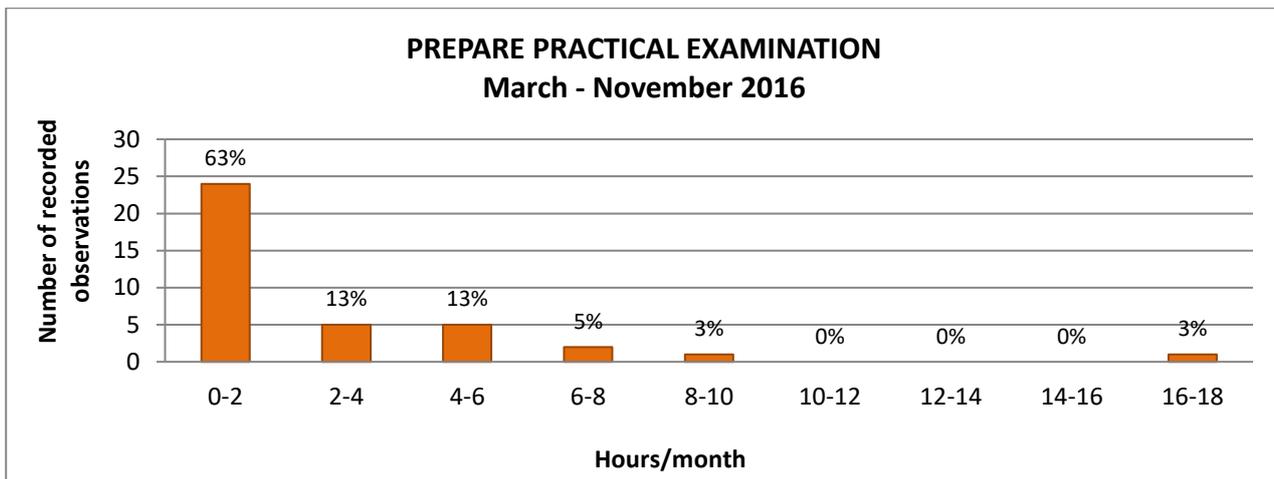
Figure 7.15: Hours spent on preparing for practical examination

The recorded prepare practical examination hours show an average (mean) of 5.65 hours for the Central region with a standard deviation of 5.44 hours followed by the Western Cape region with an average (mean) of 4.17 hours and a standard deviation of 3.82 hours and Tshwane region with an average (mean) of 1.57 hours and a standard deviation of 1.04 hours. In total the average (mean) is 3.01 preparation for practical examination hours with a standard deviation of 3.17 hours. The average of the Western Cape region is much higher than the overall average while Tshwane region's average is lower and the Central region has a much lower average than the overall average.

Practical examination took zero to 15 hours per month as indicated by 59% (n=22) of the recorded observations (n=37) over the nine-month period and illustrated in Figure 7.16.
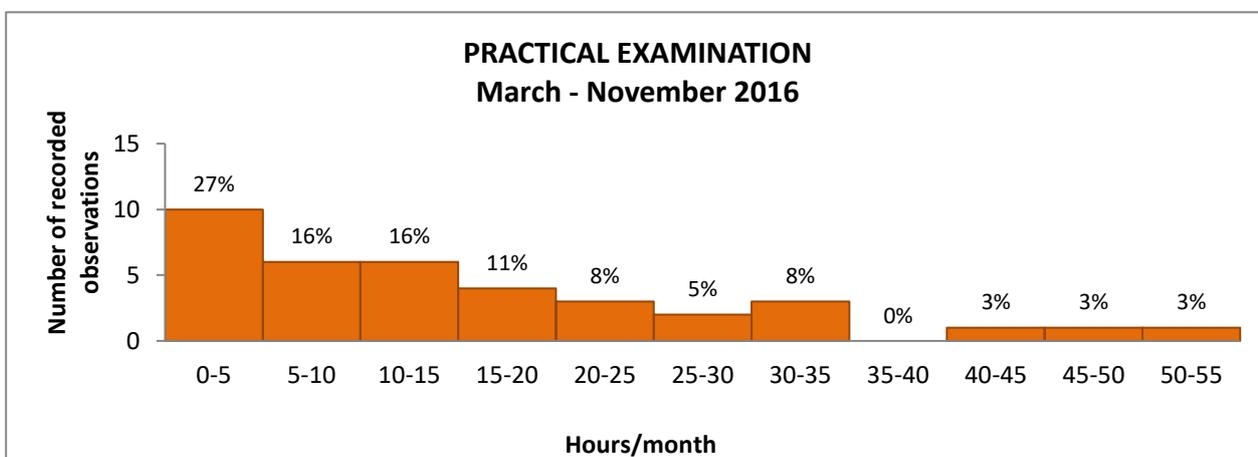
Figure 7.16: Hours spent on practical examination

The recorded practical examination hours show an average (mean) of 21.99 hours for the Western Cape region with a standard deviation of 17.37 hours followed by Tshwane region with an average (mean) of 13.93 hours and a standard deviation of 8.77 hours and the Central region with an average (mean) of 4.96 hours and a standard deviation of 4.17 hours. In total the average (mean) is 15.77 practical examination hours with a standard deviation of 13.42 hours. Tshwane region's average is the closest to the total average while the Western Cape region is much higher and the Central region much lower than the overall average.

Figure 7.17 shows that zero to four hours per month were spent on clinical allocation of students as indicated by 78% (n=53) of the recorded observations (n=68) over a period of nine months.
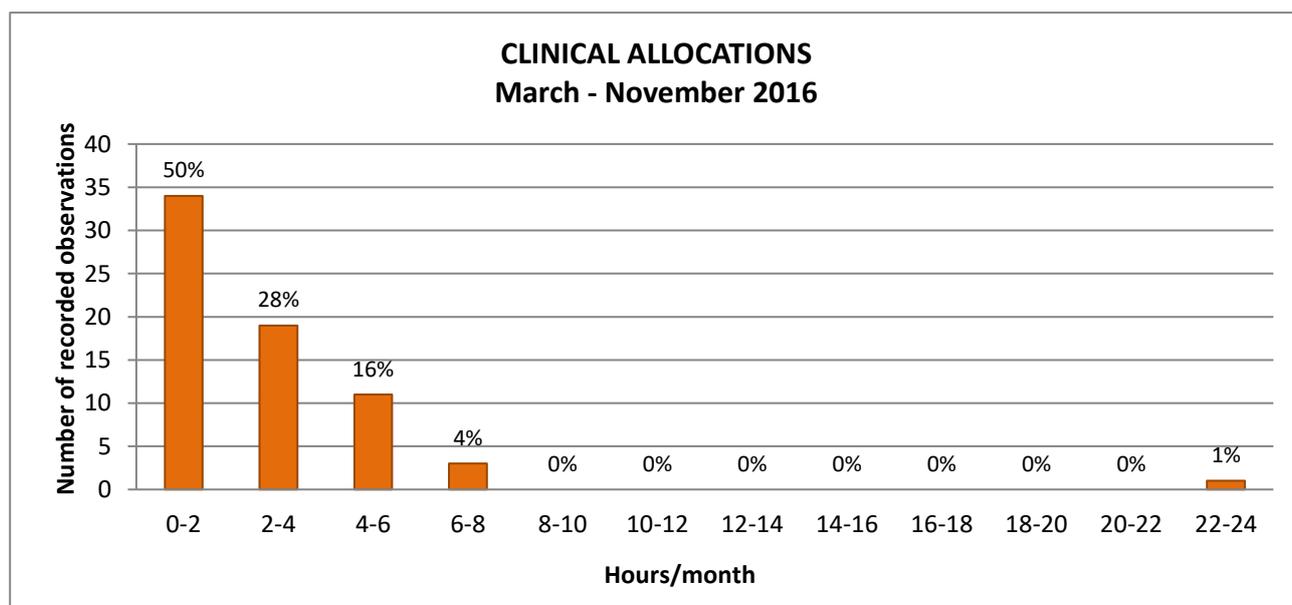
Figure 7.17: Hours spent on clinical allocation

The recorded clinical allocation hours indicate an average (mean) of 4.13 hours for the Central region with a standard deviation of 1.92 hours followed by the Western Cape region with an average (mean) of 2.85 hours and a standard deviation of 1.99 hours and Tshwane region with an average (mean) of 2.38 hours and a standard deviation of 3.84 hours. In total the average (mean) is 2.83 clinical allocation hours with a standard deviation of 3.05 hours. The average of Tshwane region is the closest to the total average

while the Central region is higher and the Western Cape region is lower than the overall average. Table 7.2 summarises the various clinical practice activities.

Table 7.2: Summary of the various clinical practice activities of the clinical practice workload

Clinical practice activities	Western Cape region average hours/month	Central region average hours/month	Tshwane region average hours/month	Average hours/month
Clinical accompaniment	19.04	4.85	20.68	18.46
Assessments	13.78	13.79	9.73	11.82
Prepare demonstrations	1.82	0.90	1.61	1.65
Demonstrations	2.88	1.03	3.58	3.16
Prepare practical examination	4.17	5.65	1.57	3.01
Practical examination	21.99	4.96	13.96	15.77
Clinical allocation	2.85	4.13	2.38	2.83
Total	**66.53**	**35.31**	**53.51**	**56.70**

An average of 56.70 hours was spent monthly on clinical practice activities. This is 34% of the 168 hours a nurse educator works per 21 working days per month. The Western Cape region spent an average of 66.53 hours (40%) on clinical practice activities followed by Tshwane region with an average of 53.51 hours (32%) and the Central region with an average of 35.31 hours (21%). The American Association of Colleges of Nursing (2005), Premji *et al.* (2010:880-881) and Williams and Taylor (2008:900) suggest allocations of up to 20% of a nurse educator's time be dedicated to faculty practice. These authors do not specify which clinical practice activities were taken into account in determining the faculty practice workload.

The recordings of the various administrative activities of the nurse educators are presented in Figures 7.18 to 7.22. It includes the management of emails, letters and

monthly reports of the students, making photocopies, record-keeping, counselling and learner support.

The management of emails took 10 to 15 hours per month for 39% (n=43) and 10 to 20 hours per month for 61% (n=67) of the received observations (n=109) over the nine-month period as indicated in Figure 7.18.
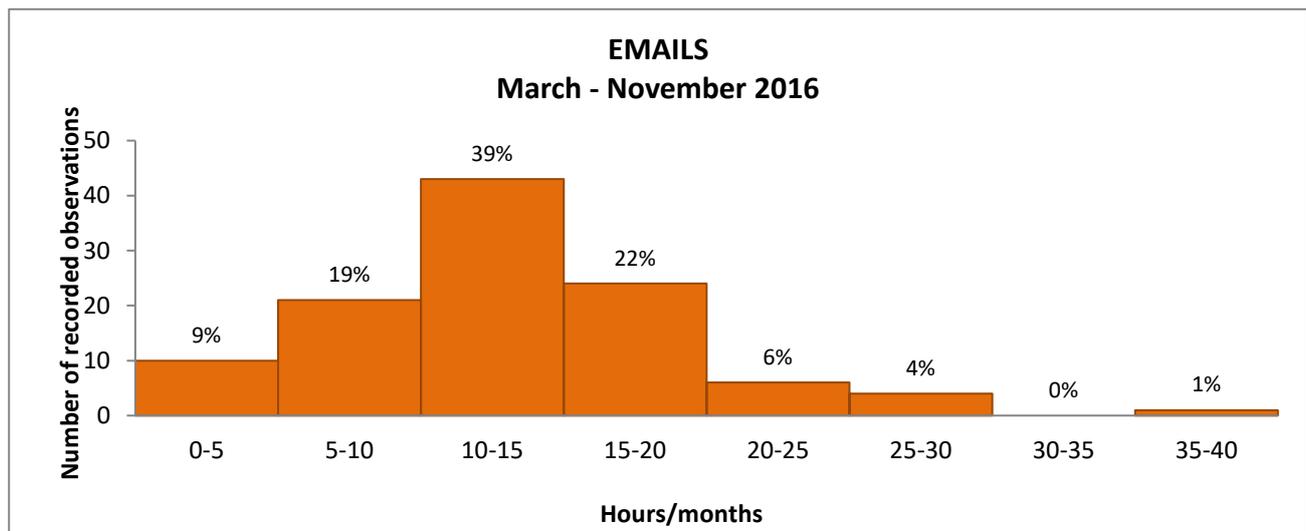
Figure 7.18: Hours spent on emails

The recorded email hours show an average (mean) of 14.37 hours for the Central region with a standard deviation of 5.39 hours followed by Tshwane region with an average (mean) of 13.72 hours and a standard deviation of 7.31 hours and the Western Cape region with an average (mean) of 11.60 hours and a standard deviation of 3.98 hours. In total the average (mean) is 13.09 hours spent on emails with a standard deviation of 6.17 hours. The average of Tshwane region is the closest to the total average while the Central region is higher and the Western Cape region lower than the overall average.

Figure 7.19 shows 59% (n=35) of the recorded observations (n=59) indicated time spent on report writing takes zero to two hours per month over the nine-month period.

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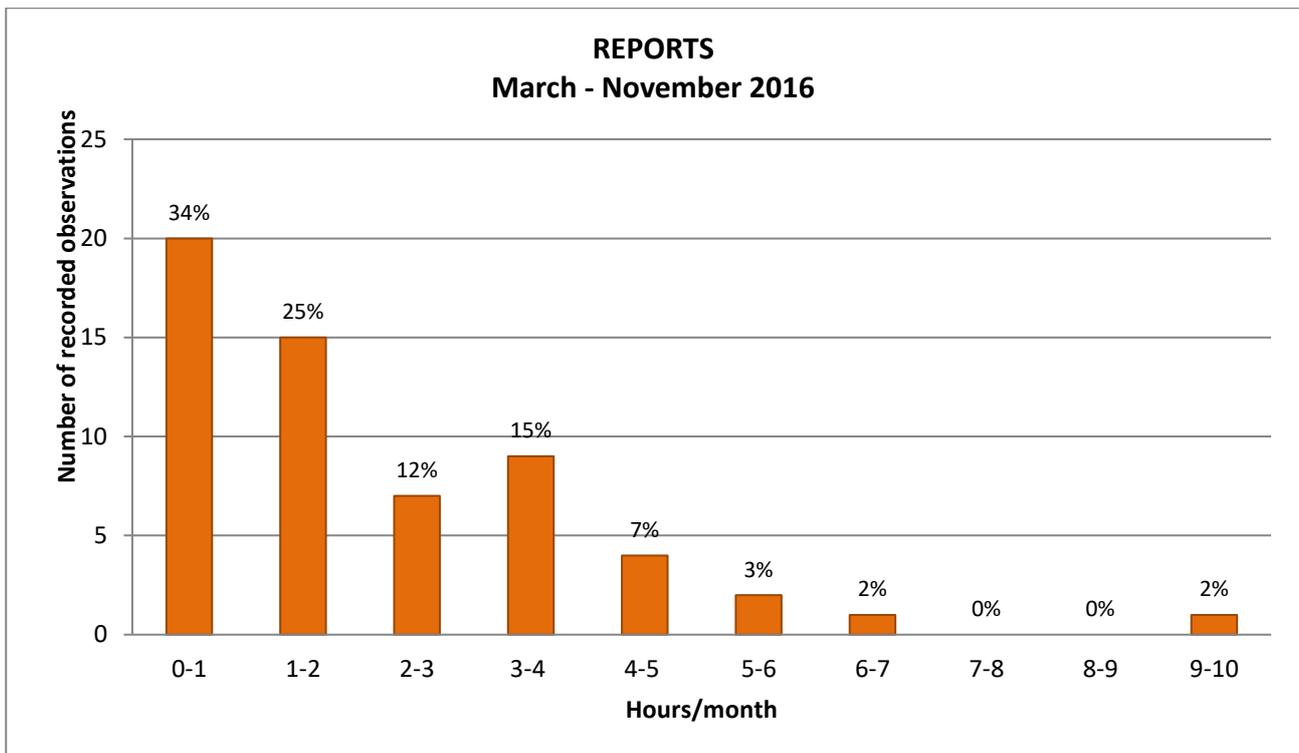
Figure 7.19: Hours spent on reports

The recorded report hours indicate an average (mean) of 2.71 hours for the Western Cape region with a standard deviation of 2.26 hours followed by the Central region with an average (mean) of 2.40 hours and a standard deviation of 1.43 hours and Tshwane region with an average (mean) of 1.83 hours and a standard deviation of 1.65 hours. In total the average (mean) is 2.25 hours spent on reports with a standard deviation of 1.87 hours. The average of Tshwane region is the closest to the total average while the Western Cape region is higher and the Central region lower than the overall average.

Over the period of nine months, according to 73% (n=76) of the received observations (n=1040), it took zero to 30 hours per month to carry out the record-keeping activities as indicated in Figure 7.20.

RECORD-KEEPING
March - November 2016
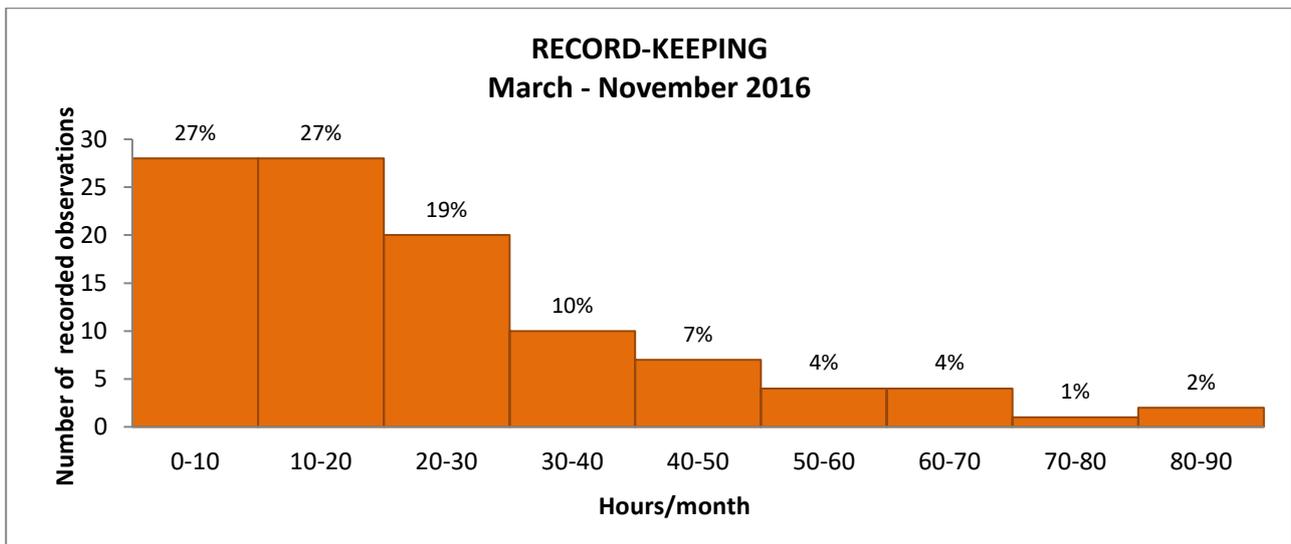
Figure 7.20: Hours spent on record-keeping

The recorded record-keeping hours indicate an average (mean) of 27.57 hours for the Western Cape region with a standard deviation of 21.18 hours followed by Tshwane region with an average (mean) of 21.94 hours and a standard deviation of 17.83 hours and the Central region with an average (mean) of 18.19 hours and a standard deviation of 16.61 hours. In total the average (mean) is 23.29 hours spent on record-keeping with a standard deviation of 18.97 hours. The average of Tshwane region is the closest to the total average while the Western Cape region is much higher and the Central region much lower than the overall average.

Figure 7.21 shows zero to one hour per month was spent by nurse educators over a period of nine months on making photocopies as indicated by 52% (n=27) of the recorded observations (n=52).

PHOTOCOPIES
March - November 2016
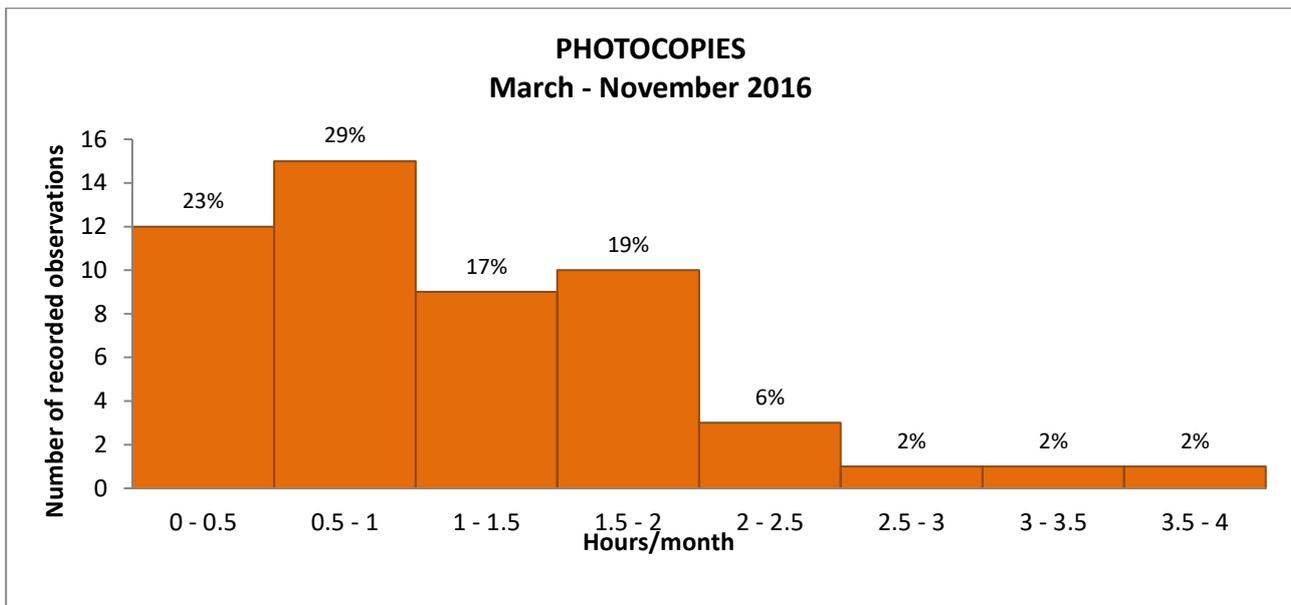
Figure 7.21: Hours spent on photocopies

The recorded photocopying hours indicate an average (mean) of 1.66 hours for the Western Cape region with a standard deviation of 0.90 hours followed by Tshwane region with an average (mean) of 1.08 hours and a standard deviation of 0.66 hours and the Central region with an average (mean) of 0.53 hours and a standard deviation of 0.25 hours. In total the average (mean) is 1.27 hours spend on photocopies with a standard deviation of 0.81 hours. The average of Tshwane region is the closest to the total average while the Western Cape region is higher and the Central region lower than the overall average.

The counselling and support of learners took approximately one to three hours per month for 71% (n=31) of the received observations (n=44) over the nine-month period as indicated in Figure 7.22.
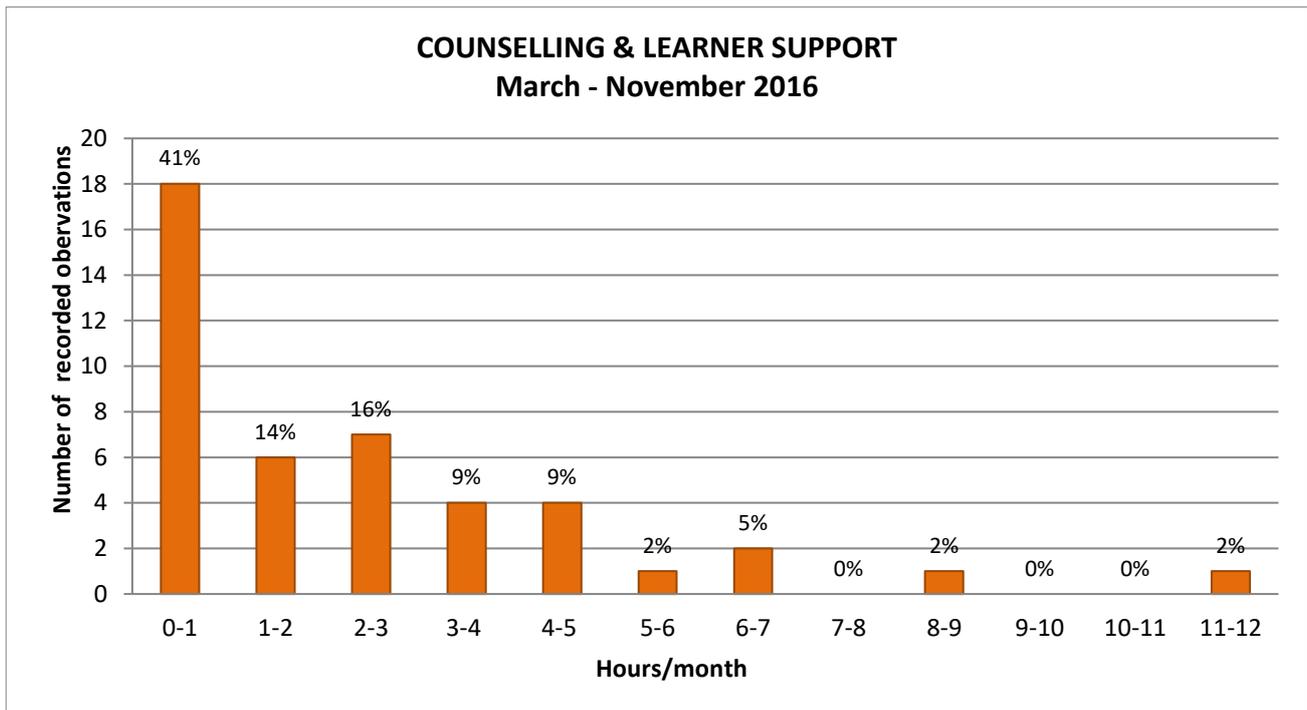
Figure 7.22: Hours spent on counselling and learner support

The recorded counselling and support of learner hours indicate an average (mean) of 2.70 hours for Tshwane region with a standard deviation of 2.88 hours followed by the Western Cape region with an average (mean) of 2.47 hours and a standard deviation of 2.25 hours and the Central region with an average (mean) of 2.24 hours and a standard deviation of 2.25 hours. In total the average (mean) is 2.53 counselling and learner support hours with a standard deviation of 2.47 hours. The average of the Western Cape region is the closest to the total average while Tshwane region is higher and the Central region lower than the overall average. In Table 7.3 the various administrative activities are summarised.

Table 7.3: Summary of the various administrative activities of the administrative workload

Administrative activities	Western Cape region average hours/month	Central region average hours/month	Tshwane region average hours/month	Average hours/month
Emails	11.60	14.37	13.72	13.09
Reports	2.71	2.40	1.83	2.25
Record-keeping	27.57	18.19	21.94	23.29
Photocopies	1.66	0.66	1.08	1.27
Counselling and learner support	2.47	2.24	2.70	2.53
Total	**46.01**	**37.86**	**41.27**	**42.43**

An average of 42.43 hours was spent monthly on administrative activities which is 25% of the 168 hours a nurse educator works per 21 work days per month. The Western Cape region spent an average of 46.01 hours (27%) on administrative activities followed by Tshwane region with an average of 41.27 hours (25%) and the Central region with an average of 37.86 hours (23%). In their 40:40:20 formula, the American Association of University Professors (2000:69) and Mancing (1994:32) suggest an allocation of 20% service time as a standard. These sources do not specify which administrative activities were taken into account to determine the service time.

The total average time spent by the nurse educator on teaching workload activities (74.25 hours), clinical practice workload activities (56.70 hours) and administrative workload activities (42.43 hours) are 173.38 hours per month. The total monthly average time spent change significantly when the average hours of the various other monthly activities are also taken into account. The recordings of the various other activities of the nurse educators are presented in Figures 7.23 to 7.29 which include travelling, meetings, workshops, work at home, review study material, development of study material and ad hoc. Of the received recorded observations (n=103) showed 91% (n=94) meetings took between zero to ten hours per month over the nine-month period as indicated in Figure 7.23.
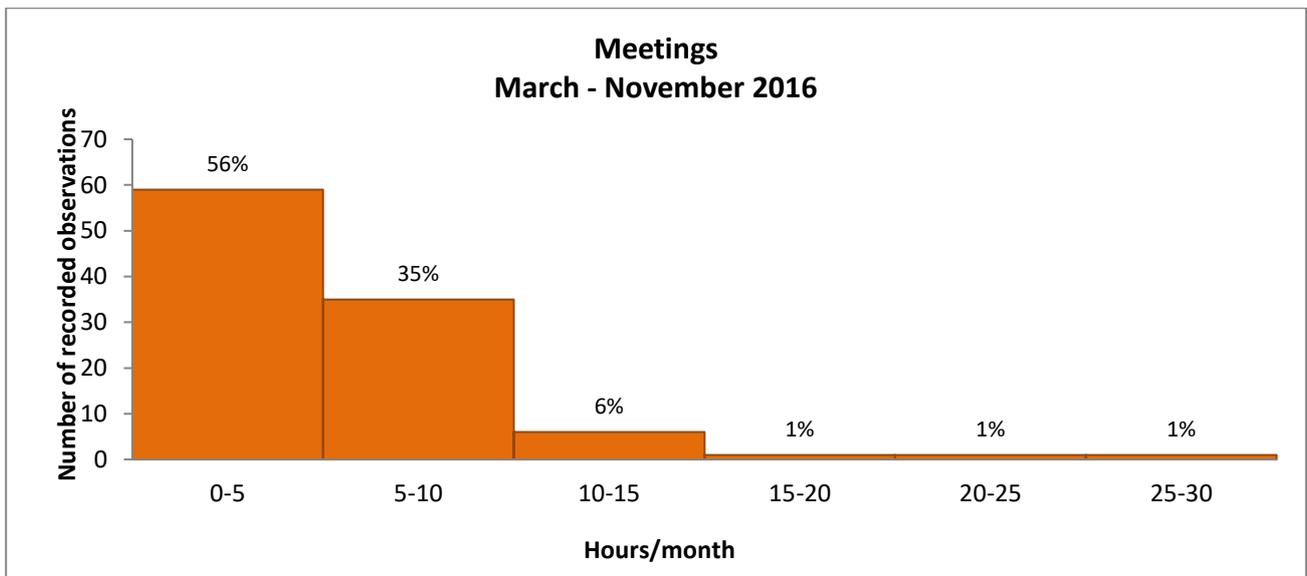
Figure 7.23: Hours spent on meetings

The recorded meeting hours indicate an average (mean) of 6.11 hours for the Central region with a standard deviation of 6.64 hours followed by Tshwane region with an average (mean) of 5.67 hours and a standard deviation of 3.42 hours and the Western Cape region with an average (mean) of 4.10 hours and a standard deviation of 4.64 hours. In total the average (mean) is 5.15 hours spent on meetings with a standard deviation of 4.34 hours. The average of Tshwane region is the closest to the total average, while the Central region is much higher and the Western Cape region lower than the overall average.

Figure 7.24 shows zero to 10 hours per month was spent on workshops over a period of nine months as indicated by 73% (n=25) of the recorded observations (n=34).
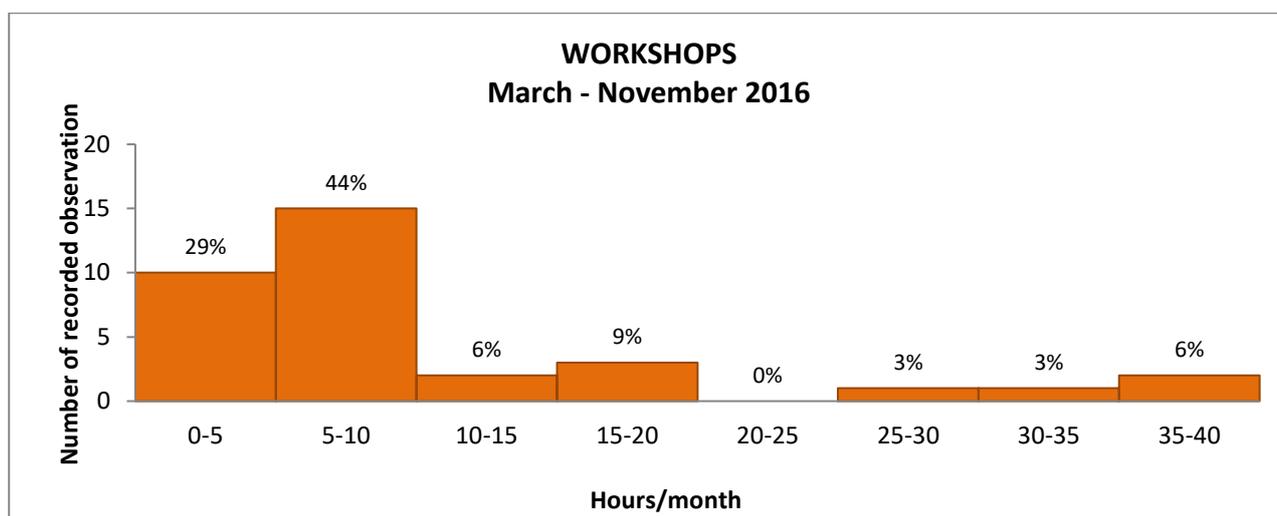
Figure 7.24: Hours spent on workshops

The recorded workshop hours indicate an average (mean) of 18.26 hours for the Central region with a standard deviation of 10.54 hours followed by the Western Cape region with an average (mean) of 9.48 hours and a standard deviation of 2.73 hours and Tshwane region with an average (mean) of 8.01 hours and a standard deviation of 1.83 hours. In total the average (mean) is 9.49 hours spent on workshops with a standard deviation of 1.62 hours. The average of the Western Cape region is the closest to the total average while the Central region is much higher and Tshwane region lower than the overall average.

During the nine-month period 71% (n=68) of the recorded observations (n=95) indicated travelling time of zero to 15 hours per month as shown in Figure 7.25.

TRAVELLING
March - November 2016
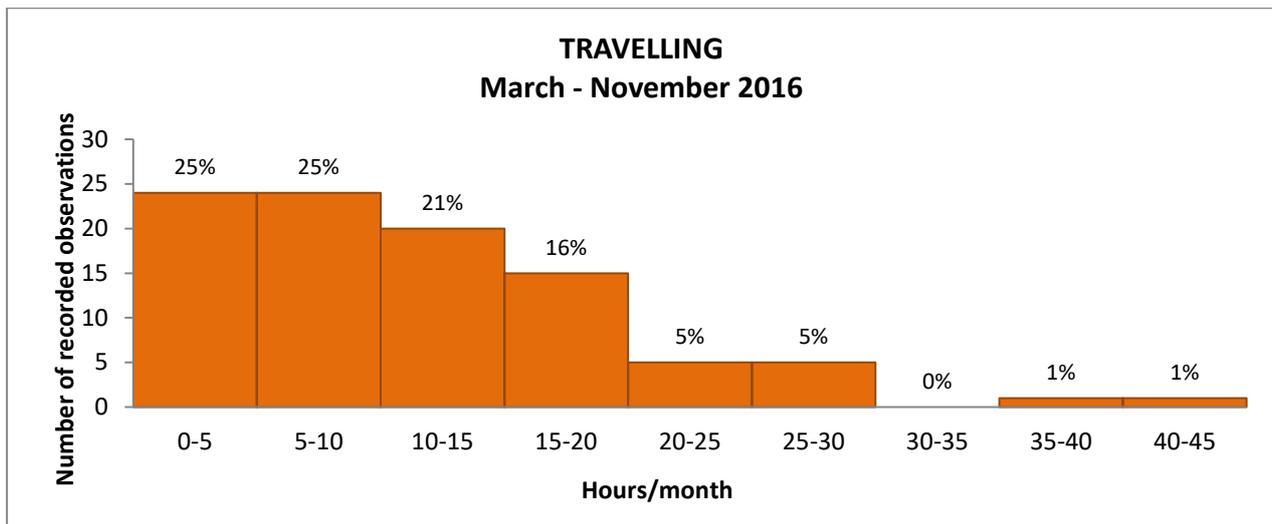
Figure 7.25: Hours spent on travelling

The recorded travelling hours indicate an average (mean) of 13.90 hours for the Western Cape region with a standard deviation of 8.07 hours followed by Tshwane region with an average (mean) of 9.73 hours and a standard deviation of 8.20 hours and the Central region with an average (mean) of 8.88 hours and a standard deviation of 9.09 hours. In total the average (mean) is 11.32 hours spent on travelling with a standard deviation of 8.36 hours. The average of the Western Cape region is much higher than the total average while the Central region and Tshwane region are lower than the overall average.

Seventy-one per cent (71%) (n=26) of the recorded observations (n=37) over the nine-month period indicated that between zero to 10 hours per month were spent on the review of study material as shown in Figure 7.26.

REVIEW STUDY MATERIAL
March - November 2016
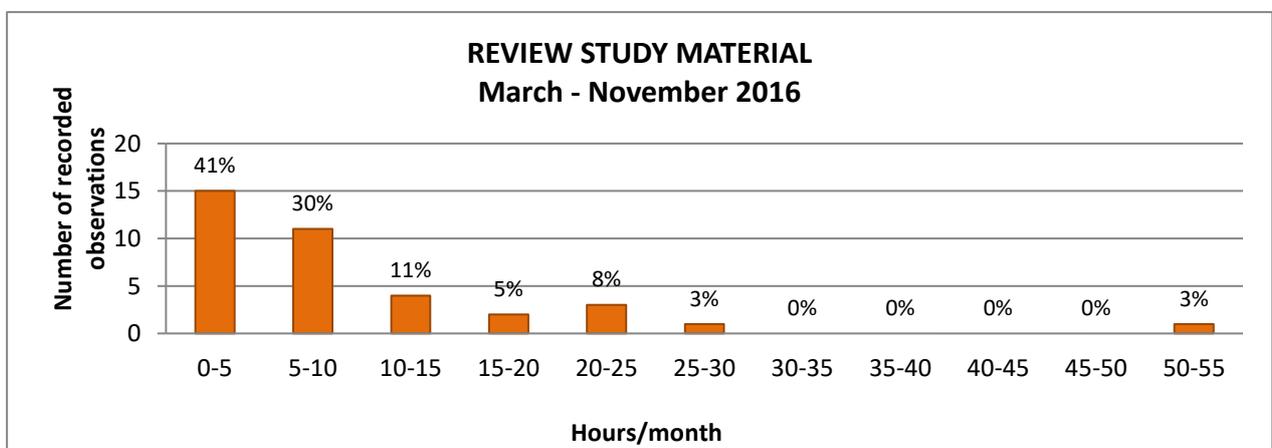
Figure 7.26: Hours spent on review of study material

The recorded review of study material hours show an average (mean) of 12.61 hours for the Central region with a standard deviation of 14.95 hours followed by Tshwane region with an average (mean) of 8.41 hours and a standard deviation of 6.61 hours and the Western Cape region with an average (mean) of 5.61 hours and a standard deviation of 7.92 hours. In total the average (mean) is 9.05 hours spent on the review of study material monthly with a standard deviation of 10.08 hours. The average of Tshwane region is the closest while the average of the Central region is much higher than the total average and the Western Cape region is lower than the overall average.

Figure 7.27 illustrates 79% (n=26) of the recorded observations (n= 33) on the development of study material took zero to 20 hours per month over the nine-month period.
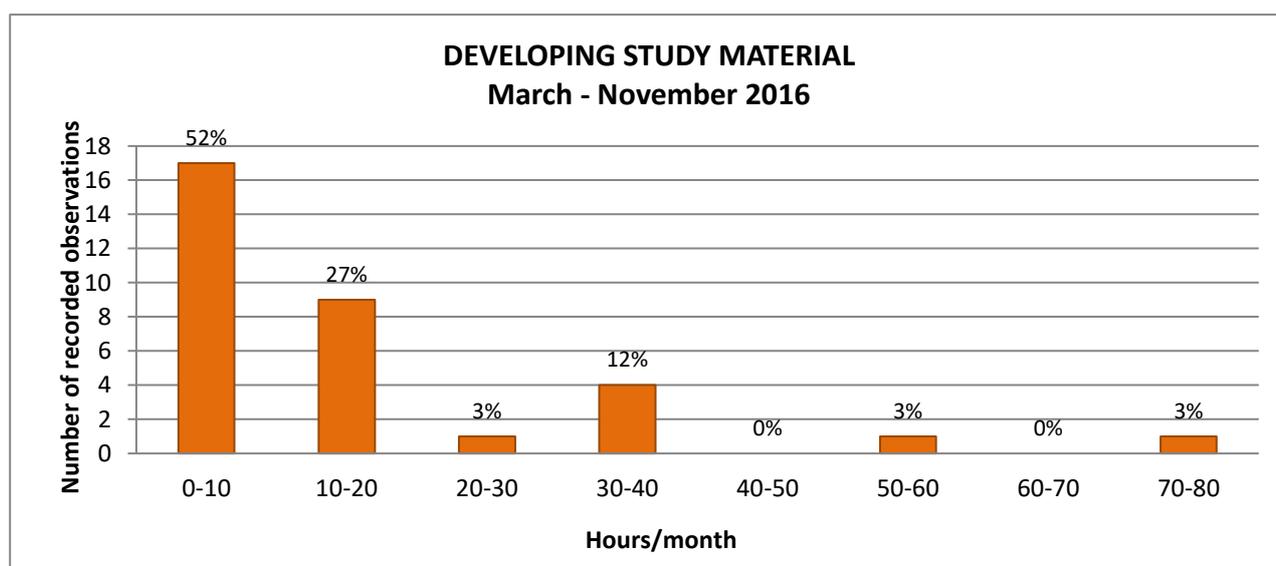
Figure 7.27: Hours spent on developing study material

The recorded developing study material hours show an average (mean) of 20.85 hours for Tshwane region with a standard deviation of 22.55 hours followed by the Central region with an average (mean) of 18.42 hours and a standard deviation of 16.83 hours and the Western Cape region with an average (mean) of 9.58 hours and a standard deviation of 9.57 hours. In total the average (mean) is 14.80 hours spent monthly on the development of study material with a standard deviation of 16.10 hours. The average of Tshwane region

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is much higher than the overall average followed by the high average of the Central region while the Western Cape region has a lower average than the overall average.

Seventy-eight per cent (78%) (n=41) of the recorded observation (n=53) indicated that zero to 10 hours per month were spent on ad hoc activities such as student interviews and reception duties over the nine-month period as shown in Figure 7.29.
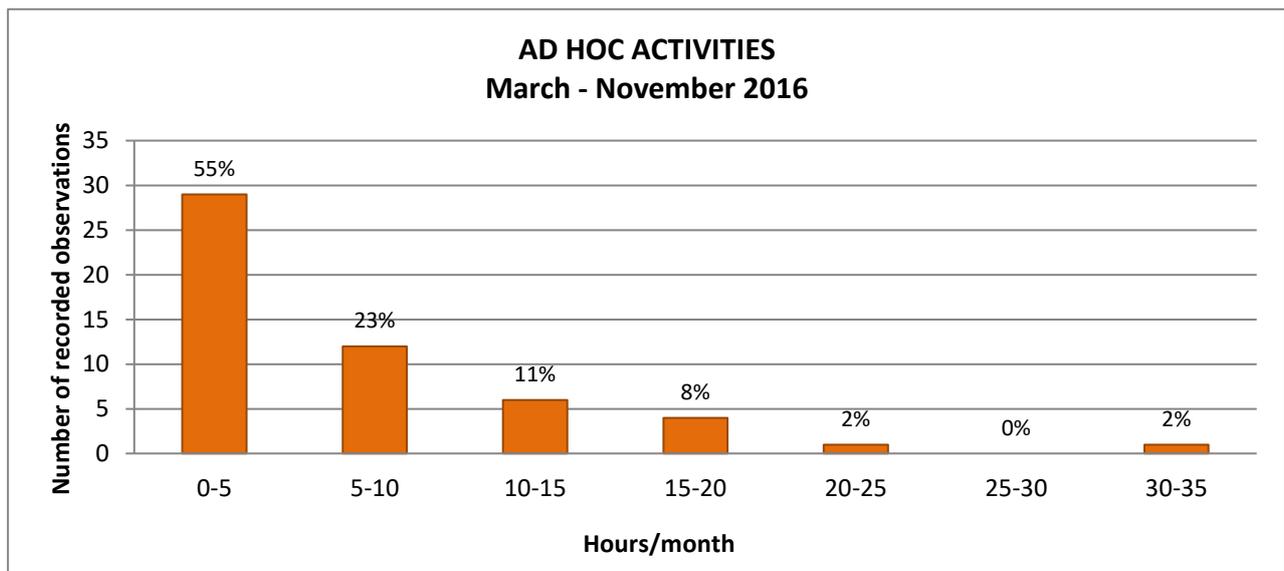
Figure 7.28: Hours spent on ad hoc activities

The recorded ad hoc hours show an average (mean) of 8.03 hours for the Central region with a standard deviation of 10.72 hours followed by Tshwane region with an average (mean) of 6.71 hours and a standard deviation of 6.10 hours and the Western Cape region with an average (mean) of 4.38 hours and a standard deviation of 4.11 hours. In total the average (mean) is 6.34 hours monthly spent on ad hoc activities with a standard deviation of 6.771 hours. The average of Tshwane region is the closest to the overall average while the Western Cape region has a higher average and the Central region a lower average than the overall average. In Table 7.4 a summary is given of the various other activities of the nurse educators.

Table 7.4: Summary of the various other activities of the nurse educators' workload

Other activities	Western Cape region average hours/month	Central region average hours/month	Tshwane region average hours/month	Average hours/month
Meetings	4.10	6.11	5.67	5.19
Workshops	9.48	18.26	8.01	10.45
Travelling	13.90	8.88	9.73	11.32
Review study material	5.61	12.61	8.41	9.05
Develop study material	9.58	18.42	20.85	14.80
Ad hoc activities	4.38	8.03	6.71	6.34
Total	**47.05**	**72.31**	**59.38**	**57.15**

An average of 57.15 hours was monthly spent on other workload activities which take up 36% of the 160 hours a nurse educator works per month. The Central region spent an average of 72.31 hours (45%) on other workload activities followed by Tshwane region with an average of 59.38 hours (37%). The Western Cape region spent an average of 47.05 hours (29%) on other workload activities. The total average hours a nurse educator spent on all workload activities on a monthly basis, according to the workload diaries, was 230.95 hours which is an average 62.95 hours more than the normal 168 working-hour month of the nurse educator. This corresponds with the verbatim quotes of the individual and focus group interview participants about their workload experience (cf. Ch. 6 sect. 6.2.1). The affirmation between the narrative (interviews) and numerical (questionnaire) results that nurse educators spend many more hours on work than expected may be one of the reasons why they spend time at home and after hours on work-related activities. If faculty workload exceeds 40 hours per five-day work week, the morale of the nurse educators is affected by their heavy workload (Voignier *et al.*, 1998:35).

Eighty-eight per cent (88%) (n=65) of the recorded observations (n=74) show over the nine-month period, nurse educators spent approximately 10 to 20 hours per month doing job-related work at home as illustrated in Figure 7.28.
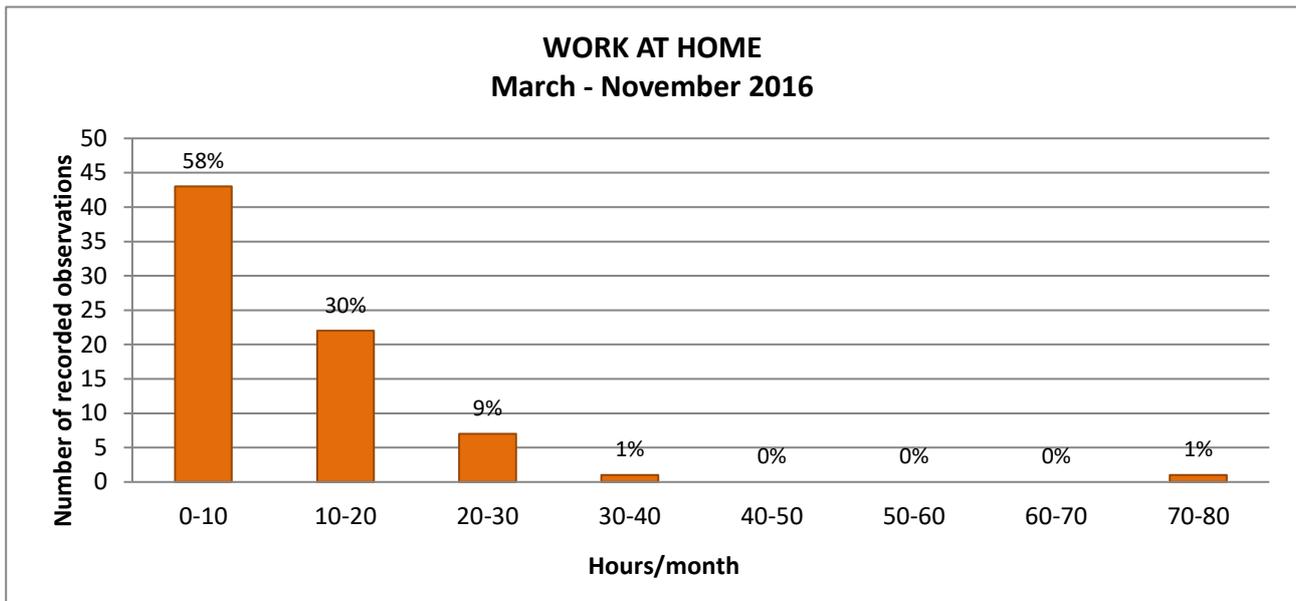
Figure 7.29: Hours spent on work at home

The recorded work-at-home hours show an average (mean) of 13.32 hours for The Central region with a standard deviation of 4.86 hours followed by Tshwane region with an average (mean) of 12.90 hours and a standard deviation of 12.59 hours and the Western Cape region with an average (mean) of 10.33 hours and a standard deviation of 5.84 hours. In total the average (mean) is 11.95 hours spent monthly on work at home with a standard deviation of 10.21 hours. The average of the Western Cape region is the closest to the overall average while Tshwane region and the Central region have higher averages than the overall average.

In Table 7.4 the average hours a participant with a specific qualification spent on some workload activities of a typical nurse educator is illustrated.

Table 7.5: Summary of the average hours a participant with a specific qualification spent on some workload activities of a typical nurse educator

Workload activity	Diploma	Degree	Honours	Masters
Facilitation	48.25	31.87	38.83	26.17
Teaching preparation	9.88	8.98	24.10	9.97
Marking	7.76	12.05	7.01	11.32
Setting tests	7.65	11.61	13.65	8.47
Moderation	-	3.64	6.62	8.24
Invigilation	3.36	3.00	2.40	4.61
Clinical accompaniment	16.27	21.58	27.22	12.85
Assessments	12.72	6.78	14.93	13.57
Demonstration	3.53	2.60	7.95	2.13
Prepare practical examination	3.82	2.55	1.50	3.86
Practical examination	32.35	12.80	14.70	16.51
Emails	18.38	14.00	9.78	12.54
Reports	1.27	2.69	2.14	2.08
Record-keeping	34.96	22.14	20.47	22.45
Counselling and learner support	2.30	2.48	1.15	2.88
Meetings	5.42	3.82	4.12	6.38
Workshops	14.64	14.41	6.81	8.91
Develop study material	-	9.88	-	18.89
Work at home	10.10	10.43	18.7	10.64

Data analysed from the workload diaries received indicated respondents worked an average of 62.95 hours monthly over and above the 168-working-hour month. During the peak months of April, May, July, October and November respondents worked an average of 72 to 82 hours per month overtime which increased to 96 hours per month during July.

In brief, the minimum requirements for the academic qualifications of a nurse educator in South Africa are determined by legislation; hence, it is essential for nurse educators to meet these requirements (Republic of South Africa, 2005:30; SANC, 2013a:20). The high percentage of graduated nurse educators not only confirms that nurse educators comply with legislation but also that the private higher education institution supports the nurse educators with self-development and self-enrichment (See also Figure 7.2) (Potgieter, 2017:219; Beres, 2006:145). At the time of study 44% of nursing educators who completed the workload diaries (see Figure 7.2) had a higher degree, e.g., a Masters which is required not only by South African legislation but also supported by international nursing organisations such as the International Council of Nurses (ICN) and Sigma Theta Tau International (STTI) (Bruce & Klopper, 2016:108). The retirement of the current 51- to 60-years age group (see Figure 7.3) in the next three to eight years may have a major impact on the workload of the nurse educators employed at this private higher education institution. At the moment they are part of the cadre of well-qualified nurse educators with the necessary professional knowledge and skills who train qualified, experienced nurses to enter the nursing environment with confidence. The retirement of skilled nurse educators with expertise and knowledge may have a negative effect on the workload of the remaining nurse educators. The latter's workload will increase if suitably graduated and experienced new nurse educators are not appointed to continue the high level of training maintained at this private higher education institution (Bruce & Klopper, 2016:29; Rispel, 2016).

From the 1 620 recorded observations made, it was calculated that a nurse educator spends an average of 74.25 hours per month on teaching activities alone (44% of the total workload) (cf. Ch. 2 sect. 2.2.1). This reflects the view of Candela *et al.* (2015:586) that teaching should be the largest component of the assigned workload it consisted of 11 to 40 hours on the facilitation of contact sessions, 10 hours on teaching preparation, five to 10 hours on setting tests, five to 10 hours on invigilation of tests and examinations, zero to five hours on moderation and zero to 10 hours on marking students' work.

Literature indicates anything between one and three times the facilitation time should be allocated to preparation time, depending on whether it is a new or an existing subject. Wankat and Oreovicz (2011:1) suggest two hours' preparation time for new lectures and half-an-hour for lectures already used and prepared from existing material. The key message from these authors is to focus on the most important parts of the lecture and

spend more time on the development and use of active learning activities. The University of Wollongong (2011:3) allocates five hours per hour of teaching for new subjects; two to three hours per hour for a lecture given before; two hours of marking time for each student and subject coordination time of 7.5 hours per student. Yuker (1984:43) allocates nine to 12.5 hours preparation time for five and more hours teaching in class per week. Data recorded during the study reflected an imbalance between actual facilitation time and preparation time of nurse educators indicating more lecture preparation time should be considered.

Secondly, an average of 56.70 hours per month (34% of total workload) was spent by a nurse educator on the clinical practice activities. The hours per activity were as follows: zero to 10 hours on clinical accompaniment; zero to 10 hours on conducting assessments; zero to three hours on the preparation for demonstration; zero to four hours on demonstrations; zero to two hours on the preparation for practical examinations; zero to 15 hours on practical examinations and zero to four hours on the clinical allocation of students. Although some authors (Premji *et al.*, 2010:880-881; Williams & Taylor, 2008:900) suggest this component should be more than 20% of the nurse educator's workload (cf. Ch. 2 sect. 2.2.2), Brady (2010:5) advises two hours of clinical practice time should be allocated for each hour of classroom time.

Thirdly, an average of 42.43 hours per month (25% of workload) was spent by the nurse educators on the administrative workload activities. These hours were distributed as follows: 10 to 20 hours on the management of emails; zero to two hours on writing reports; zero to 30 hours per month on record-keeping; zero to one hour on photocopying and one to three hours on counselling and student support. This monthly administrative workload is considerably high for a nurse educator (Tight, 2010:211) (cf. Ch. 2 sect. 2.2.3). From as early as 1984, educators have been allocating more than 20% of their time to meetings and administrative activities (Yuker, 1984:6-7).

These total monthly averages changed significantly when other activities such as meetings, workshops, travelling, review of study material, development of study material and ad hoc activities were taken into account. From the aforementioned, it is obvious why nurse educators work an average of 62.95 additional hours in excess to a 168 working-

hour month. There was a significant difference in the average time spent on the different workload activities by the respondents with specific qualifications (see Table 7.4).

The time of the academic faculty is divided into 40% teaching, 40% research and 20% service by the American Association of University Professors (2000:69) and Mancing (1994:32). Within the United Kingdom context, Tight (2010:207) divides the academic faculty time in an average of 40% teaching, 31% research and 18% administration. In Namibia, the Polytechnic of Namibia (2003:2) divides the time of a faculty member into 60% teaching, 30% research and 10% administration and service. Time allocated to the different workload activities differ from institution to institution. As Yuker already indicated in 1984, it is best to weight workload activities against the institution's mission and goals (Yuker, 1984:14).

The diaries of the nurse educators who participated in the study showed that 42% of their time was spent on teaching activities, 33% on clinical practice activities and 25% on administrative activities. With very limited literature available on the workload activities of nurse educators a comparison was drawn with a study done in 1993 by Khumalo and Uys (1993:58). According to the findings, nurse educators spent 35% of their time weekly on classroom teaching, 21% on preparation, 5% on clinical teaching, 0.5% on meetings, 19% on marking tests and examinations and 19% on administration. Importantly, hardly any allowance was made for the clinical practice component. With the clinical component separated from the academia, it is clear literature at the time of this study did not effectively address the integrated academic and practical training activities of the nurse educator.

7.2.2   Delphi technique

In this section, the findings of the data obtained through the Delphi technique are presented and discussed. The Delphi survey questionnaire was compiled by using the information obtained from the literature review as well as from the findings of the workload diaries of the previous section (cf. sect. 7.2.1). The Delphi exercise was conducted in three rounds over a period of one-and-a-half months (4 November 2017 to 14 December 2017). A comprehensive discussion is provided after firstly reporting on the third round of

implementation by comparing the results of all the narrative findings in Chapter 6 and the numerical findings reported in Chapter 7 (cf. sect. 7.2.1 & 7.2.2).

The purpose of administering the Delphi survey questionnaire was to generate additional data from a group of expert nurse educators to embed this investigation into the workload activities of nurse educators in as broad as possible personal experiences and perspectives. As mentioned many times, current faculty workload models do not fit the profile and needs of this private higher education institution and the nurse educators. It was vital to get as much and as varied as possible inputs to obtain a very clear and thorough understanding of the existing situation in order to attempt changing the situation for the benefit of employees and the organisation. Furthermore, involving the group of expert nurse educators was done in an attempt to achieve some measure of consensus among the respondents about the relative desired time spent on the different workload activities. These activities included the teaching, clinical, research and administrative activities of the workload of nurse educators.

The aim in this instance was to respond to the last subsidiary research question stated in Chapter 1 (cf. sect. 1.4). The question addressed the manner in which the concept of nurse educator workload could be better understood, especially within a private higher education institutional context. Tables are used to indicate the findings of the three rounds of the Delphi exercise. Further explanations are provided on possible reasons emerging from the results of the Delphi exercise.

As regards using the Delphi survey to generate data, according to literature as mentioned in Chapter 5 (cf. sect. 5.3.1.2), the size of an expert panel usually varies between 12 and 50 panel members. The panel of 33 members purposively selected for the study was thus considered acceptable (Ab Latif *et al.*, 2016:90; Keeney *et al.*, 2011:48-53). The panel of 33 permanently employed respondents were selected from six of the nursing education sites of the private higher education institution in their capacity as registered, experienced and informed nurse educators who were involved on a daily basis with the workload issues under investigation. The respondents agreed to participate and responded to the Delphi survey questionnaires across three rounds.

7.2.2.1 Findings from the first round of the Delphi exercise

The pre-existing information concerning the time spent by nurse educators on each workload activity was used as a basis for the development of the survey questionnaire. It presented the respondents with 34 workload activities and an option for individual opinions on each activity (Hasson *et al.*, 2000:1011). An invitation was sent to all respondents via email which provided information on the Delphi survey, the purpose of the study and an informed consent form. A unique access link to the Delphi survey link was also sent to the email addresses of all panel members (see Addendum H).

The respondents were guided with specific instruction on how to complete the statements of the first round in the Delphi questionnaire. The questionnaire consisted of six sections, namely (a) consent, (b) demographic information and teaching activities, (c) clinical activities, (d) administrative activities, (e) research activities and (f) ad hoc activities. The responses of the first round were analysed by using the EvaSys survey automation suite. The response rate in the first round of the Delphi was 75.8% (n=25). Consensus was reached on two of the statements whereby an 80% agreement level was used as consensus reached for the purpose of this exercise. All 25 (100%) respondents agreed to participate in the first round of the Delphi exercise.

Table 7.5 indicates the two statements – one related to clinical workload activities and the other to administrative workload activities. The table indicates the achieved consensus as well as the relative time spent on each of the activities, the number of respondents, the percentage of consensus and the mean and standard deviation of each statement. Respondents ranked each item on a 4-point Likert scale where 1 = "Strongly disagree"; 2 = "Disagree"; 3 = "Agree" and 4 = "Strongly agree".

Table 7.6: Summary of the two statements which achieved consensus in the first round of the Delphi survey

Statement	Relative hours spent	Number of respondents	Consensus %	Mean	Standard deviation
The amount of hours spent to prepare for a demonstration.	2	25	80	2.9	0.8
The amount of hours spent to write the progress reports of students monthly.	24	24	83	2.9	0.4

The opinions of some of the respondents with regard to the amount of hours spent on preparation for a demonstration, the following sample responses show respondents thought the hours could be less or more:

- "… *can be less based on experience…*"
- "*Could be more if it is a new procedure that needs to be studied.*"

Some of the feedback on the amount of hours spent to write the monthly progress reports of the students rendered interesting responses as indicated:

- "*… all depends on the total number of students and info needed for report…*"
- "*… reports are hand written as well as electronically…*"

7.2.2.2 *Findings from the second round of the Delphi exercise*

The questionnaire consisted of the same six sections as explained in the first round (cf. sect. 7.2.2.1). Statements on which consensus was not achieved were adjusted in accordance with the opinions of the respondents (n=25) to these statements. The statements related to the relative time spent on teaching activities, clinical practice activities, administrative activities and research activities. The same invitation procedure used in the first round was followed to invite the respondents for participation in the second round (cf. sect. 7.2.2.1). The invitation was accompanied by the feedback report of the first round (see Addendum I).

The responses of the second round was analysed by EvaSys survey automation suite. The response rate in the second round was 72.7% (n=24). Consensus was reached on ten of the statements. This brought the total number of consensus statements to 12 after the second Delphi round.

Table 7.6 shows the ten statements – two on the teaching workload activities, three on clinical workload activities, three on administrative workload activities and two on ad hoc activities. The table also indicates the relative time spent on each of the activities, the number of respondents, the percentage of consensus and the mean and standard deviation of each statement.

Table 7.7: Summary of the statements which achieved consensus in the second round of the Delphi survey

Statement	Relative hours/minutes spent	Number of respondents	Consensus %	Mean	Standard deviation
The amount of hours spent to counsel a student.	30 minutes –1 hour	24	91.7	3	0.5
The amount of hours spent per student on student remediation.	1 – 2	22	81.8	2.9	0.5
The amount of hours spent to do a demonstration.	2 – 6	23	82.2	2.9	0.6
The amount of hours spent per student during a clinical examination.	1 – 3	22	81.8	3	0.9
The amount of hours spent to compile a monthly planner for the clinical accompaniment of students.	1 – 3	24	87.5	3	0.7

Statement	Relative hours/minutes spent	Number of respondents	Consensus %	Mean	Standard deviation
The amount of hours spent to write a student's three-monthly report.	15 – 45 minutes	23	91.3	3	0.5
The amount of hours spent per month on the loading of test-, examination-, assignment marks on the electronic files of the students.	3 – 8	24	91.7	3	0.6
The amount of hours spent to complete a student on completion of the course or programme.	2 – 3	24	83.3	2.9	0.5
The amount of hours spent to attend meetings per week.	1 – 3	24	91.7	3	0.6
The amount of hours spent to prepare a venue for class or life support.	2 – 3	22	90.9	3	0.4

In the opinion of some of the respondents regarding the amount of hours spent to counsel a student, the following represent a sample quote:

- *"… it depends on the type of problem or challenge of the learner you can take 2 hours…"*

Responses to the amount of hours spent per student during a clinical examination included the following sample quote pertaining to clinical examinations done in the theatre:

- "…*depends on the case in theatre – can be up to 5 hours…"*

Some of the respondents reported on the amount of hours spent per month on the loading of test-, examination- and assignment marks etcetera on the electronic files of students as follows:

- *"… depend on the size of the class…"*
- *"… depending on amount of results and group size…"*

7.2.2.3 Findings from the third round of the Delphi exercise

Based on the opinions of the respondents to the second round of the Delphi (n=24), adjustments were made to statement 2.29 in the questionnaire on which no consensus was reached. The same invitation procedure of the first round was followed to invite the respondents for the third round (cf. sect. 7.2.2.1). The invitation was accompanied by the feedback report of the second round (see Addendum J).

The responses of the third round was analysed by EvaSys survey automation suite. The response rate in the third round was 72.7% (n=24). After the third round, consensus was reached on ten of the twenty statements. The combined two statements in the first round, the ten statements of the second round and the ten statements of the third round at which consensus was reached brought the total consensus items to 22. All 24 (100%) respondents agreed to participate in the third round of the Delphi technique.

Table 7.7 indicates the ten consensus statements – eight on teaching workload activities, one on clinical workload activities and one on administrative workload activities. The table also shows the time spent on each of the activities, the number of respondents, the percentage of consensus and the mean and standard deviation for each statement.

Table 7.8: Summary of the statements which achieved consensus in the third round of the Delphi survey

Statement	Relative hours/minutes spent	Number of respondents	Consensus %	Mean	Standard deviation
The amount of hours spent weekly to facilitate contact sessions.	30	24	83.3	2.9	0.6
The amount of hours spent to set a 50-point test paper.	3 – 8	23	82.6	2.9	0.8

Statement	Relative hours/minutes spent	Number of respondents	Consensus %	Mean	Standard deviation
The amount of hours spent to set a 100-point examination paper.	20 – 25	21	81	2.9	0.7
The amount of hours spent on the moderation of test or examination papers per month.	8 – 16	21	85.7	3	0.5
The amount of hours spent to mark a 100-point assignment.	2 – 4	22	86.3	3	0.7
The amount of hours spent to invigilate tests or examinations per week.	1.5 – 3	24	91.6	3	0.4
The amount of hours spent on the review of study material per month.	20 – 30	23	80	2.9	0.6
The amount of hours spent on the development of study material per module.	30 – 42	24	80	3	0.6
The amount of hours spent to prepare for clinical examination of a group of students.	3 – 6	24	80	3	0.7
The amount of hours spent to write and answer emails per day.	1 – 3	24	80	3	0.7

The respondents' feedback on the amount of hours spent weekly to facilitate contact sessions included the following two sample quotes:

- "*Dependent on the topic for contact session and the amount of students.*"
- "*Depends on how many groups are in block.*"

The opinion of some of the respondents about the amount of hours spent to set a 50-mark test paper pointed out some interesting factors as shown in the sample quotes:

- "*… depending on new or old questions…*"
- "*… depends on how many papers per group…*"

Regarding the amount of hours spent on the moderation of test or examination papers per month, the following represent sample quotes:

- "*… depends on the amount of papers needing moderation…*"
- "*… depends on the amount of subjects to moderate and the time of the year.*"

It became clear from the Delphi exercise that most of the consensus on items occurred during the second and third rounds of implementation. The statements in the third round on which consensus was not reached may be due to the role that individual preference plays. These statements were also analysed because the average (mean) value and standard deviation could indicate the prevailing tendency in the thinking patterns of the panel. Table 7.8 indicates the ten non-consensus statements (i.e. those below the cut-off figure of 80%). Four pertained to the teaching workload activities; three were related to clinical workload activities; one was with regard to administrative workload activities; one concerned research workload activities and another one focused on ad hoc workload activities. The table also includes the relative time spent on each of the activities, the number of respondents, the percentage of consensus and the mean and standard deviation of each statement.

Table 7.9: Summary of the non-consensus statements which did not achieve consensus in the third round of the Delphi survey

Statement	Relative hours/minutes spent	Number of respondents	Consensus	Mean	Standard deviation
Amount of hours spent to prepare for a contact session (including life support).	1 – 2	24	53.5	2.5	0.9
Amount of hours spent to mark a 50-mark test.	30 – 45 minutes	23	73.9	2.9	0.6
Amount of hours spent to mark a 100-mark examination paper.	1 – 2	20	75	2.9	0.7
Amount of hours spent to format a test or examination paper.	1 – 2	23	78.2	2.8	0.8
Amount of hours spent on the clinical accompaniment of a student per month.	6 – 24	24	66.7	2.8	0.8
Amount of hours spent on clinical assessment of a student.	3 – 4	23	65.2	2.7	0.8
Amount of hours spent per month on the clinical allocation of students.	4	22	72.7	2.7	0.9
Amount of hours spent monthly on your role and function as a course or programme coordinator.	20 – 24	22	68.2	2.8	0.6

Statement	Relative hours/minutes spent	Number of respondents	Consensus	Mean	Standard deviation
Amount of hours spent daily on research for own personal development.	2 – 6	23	52.1	2.8	1.2
Amount of hours spent monthly on travelling to and from hospitals.	20 – 45	22	77.3	3	0.9

With regard to the amount of hours spent to prepare for a contact session (including life support) the following represent sample quotes:

- *"… infection control contact session preparation can be 6 – 8 hours long, especially for Skype…"*
- *"… it can be longer if the contact session is new and have not been presented before…"*
- *"… new lectures take longer and updating needs more hours…"*

Respondents' opinions as regards the amount of hours spent per month on the clinical accompaniment of a student were similar in that less than six hours were spent on this activity as the following two sample quotes indicate:

- *"… it is not possible to spend 6 hours per student. A 6-hour guided practice learning (GPL) day means: 2-4 students and 1 educator."*
- *"… less than 6 hours per student due to educator shortage and poor clinical support we sometimes have 6 hours of clinical accompaniment for three students at once."*

The statement about the amount of hours spent daily on research for own personal development rendered similar responses as the following sample quotes show:

- *"… do not have the time to do this…"*
- *"… no time available…"*
- *"I do little research at the moment."*

The views of some respondents on the amount of hours spent monthly on travelling to and from hospitals showed similar responses as the three sample quotes indicate:

- *"… certain months will be more when travelling outside of the region…"*

- *"… depending on the radius for travelling…"*
- *"… depends on the region. Proximity of learning centre to hospitals…"*

The numerical findings outlined above (cf. sect. 7.2.1 & 7.2.2) not only provides evidence of the type of workload activities of nurse educators within a private higher education context, but it indicates the relative amount of time spent on each workload activity as well. In the next section scenarios will be used for the interpretation and comparison of the narrative findings and numerical results outlined in Chapter 6 and Chapter 7 respectively.

7.3   INTERPRETION AND COMPARISON OF THE FINDINGS

Authors such as Soliman (1999:3) reminds us of the importance of having a clear understanding of the teaching, clinical practice, research and administrative components as well as the time involved in each activity of each workload component of the workload of nurse educators. The essence lies in the strong link between the related issues of workload, employee motivation and the employees' job satisfaction and productivity as explained in Chapter 2 of this thesis.

The interpretation and comparison of the narrative and numerical findings outlined in Chapters 6 and 7 which related to the workload, productivity and job satisfaction of nurse educators were based on (a) the actual monthly schedules of nurse educators and (b) the data from individual interviews with nurse educators. From this information three possible scenarios may develop as outlined next. The calculated time in the scenarios reflect the relative time of the workload activities as determined during the three rounds of the Delphi survey (see Tables 7.5, 7.6, 7.7 & 7.8).

The first scenario (Table 7.9) is an example of the applied findings (calculations) on the typical workload of a nurse educator who is a coordinator of a basic nursing programme and who has two student intakes over a nine-month period. This educator does not have an intake of short course or CPD students over the same period.

Table 7.10: First scenario as an example of the applied findings to the typical workload of a nurse educator over a nine-month period

Activity	February Hours	March Hours	April Hours	May Hours	June Hours	July Hours	August Hours	September Hours	October Hours	November Hours
Contact sessions	90	55	27	126	0	45	27	63	54	0
Develop new study material	32	36	56	0	162	32	56	36	0	136
Invigilation	2	2	0	2	0	2	0	2	6	0
Compile tests	8	8	0	8	0	8	0	8	0	0
Mark tests	9	9	0	6	0	6	0	6	0	0
Mark assignments	0	0	0	28	0	0	0	0	0	0
GPL	45	18	12	0	6	60	30	24	24	0
BLS	0	0	10	10	0	0	0	20	0	20
Practical examinations	0	0	38	46	0	0	0	0	46	0
Student interviews	0	0	8	0	0	0	0	0	0	8
Administration	8	36	24	8	0	8	0	18	16	0
Meetings	0	4	0	0	0	2	0	8	0	4
Conferences	0	0	0	0	0	24	0	0	32	0
Total	**194**	**168**	**175**	**234**	**168**	**187**	**113**	**185**	**178**	**168**
Excess time	**26**	**0**	**7**	**66**	**0**	**19**	**-55**	**17**	**10**	**0**
Travel (km)	**192**	**344**	**120**	**148**	**112**	**200**	**148**	**212**	**312**	**400**

As seen in Table 7.9, the nurse educator in this scenario worked an excess time of more than 168 hours per month for at least six months of the year except for August when she had leave as well as for the months of March and November. During May and September, the peak months as indicted by the findings of the workload diaries, this nurse educator worked 66 hours overtime in May and 17 hours overtime in September respectively. This

may be why the nurse educators experience their workload in the way indicated in the narrative findings of section 6.2. Literature also indicates a link between increases in nurse educators' workload and decreases in their job satisfaction and productivity (Mahoney, 1996:35; Soliman & Soliman, 1997:136).

The time spent on clinical accompaniment of the students is very limited when taking into account that each student is entitled to six hours of practical guidance per month (Private healthcare provider, 2013:2). For the period February to March this nurse educator was responsible for the clinical accompaniment of 10 students. By implication these 10 students had to receive an accumulated 60 hours of clinical support per month and not the little amount of time as indicated in Table 7.9. The primary cause of the reduced clinical accompaniment may be ascribed to the fact that most affiliated private hospitals do not allow the students to be available for six hours a month because they are seen as part of the workforce. This factor was reflected in the opinion of a participant in the third round of the Delphi survey and possibly the reason why consensus on the real time spent was not achieved. For the period June to November this nurse educator was responsible for the clinical accompaniment of seven students with similar results. This is possibly why the respondents experienced clinical accompaniment in the narrative findings as 'obstructive' clinical development. Travel time (see Table 7.9) is difficult to determine because time in city traffic differs from travelling time in rural areas. Time spent on travelling has major effects on nurse educators' workload. It was aptly referred to as "*dead time*" by one of the participants in the narrative data obtained during the interviews (cf. Ch. 6 Table 6.18). It may also be the possible reason why consensus on the real time spent on travelling in the Delphi survey was not achieved.

The second scenario (Table 7.11) is an example of the applied findings (calculations) to the typical workload of a nurse educator who is a coordinator of a basic nursing programme and who has two student intakes over a nine-month period. This educator is a national coordinator of a short course (April intake) and two CPD courses (April and August intake) over the same period.

Table 7.11: Second scenario as an example of the applied findings to the typical workload of a nurse educator over a nine-month period

Activity	February Hours	March Hours	April Hours	May Hours	June Hours	July Hours	August Hours	September Hours	October Hours	November Hours
Contact sessions	0	27	9	27	9	9	18	18	0	0
NICU workshop	0	0	0	0	0	0	26	0	0	26
Compile tests	32	0	0	0	0	0	0	40	0	0
Mark tests	0	0	0	6	26	6	0	2	0	0
Mark assignments	0	0	0	0	0	0	32	0	0	0
GPL	88	36	18	72	60	112	24	44	12	24
BLS	11	30	0	0	11	0	0	22	22	11
ACLS	0	26	26	0	0	0	0	26	26	28
Practical examinations	0	0	38	0	0	0	0	0	40	0
Student interviews	0	0	16	0	0	0	0	0	0	8
Administration	24	49	48	48	72	16	46	8	40	72
Meetings	0	0	0	6	0	0	2	8	0	3
Leave	40	0	16	0	0	0	72	0	40	0
Total	**195**	**168**	**171**	**159**	**178**	**143**	**220**	**172**	**180**	**172**
Excess time	**27**	**0**	**3**	**-9**	**10**	**-25**	**52**	**4**	**12**	**4**
Travel (km)	**312**	**172**	**165**	**1528**	**120**	**1452**	**1528**	**2764**	**166**	**234**

The excess time this nurse educators worked monthly ranged between three to 27 hours per month without taking into account the extensive travelling she had to undertake. The travelling for May, July, August and September appear to be outliers because these were the months during which she travelled by car to do clinical accompaniment of the short course students at national level. The excess time spent on work monthly ranges between three to 27 hours per month without taking into account the extensive travelling of the nurse educator. It may also be difficult for the nurse educator to plan travel time ahead because the students of the different CPD and short courses are only announced a month before the time and could thus have major effects on workload. The narrative data

produced some insight into the travelling dilemma. A participant's verbatim quote reflected: "*I travel a lot … sometimes I travel after hours*" (cf. Ch. 6 Table 6.18) while the Delphi questionnaire results showed 71% of the respondents indicated they travelled up to 15 hours per month (see Figure 7.25).

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The unproductive time spent travelling may be the reason why consensus on the time spent on travelling was not achieved in the third round of the Delphi exercise. Currently, within the context of the private higher education institution where the study was conducted, no substitute is provided for nurse educators who are on leave or sick leave. In other words, her administrative duties, marking of tests, preparation and similar or ad hoc work activities are not attended to because the workload of such and educator cannot be absorbed by another nurse educator as they all have a full workload. This was also confirmed by the narrative findings of the individual interviews and focus group interviews (cf. Ch. 6 Table 6.2).

Table 7.11. provides an example of the extent and spread of the workload of a nurse educator at the Bloemfontein nursing education site for the period January to September. This situation was highlighted in a verbatim quote from the individual's interview transcript: "*My current workload is hectic because we have a lot of different programmes running … We rely on the mentors in the hospitals for clinical component because we do not have the capacity to get to the hospitals in the second part of the year. It feels as if the situation gets out of control with some courses because you just do not get to it.*" (NE4 CEN P1 L18 & 19 & P5 L 7, 17 & 18) (cf. Ch. 6 Table 6.2).

Table 7.12: Summary of an example of the extent and spread of the workload of a nurse educator at the Bloemfontein nursing education site

Programmes / courses	Programme/ course commences	Clinical facility	Distance from nursing education site (one-way)	Nursing category
ODA 1st year	January	Bloemfontein	50 m	-
ODA 2nd year		Hoogland	251 km	-
Short course – Operating theatre	April	Howick	536 km	Registered nurses
CPD – endoscopy	August	Newcastle	500 km	Registered nurses
CPD – circulating	August	Pietermaritzburg	565 km	Nursing auxiliary
CPD – Anaesthetic and recovery	August	Victoria	760 km	Registered nurses Enrolled nurses Nursing auxiliary
CSSD supervisors	August	Welkom	250 km	Registered nurses
CPD – Orthopaedic	August	Kimberley	161 km	Registered nurses

As can be seen in Table 7.12, the participant had to teach 40 students in 10 different programmes and courses allocated between seven hospitals (also see Table 6.4) in 2016. Two programmes started in January, the short course in April and the seven CPD courses in August. Based on the verbatim quote, the participant's responsibilities as a nurse educator were presenting contact sessions, marking of tests, assignments and portfolio of evidence of these programmes and courses, being regional coordinator of the CPD and short course and doing the clinical accompaniment of the ODA, short course and CPD course students. Table 7.13 summarises the total number of contact sessions, tests, examinations, assignments and portfolio of evidence that needed to be marked as well as the clinical procedures the participant had to evaluate the students on (see Table 6.4).

Table 7.13: Summary of the total number of contact sessions, tests, examinations, marking of assignments and portfolios of evidence as well as the assessment of clinical procedures of the nurse educator at the Bloemfontein nursing education site

Programme /course	Number of students	Contact sessions	Tests	Examination theory & practice	Assignments	Portfolio of evidence	Clinical procedures
ODA 1st year	7	40	17	35	7	7	70
ODA 2nd year	9	27	16	35	9	0	0	81
Short course – operating theatre	6	6	12	6	6	6	120
CPD – endoscopy	1	-	1	-	-	-	-	-
CPD – circulating	2	4	4	-	-	-	2	-
CPD - anaesthetic and recovery	7	4	14	-	-	-	7	-
CSSD supervisors	1	2	1	-	-	-	1	-
CPD – orthopaedic	7	2	14	-	-	-	7	-
Grand total	**40**	**85**	**79**	**76**	**22**	**13**	**30**	**271**

Sixty-seven of the contact sessions were presented in class and the rest, which comprised of 18 contact sessions of the short course and CPD courses, were presented via Skype. The clinical accompaniment of the CPD students were done by the mentors in the hospitals because the nurse educator did not have the capacity to do the clinical accompaniment of the CPD students who commenced with the CPD courses in August. The clinical accompaniment of the ODA and short course students were all done by the nurse educator in the example.

September was indicated by the educator as a peak month, because of the theoretical and clinical examinations of students in the six short courses, the completion of the practical procedures of the first- and second-year ODA students and the contact sessions of the CPD courses. Due to the sample workload of this educator, the preparation of the 85 contact sessions had to take place after hours. If two hours of preparation time is allowed per contact session as indicated in the Delphi findings, then the participant would have done approximately 170 hours of work at home. In Table 7.13 the calculated hours spent

on the activities in accordance with the Delphi findings are summarised (see Tables 7.5, 7.6, 7.7 &7.8).

Table 7.14: Summary of the total hours spent on contact sessions, marking tests, examinations, assignments and portfolio of evidence as well as the assessment of clinical procedures of the nurse educator at the Bloemfontein nursing education site

Programme/Course	Contact sessions (hours)	Marking tests, examinations, assignments, portfolio of evidence (hours)	Clinical procedures & practical examination (hours)
ODA 1st year	280	139	308
ODA 2nd year	189	82	360
Short course – operating theatre	42	69	504
CPD – endoscopy	-	45 minutes	-
CPD – circulating	24	24	-
CPD – anaesthetic and recovery	24	39	-
CSSD supervisors	12	4 hours & 45 minutes	-
CPD – orthopaedic	12	39	-
Grand total	**583**	**397,5**	**1 172**

From January to September, the nurse educator spent a total of 2 152 hours on work. This indicates she worked an excess of 640 hours over the nine-month period. This is an average of 71 hours in excess to a 168 normal working-hour month of 21 working days. In the individual interviews with the sample nurse educator, the distances travelled were mentioned (cf. Ch. 6 Table 6.2). However, it is not clear how many times the sample educator travelled to the various clinical facilities. As mentioned in the first scenario, travelling time has a major effect on the workload of nurse educators in the relevant private higher education institution, but it is difficult to determine how much time is actually spent on the road.

Some of the verbatim quotes in Table 6.17 indicate the time spent on travelling. For instance, a remark from another participant from the same nursing education site provides

an indication: "… *many unproductive hours are spent on the road ... we are in the region for a week at a time ... two days are used for travelling and three productive days for student guidance ... therefore the quality time spent with the student is actually very little* ..." (NE4 CEN P10 L16-21). The quote confirms that the typical nurse educator experiences a high workload; even attempting to calculate the workload over a given time period is unattainable and impossible. This stance is well supported by the narrative and numerical findings in Chapter 6 and Chapter 7 respectively. Productivity within the work environment thus seems to be a key factor in the success and effectiveness of each individual nurse educator. Indeed, their job satisfaction may depend heavily on the extent to which their expectations and needs are met (Dorasamy & Letooane, 2015: 259; Kusku, 2003:347; Sohail *et al.,* 2014:41-45).

7.4   SYNTHESIS

The findings from the numerical data in Chapter 7 revealed that the time spent on teaching, clinical practice, administrative and research activities dominate and largely determine the working life of nurse educators (cf. sect. 7.2.1 & 7.2.2; also see Seaberg, 1998:7). These aforementioned activities were seen as the sum total of all workload activities related to the professional duties and responsibilities of participating nurse educators as it related to their teaching, clinical practice, administrative and research workload components. It also linked into the elements of the conceptual framework and forms part of the throughput of the system (see Figure 4.5).

Nursing as a practice-orientated profession comprises academic and clinical practice education. It is thus important to understand the different activities within the workload of nurse educators and the time spent by them on each of these differing activities. This aspect was highlighted by the numerical data reported from nurse educators' workload diaries and the results from the Delphi survey as reported on in this chapter. It is important to ensure the distribution of workload remains consistent among nurse educators because a healthy work environment, nurse educators who perceive they are treated fairly and who note that their work is valued and rewarded may be more tolerant of an increasing workload (Shirey, 2006:95). As stated by Rosser (2004:285), the two hallmarks that impact positively on the work life satisfaction of nurse educator are fairness and being rewarded for the value they add to their work environment. This is even more important to the nurses

in their twenties and thirties entering the world as nurse educators – these are the generations who, as stated by Cipriano (2007:10), "work to live and do not live to work".

Considering the conceptual framework developed for this study (see Figure 4.5) it was crucial to understand and address the total workload of nurse educators in order to enhance the productivity and job satisfaction of this complement of staff in health education output environments (see Figure 4.5). It goes without saying that nurse educators have certain expectations, needs and goals which are based on performance, efforts and rewards as revealed by motivational theories such as the expectancy theory (see Section 4.5). The development of a suitable workload model for nurse educators thus seems critical against the background of the recorded 1 620 observations pertaining to the range and spectrum of their workload activities. For instance, the participating nurse educators indicated an average of 74.25 hours monthly spent on teaching activities (see Table 7.1); 56.70 hours on clinical practice activities (see Table 7.2) and 42.43 hours on administrative activities (see Table 7.3).

The workload profile of the typical nurse educator changes significantly when other monthly activities are added. These include travelling, workshops and other work-related activities. The total average hours that nurse educators seem to spend on all workload activities on a monthly basis is 230.95 hours (see Tables 7.1, 7.2, 7.3 & 7.4) which represent an average of 62.25 hours in excess of a 'normal' working month of 168 hours. During the peak months of April, May, July, October and November respondents are working an average of 72 to 82 hours per month overtime which can easily increase to 96 hours for July. This average number of hours per month represents only three (teaching, practical and administrative) of the four workload components of a nurse educator. It therefore implies serious imbalances exist in the work life of the nurse educators who participated in this study.

Within a higher education context it is important to allow time for the research component of nurse educator workload. Research is particularly necessary to promote the future of the nursing profession and for the scholarly growth and development of nurse educators (Candela *et al*., 2015:587). Scholarly teaching also cultivates the theory-practice integration for nurse educators and thus cannot be neglected (Bruce & Klopper,

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2016:377). As highlighted earlier in the conceptual framework for this study (see Figure 4.5), these four nurse educator workload components form part of the institution's throughput system; they are interrelated and dependent on one another in the private higher education environment a (see Figure 4.5; also see Smit *et al.*, 2011:323).

The three-round Delphi exercise aimed at deepening the investigation of nurse educator workload activities. Also notable, it was done to achieve some measure of consensus among the nurse educator respondents on the realistic time spent on their different workload activities. This supports confirmation that input from all the parties was obtained in the development towards a credible educator workload model. An 80% agreement level was used as a measure of consensus with the response rate in the first round of more than 75% (75.8; n=25) and consensus reached regarding two of the statements. In the second and third rounds the response rate was over 70% (72.7; n=24) and consensus was reached in ten of the workload activity statements.

In total, consensus was reached in twelve of the workload activity statements by the expert panel (see Tables 7.5, 7.6 & 7.7). The ten statements for which no consensus was achieved (see Table 7.9) could in all probability be ascribed to the role that individual nurse educator preferences play. In addition, the calculated mean values and standard deviations may indicate a predominant tendency of 65% and more as consensus by the panel of experts. The numerical findings outlined in sections 7.2.1 and 7.2.2 not only provided evidence of the type of workload activities of participant nurse educators but also indicated the relative amount of time spent on each workload activity.

When one considers the contributions of Allen (1997:27), Harden and Crosby (2000:334), Ruth (2001:196) and Perks (2014) with regard to the importance of categorising the workload activities of educators, the facilitation of weight allocation to each workload category is possible and may even enhance the effective management thereof. Zibrowski *et.al.* (2008:336-342) and Rosser and Tabata (2010:456) are in agreement that the total time spent by nurse educators on professional activities and educational duties such as teaching, research and service need to be taken into account with the development of a realistic workload model. As a standard, the formula 40:40:20 is used to calculate faculty time which represents 40% teaching, 40% research and 20% service (American

Association of University Professors, 2000:69; Mancing, 1994:32). Importantly, Premji *et al.* (2010:880-881) and Williams and Taylor (2008:900) state at least 20% of nurse educators' time should be allocated to clinical practice.

Relevant literature further points out that different workload formulas, credit hours, contact hours and other means of calculation could be used to calculate educator workload, but as Perks (2014) points out, the best way may be to consider and calculate all the workload activities and the time spent on each workload activity. It is possible for a nursing education institution to ensure a balanced workload distribution between practice and academic responsibilities (Sawyer *et al.*, 2000:513) if such and institution develops its own criteria for a fair and balanced workload (Lobo & Liesveld, 2013:277). Productivity is associated with workload, internal motivation, institutional incentives and external stimulation (Allen, 1997:25). Individual nurse educators experience their workload differently, so to avoid counterproductive behaviour, a reasonable workload is of utmost importance (Jenkins, 2004). It will not only promote productivity but also the job satisfaction of the nurse educator (Altaf & Awan, 2011:93; Hammen, 2006:466).

What also seems significant is that the workload of nurse educators and the allocation of duties need to be based on insight and understanding of the complex and multidimensional theoretical and clinical components of nursing education (Langmead & Kenway 1998:29; Soliman & Soliman 1997:138; Southon & Braithwaite 1998:24). Time-based workload models represent the most comprehensive coverage of academic work of nurse educators which are directly linked to human resourcing and costing of units (Vardi, 2009:506). Such models also assist with the analysis and planning of individual workloads, development of academic workload profiles, effective time management and the measuring of productivity (Soliman, 1999:4).

The findings from the narrative data (Chapter 6) and the numerical data (Chapter 7) generated and analysed in this study clearly point to a better understanding of what nurse educators in a private higher health education institution are currently doing, how they experience their workload and the challenges that accompany such workloads. In the final chapter, Chapter 8, conclusions are drawn from the findings, their implications are pointed out and the limitations of the study are accounted for.

CHAPTER 8

CONCLUSIONS AND IMPLICATIONS

8.1 INTRODUCTION

With this study the researcher embarked upon a scholarly journey to address the challenges facing the workload pressures which negatively affect the productivity and job satisfaction of the modern day nurse educator at higher education institutions nationally and potentially worldwide. The researcher illustrated the effectiveness of investigating various theoretical perspectives, identifying the relevant concepts and linking it to the real-life 'manageable workload' of nurse educators to better understand its impact on the private higher nursing education milieu. To elicit a profound understanding of the influence the current high workload have on productivity and job satisfaction of nurse educators at a multi-campus private higher education institution, the researcher engaged with expert views and raw data. The study outcome indicated the extent to which the current application of the nurse educators' workload might contribute to inefficiency in their output.

The history of the private higher education institution's training function extends over a period of 30 years and spans over seven nursing education sites across six of the nine provinces in South Africa. Since accreditation as a private higher education institution in 2008, the increase in nurse educators was proportional to the rapid increase in the number of nursing and operating department assistant students. However, it became apparent that the allocated nurse educator complement did not effectively keep up with the increases in the number of training programmes and courses currently offered by the institution.

Dynamic changes took place in the field of nursing education in South Africa and, as a result, the nurse educators at private higher education institutions faced several changes in their roles of responsibilities as well as their working lives. During the same period, they had to respond to new and complex challenges introduced by culturally diverse student groups which, in turn, meant more dedicated effort and higher levels of motivation concomitant with greater demands to remain effective and productive within a competitive business environment. To provide high quality nursing education, the need arose to

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address the potential problem of work overload while at the same time assuring optimal productivity and job satisfaction for nurse educators. General workload model studies to date do not make provision for the diverse educational workload of nurse educators such as theoretical and clinical accompaniment of basic programmes, in-house courses, short courses and CPD courses. This scenario created the need for research into the workload of nurse educators at a multi-campus private higher education institution.

The main research question that motivated this study (cf. Ch. 1 sect. 1.4) was formulated as:

> *"What constitutes a suitable workload model related to productivity and job satisfaction of nurse educators?"*

To address the main question, four subsidiary questions were formulated.

- How may the concepts of 'workload' and 'manageable workload' of nurse educators be better understood in private nursing education contexts?
- How do nurse educators at one multi-campus private higher education institution view the influence of their current workload on productivity and job satisfaction?
- What constitutes an expert view of the realistic time spent regarding workload activities of nurse educators at a private higher education institution?
- What are the characteristics of a suitable workload model to possibly improve the productivity and job satisfaction of nurse educators within a private higher education context?

The first part of the study aimed to achieve a better understanding of six key concepts, namely 'workload', 'workload balance', 'workload model', 'productivity', 'job satisfaction' and 'the academic role' of nurse educators (see Figure 2.1). A better understanding of these fundamental building blocks was obtained from the qualitative data generated from the nurse educators in this study (see Chapter 6).

A conceptual framework for the study of the workload phenomenon of a nurse educator was developed as observed within private nursing education (see Chapters 2, 3 & 4). The

continuous challenges and changes in private nursing education have both direct and indirect implications for the workload and working lives of nurse educators. As such, it contributes to the complexity of nursing education and the training environment as well as the heavy workload of the nurse educators in the private higher education institution. Hence, it justified further investigation. Considering the factors mentioned in Chapters 2, 3 and 4, it became clear that a suitable theoretical lens was required for the empirical part of the study in order to analyse and interpret the relevant data (cf. Ch. 4 sect. 4.2, 4.3 & 4.4).

Plowright's Framework for an Integrated Methodology (FraIM) was employed to address the main research question from a methodological and design point of view. Nurse educator workload diaries, interviews with nurse educators and a modified Delphi exercise was used to investigate the workload activities of a group of nurse educators within a private higher education context and to achieve expert consensus on the realistic time spent on nurse educator workload activities.

Considering the foregoing, some factual and conceptual conclusions could be drawn from the findings of the study and a number of implications could be pointed out. The chapter concludes with the research limitations of the study and a synthesis.

8.1   CONCLUSIONS

8.2.1.   Factual conclusions

The factual conclusions were based on the empirical findings of the study, namely from the focus group interviews, individual interviews, workload diaries and the Delphi exercise (Trafford & Leshem 2012:140). The main point that emerged from the different data sets was that the overall workload of the nurse educators in the study was excessive, ineffective and demoralising and required urgent revision. To inform a more suitable workload model, one first needs to understand the factors leading to the ineffectiveness of the current workload practice which emerged from the factual information as explained next.

8.2.1.1   Inadequate time allocation per workload activity

The study provided sufficient evidence that the actual time spent on each of the teaching, clinical practice, research and administrative workload activities dictate the working life of the participant group of nurse educators (cf. Ch. 7 sect. 7.2.1 & 7.2.2). It was evident from the data that the activities in one component of the workload of the nurse educator have an impact on the activities of other components (cf. Ch. 6, Ch. 7 sect. 7.3 & Ch. 4 Figure 4.5). For example, when a nurse educator spends too much time in class, there is limited time available for the clinical accompaniment of nursing students in the clinical practice environment (cf. Ch. 6 sect. 6.2.1). The findings discussed in Chapter 7 (cf. sect. 7.2.1 & 7.2.2) not only provided evidence of the type of nurse educator workload activities but it also gave an indication of the relative amount of time spent on each workload activity. The findings thus revealed the time spent on each individual workload activity, the average hours spent on each workload activity (see Tables 7.5, 7.6 & 7.7) as well as the total average hours spent on all workload activities monthly (see Tables 7.1, 7.2, 7.3 & 7.4). This information seems crucial if one wants to contribute to a more effective time management dispensation for nurse educators.

Despite the identified private higher education institution's moving away from traditional teaching, the current way of doing is not optimal due to a teacher centered approach. To bridge this gap successfully a paradigm shift might be needed away from the nurse educator to an approach where students are given much more responsibility in the learning process (Harden & Crosby, 2000:334).

Although consensus could not be reached among expert participants on the realistic time to be allocated for the research activities of a typical nurse educator, nurse educators themselves seem to believe that they do not have adequate time available to do research (cf. Ch. 7 sect. 7.2.2.3). This was identified as a concern as research is not only a regulatory requirement (SANC, 2013a) but also an area where the knowledge base of the nurse educator is broadened and which contributes to further skills development. It became evident that the participant nurse educators have complex and multidimensional educational workloads as evidenced from the qualitative findings (see Tables 6.3 & 6.4). Consequently, they experience their current workload as overwhelming (see Table 6.2) and the impact of the current nurse educator workload (cf. Ch. 6 sect. 6.2.9) may

contribute to superficial training, clinically incompetent nursing students and to the burnout of nurse educators.

8.2.1.2   Improved scheduling of programmes and courses

The study involved a group of nurse educators who are faced with 56 programmes and courses offered at seven nursing education sites of the identified higher education institution commencing at different dates during the academic year. These different programmes and courses not only result in peak work loading throughout the year but it also divides the attention of the nurse educators (cf. Ch. 6 section 6.2.2.1, Tables 6.3 & 6.4) as each educator is responsible for a programme and at least two courses.

It was observed that a key activity such as clinical accompaniment seems to be compromised by the unavailability of students that is drawn in as part of the hospitals' workforce, a situation which is also being aggravated when students are not available, even if they were scheduled (see Table 6.13). Apparently it is very difficult to reinstate a failed appointment due to a lack of flexibility of nurse educators caused by their work overload.

8.2.1.3   Excessive non-core workload

The empirical findings confirmed that the various nurse educator workload activities (cf. Ch. 7 sect. 7.2.1) are divided into four components, namely teaching, clinical, practice, administration and research. The monthly average shown is 74 hours (44% of total working hours) for the teaching component (see Table 7.1), 56.7 hours (34%) on the clinical practice component (see Table 7.2) and 57 hours (34%) on the administrative component (Table 7.3) at the identified private higher education institution. A surprising result was that the time spent on the administrative and clinical workloads were the same. This seems ironical, especially when considering the identified private higher education institution attaches more value to the clinical practice component of the nurse educator workload. The data also indicated why nurse educators experience their administrative workload as extremely excessive (cf. Ch. 6 sect. 6.2.2.1, Table 6.7). These findings confirm that practical learning of students is regularly sacrificed as a consequence of an increased nurse educator workload as is also pointed out by Griscti *et al.* (2005:84). Data

also indicated a clear need to review the excessive administrative workload of nurse educators (see Table 6.7).

The study provided concrete evidence of the daily challenges experienced by nurse educators to accommodate their ever-increasing travelling time within an already demanding workload. From the scenarios used as examples (cf. Ch. 7 sect. 7.3) it became clear that the excessive distances nurse educators have to travel between the different clinical facilities and the nursing education sites pose a problem (see Table 6.16). Although it remains complex to accurately allocate fixed travel times between the clinical facilities due to the difference in travelling time in city and rural traffic, this unproductive time cannot be ignored and has to be reflected into any proposed workload model as it directly affects the available time for clinical practical activities.

8.2.1.4   Clinical mentorship

Insufficient mentorship by the operation mentors in the clinical facilities appears to be a main contributor to the obstructive clinical development of nursing students (cf. Ch. 6 sect. 6.2.2.2). The perception reigns that mentors in the nursing units will first prioritise their own day-to-day functional responsibilities before allocating time to student mentorship (see Table 6.11). This finding was clearly supported by the educator feedback which indicated that very little time seems available for student mentorship (see Table 6.12). However, it is expected of a nurse educator to fill the mentorship gap and accompany the students in the nursing units which adds to their workload and poses a major challenge due to the number of students allocated to nurse educators in the respective clinical facilities (see Tables 6.11, 6.12 & 6.31).

8.2.1.5   Allocation of clinical accompaniment time

Consensus by the Delphi participants in the study indicated the allocated monthly time spent on the clinical accompaniment of students to be unpractical (cf. Ch. 7 sect. 7.2.2.3). Currently, the time for guided practice learning is divided among multiple students in the affiliated private hospitals which does not allow nurse educators to spend more than six hours per student unless the students covers the sessions on their 'off' days (see Table 6.10). A key activity such as clinical accompaniment is thus often being compromised by the unavailability of students that are involved as part of the hospitals' workforce, a

situation which is aggravated when students are not available, even if they were scheduled to be so (see Table 6.13). Observations and experience have shown (see Tables 6.14 & 6.32) that it is difficult to reinstate a failed appointment due to the lack of flexibility of nurse educators – mainly caused by excessive workloads. Additional time seems to be needed for contact teaching and learning sessions in view of the additional time required for the preparation of practice-orientated activities.

8.2.2.   Conceptual conclusions

While most studies on nurse educator workload focus on faculty workload or clinical workload, the present study was the first known study in South Africa focusing on a combination of multiple workload activities of nurse educators within a private higher education context. This includes the teaching workload, clinical practice workload, research workload and administrative workload activities other than those activities reported in literature on the typical workload challenges of academic faculty (see Bentley & Kyvik, 2012:529; Colbeck, 2002:43; Pohl *et al.*, 2002:238; Ellis, 2013:303; Houston *et al.*, 2006:17; O'Shea, 1996:20; Seaberg, 1998:7; Zabriskie *et al.*, 2002:4).

Similarly, all calculations of nurse educator workload were based on the first-hand recording of time spent on each workload activity and not based on credits or formulas as generally referred to in literature. This approach informed a better understanding of the complexity of the problem and contrasts with previous research conducted by Collins (2006:27), Cowdery & Agho (2007:73), Ellis (2013:304) and Kordsadze (2013:117). These authors contributed mostly from an idealistic perspective of determining workload. The actual hours spent on activities are probably a more accurate and realistic way to calculate and understand the workload challenges of nurse educators (Soliman, 1999:4; Vardi, 2009:506).

The following conceptual conclusions may contribute to a better understanding of the nurse educator profession as well as the key concepts highlighted by the study (see Figure 4.5) – in particular within the context of the private higher education sector in the South African healthcare environment.

8.2.2.1. Enhancing productivity

Educator productivity within private higher education appears to be much more than merely the bare mathematical equation of output related to input (Allen, 1997:27). The productivity concept is also influenced by organisational, cultural and interpersonal relationships since productivity does not take place in a vacuum. An understanding of improving productivity with regard to overall nurse educator workload implies the following aspects.

Teaching productivity might be enhanced with additional accessible resources of technology (see Table 6.29), which will not only improve the overall teaching productivity of the nurse educator, but also assist the modern-day students who are more adapted to the learning opportunities offered by advanced technology (DiVall, 2014:1; Wong, Kuper, Robinson, Morra, Etchells, Wu, Shojania, 2012:795). The administrative productivity can be improved with exposure to more accessible time user-friendly electronic student files (see Table 6.30) as confirmed with a study done by Darra (2006:105) which confirms administrative productivity will be improved with exposure to more accessible time-sensitive electronic student files (see Table 6.30). The sample quotes in Table 6.31 indicate, with more time available for the nurse educator to conduct clinical accompaniment in the clinical practice environment it will directly enhance overall clinical productivity. Both the narrative findings (see Chapter 6) and the numerical findings (see Chapter 7) of the study indicated that the elimination of inefficiency might contribute to an increase in the overall productivity of the nurse educators which could significantly increase the available hours of the nurse educator to be spent on the production of well-trained competent nurses who can enter the labour-market directly after training (cf. Ch. 3 sect. 3.4.2 & 3.4.3). Due to the complexity of measuring productivity in nursing education, a proper understanding of the links among teaching, administration and clinical productivity is often misunderstood and misapplied (cf. Ch. 2 sect. 2.4).

8.2.2.2. Job satisfaction

From the study it became clear that nursing educators experienced a high level of job satisfaction despite their current workload – probably, because this is what they most wanted to do (see Table 6.27). Relevant literature reminds us that high job satisfaction is one of the most effective sources and a key factor in improving the productivity and

performance of an organisation (see Table 6.27) (Mustapha, 2013:121). The contribution of job satisfaction cannot be underestimated because it improves the teaching, clinical education/accompaniment, service and research productivity of a higher education institution (cf. Ch. 2 sect. 2.5) (Syptak, Marsland & Ulmer, 1999:27). Job satisfaction also enhances priority-setting and career development that is meaningful and centralised around staff needs and values (Akinci 2002:4; Gappa, Austin & Trice, 2007:105; Temesgen *et al.,* 2018:1). The responses of individual nurse educators regarding their workload differed in the study as individual workload pressures are experienced differently (see Table 6.2). Job satisfaction can thus change from a positive experience to a negative experience or vice versa as workload increases or decreases. One may conclude that the impact of job-satisfaction cannot be underestimated and this seems to have been criticality illustrated by the importance thereof to the identified higher education institution to maintain high levels of job satisfaction (see Tables 6.27 & 6.28).

8.2.2.3   Workload balance

From the research it appears that the lack of time due to high workload and the differentiation in the value of time between the teaching, clinical, administrative and research workload of the nurse educator are the fundamental cause of the imbalance of the daily workload of a nurse educator (see Tables 6.2; 6.5; 6.7; 6.10; 6.11 & 6.17). Sawyer *et al.* (2000:513) draw attention to the fact that a nursing education institution must strive for a balanced workload distribution between the responsibilities of a nurse educator. Ellis (2013:304) sees after hours work done by a nurse educator as a way of the nurse educator attempting to achieve all role expectations. For a successful workload balance, it implies the development of criteria and guidelines around equity, transparency and consultation based on the vision and mission of the private higher education institution (Lobo & Liesveld, 2013:277).

8.2.2.4   Partnerships for the clinical development of students

Clinical accompaniment of students plays a crucial role in the clinical practice environment for theory-practice integration and the development of a student from a dependent to a competent independent practitioner (SANC, 1992:7). The challenges with clinical mentorship and support from hospitals have been identified as a major contributor to the imbalance of the current nurse educator workload in this study (see Tables 6.10; 6.11 &

6.12). A partnership in the form of a formal contractual arrangement such as a service level agreement between higher education institutions and hospitals will address both the needs of patients (better quality service) in hospitals and the teaching, practice, administrative and research needs of the higher education institutions (Saxe *et al.*, 2004:166). An effective partnership will result in a more efficient natural integration of theory and practice in an ever-changing working and educational environment (Chafetz, Collins-Bride & White, 2004:209).

The success of such partnerships for resolving the challenges of the students clinical development depend on both parties' shared decision-making and joint ownership (Drummond-Young, Brown, Noesgaard, Lunyk-Child, Maich, Mines & Linton 2010:152), which might ultimately reduce pressure on the nurse educator's workload.

8.3   IMPLICATIONS OF THE STUDY

The conclusions drawn by the researcher, based on the findings and conclusions from this study, pointed to a number of theoretical and practical implications. The latter included a proposed workload model for nurse educators within a private higher education context.

8.3.1.   Theoretical implications

The theoretical perspectives generated from the literature relevant to this study revealed that current workload models do not seem to fit the profile and needs of employed nurse educators. The conceptual framework that thus emerged drew on various key concepts, the contextualising of the workload phenomenon as well as on resultant theories (see Figure 4.5). For instance, the the systems theory assisted towards an improved understanding of how different subsystems in nurse educator employment link and relate where the workload of the nurse educator can be seen as an open system that continually interacts with its enviroment by ways of inputs, throughputs and and outputs (cf. Ch. 4 sect. 4.2: also see Bruce & Klopper, 2016:45; Sulliven & Decker, 2005:14; Van der Walt, 2016:69). Through the exploration of the systems theory, the researcher became acutely aware of the interdependent and interrelated parts of nursing education such as the educators, their teaching, their clinical practice, their administrative duties and their research.

This complex workload system functions together as a whole to achieve particular personal, employment and institutional goals If one part does not function well, the whole of the system is affected and needs to be changed (Van der Walt, 2016:69). More specifically, the the systems theory assists to better understand the interaction of people with one another and with their environments. Also beneficial is to increase awareness that systems are dynamic and they strive to maintain their own integrity and boundaries while adapting to inevitable changes that are taking place within and outside of the system (Cornell & Jude, 2015:2; Ponomaryov, 2006:724). Similarly, a linear way of thinking (input-throughput-output) and feedback assisted with the analysis and interpretation of events within the private higher nursing education institution where the study was conducted. At the same time, the institution and its external environment impacts on the productivity and job satisfaction of nurse educators (cf. Ch. 4 sect. 4.2; also see Huber, 2013:43).

In addition, the use of the expectancy theory in this study did not only broaden the theoretical perspectives of the study but became instrumental in enhancing the researcher's understanding of different workload activities within each workload component of the particpating nurse educators. The role that rewards, effort and performance play in the behavioural choices of a nurse educator broadened the insights of the researcher as to the fact that nurse educators will always make choices that will work out best for them (Lunenburg, 2011:2; Nel *et al.*, 2011:296). Both the intrinsic and extrinsic motivation of nurse educators appear to be the driving force behind their efforts in achieving job satisfaction and productivity (cf. Ch. 4 sect. 4.5; also see Parijat & Bagga, 2014:1).

This motivational power is influenced by the relationship among the three perceptions of expectancy, instrumentality and valence. Nurse educators have certain expectations, goals and needs as employees while higher education institutions also have certain expectations of their nurse educators. In this sense, nurse educators and the higher education institution continuously need to interact to reach their mutual expectations and goals (cf. Ch. 4 sect. 4.3). In the South African the nursing education environment remains a challenge to recruit and retain competent and skilled nurse educators, so it is important to promote the motivational levels of the current highly qualified and rare nurse educators. In order to achieve this goal it appears that different employees have different expectations of different outcomes and that their decision making is based on the process theory of

expectation for different alternative behavioural choices that leads to the achievement of the desired outcomes (Abadi *et al.*, 2011; Nel & De Beer, 2015:74; Parijat & Bagga, 2014:3).

The practical implications of the study are addressed next.

8.3.2   Practical implications

The study clearly revealed the need for changes in the roles and workload of nurse educators due to significant changes in health and nursing legislation as well as increases in the academic and clinical duties of the nurse educators (cf. Ch. 2 sect. 2.6 & Ch. 3 sect. 3.3; 3.4; 3.5 & 3.6). From the empirical findings it became clear that the current workload of nurse educators at the identified private higher education institution is in need of being reviewed and redesigned to enhance the job satisfaction and the productivity of its nurse educators (cf. Ch. 6 sect. 6.2.1, 6.2.2, 6.2.3, 6.2.5, 6.2.6, 6.2.7, 6.2.8 & 6.2.9 & Ch. 7 sect. 7.3). The proposed workload model for nurse educators which is suggested in the rest of this section was derived from the numerical findings of nurse educators' workload diaries, the consensus reached in the Delphi rounds and literature (cf. Ch. 7 sect. 7.2.1 & 7.2.2). It is also important that any design for a suitable workload model should take into consideration the way in which the institution operates (Perks, 2014).

The proposed nurse educator workload model related to the present study is based on its results and findings and includes the principles as listed below:

(1) It supports the vision, mission and philosophy of the institution and company.

(2) It supports relevant and appropriate qualifications of nurse educators.

(3) It supports the appropriate orientation of nurse educators towards the policies and practices of the institution.

(4) It underscores the scope and authority of nurse educators as professionals to manage their own time.

(5) It supports a fair, transparent and effective framework for the allocation and distribution of workload among nurse educators in the relevant institution.

The fundamentals of the proposed workload model are underpinned by an analysis of the work profiles of nurse educators where teaching, clinical practice, administrative and research activities took place according to the private healthcare provider policy during a 40-hours work week and according to institutional policy over a 44 week academic year with a nurse educator student ratio of 1:30 in the classroom and 1:15 in the clinical practice environment.

Four main workload components of the proposed workload model i.e. teaching (see Table 8.1), clinical practice (see Table 8.2), administration (see Table 8.3) and research (see Table 8.4) have been identified depicting the workload associated with nurse educators. Each workload component has been subdivided into workload activities and the time allocated to each activity has been derived from the research findings and was based on data collated from a real-life training environment. It provides administrators with a practical tool to accurately plan for nurse educator person power that could be taken into account with the workload allocation of nurse educators.

The teaching component, with its associated activities and allocated times, are indicated in Table 8.1.

Table 8.1: Teaching activities and the proposed time spent on each activity

Activity	Hours spent	Comments
Preparing a contact session	2 – 3	Each hour in class
Preparing a venue for class or life support	2 – 3	Per day
Facilitate contact sessions	30	Weekly
Set a 50-point test	3 – 8	-
Set a 100-point examination paper	20 – 25	-
Mark a 100-point examination paper	1 – 2	Per paper
Mark a 100-point assignment	2 – 4	-
Moderation of test or examination papers	8 – 16	Monthly
Invigilate tests or examinations	1.5 – 3	Weekly
Format a test or examination paper	1 – 2	-

Activity	Hours spent	Comments
Review study material	20 – 30	Per month
Develop study material	30 – 42	Per module
Counselling a student	30 minutes – 1 hour	Per student
Student remediation	1 – 2	Per student

To achieve the set criteria for the teaching component and to account for an imbalance in and overloading of nurse educators, the identified private higher education institution will probably need to firstly assist the nurse educators to approach teaching and learning of students in novel ways and secondly to revise its student intake per course per academic year (cf. Ch. 6 sect. 6.2.3). In addition, the potential exists for a central test and lecture bank with a battery of moderated tests per subject from which tests can be compiled as well as a battery of standard lectures per subject and a change in the formative evaluation system (cf. Ch. 6 sect. 6.2.3).

The clinical practice component, with its associated activities and allocated times, are indicated in Table 8.2.

Table 8.2: Clinical practice activities and the proposed time spent on each activity

Activity	Hours spent	Comments
Prepare a demonstration	2	-
Do a demonstration	2 – 6	-
Clinical accompaniment	6	Per student per month
Clinical assessment of student	1 – 2	-
Prepare for a clinical examination	3 – 6	-
Clinical examination	1 – 3	Per student
Clinical allocation of students	0 – 2	Per month
Travelling to and from hospitals	20 – 45	Per month

To achieve the set criteria for the clinical practice component the private healthcare group will probably need to implement a training nursing unit in each training private hospital which can be used to get the different categories of basic student competent before placement in the different nursing units. The identified private higher education institution will probably also need to revise the current system of the allocation of CPD and short courses to nurse educators at the nursing education sites of the private higher education institution (cf. Ch. 6 sect. 6.2.3).

The administrative component, with its associated activities and allocated times, are indicated in Table 8.3.

Table 8.3: Administrative activities and the proposed time spent on each activity

Activity	Minutes spent	Hours spent	Comments
Write and answer emails	-	1 – 3	Per day
Write progress reports of thirty students	-	24	Monthly
Write three-monthly reports	15 – 45	-	Per student
Role and functions as programme coordinator	-	20	Weekly
Compile clinical accompaniment planner	-	1 – 3	Monthly
Loading marks, e.g., tests, examinations, assignments	-	3 – 8	Per month
Completing a student on completion of a course/programme	-	2 – 3	Per student
Attending meetings	-	1 – 3	Per week
Making photocopies		1	Per month
Student interviews		6	Per month

A practical implication of the criteria set for the administration component would be the appointment of additional administrative assistants at a nursing education site where six or

more nurse educators are employed. Such assistants could also assist with the invigilation of tests and examinations (cf. Ch. 6 sect. 6.2.3).

The research component, with its associated activities and allocated times, are indicated in Table 8.4.

Table 8.4: Research activities and the proposed time spent on each activity

Activity	Hours spent	Comments
Research for own professional development	1	Daily
Supervising a student	6 – 12	Monthly

It is expected of nurse educators to continuously improve their qualifications and thus it is important for them to remain scholars in their field of expertise and further develop their skills. Workload activities relating to the further development of nurse educators such as participation in formal research activities, attending of workshops, supervising students and writing articles have been identified as areas that require more attention (see Table 6.15 & Table 7.9). The time allocation for the research component mainly accounted for recent literature on this aspect.

The researcher developed a nurse educator workload model (see Figure 8.1 below) from an analytical perspective of data collected during the study, which represents the complex work environment of the nurse educator and generates a practical work sheet that provides the nursing higher education environment with a simple but effective system to measure the actual workload of nurse educators. In the model, the nursing educator is at the core of the workload with the core structures of teaching workload activities, clinical practice workload activities, administrative workload activities and research workload activities. The circle represents the relation among these activities. Within the private higher education environment, the workload of the nurse educator is not only influenced by changes of the private higher education environment but also by that of legislation, policies, regulations and technology. The time spent on the different activities is represented by the solid arrow, which indicates the time spent and loaded unto a daily practical worksheet to measure and manage nurse educator workload.
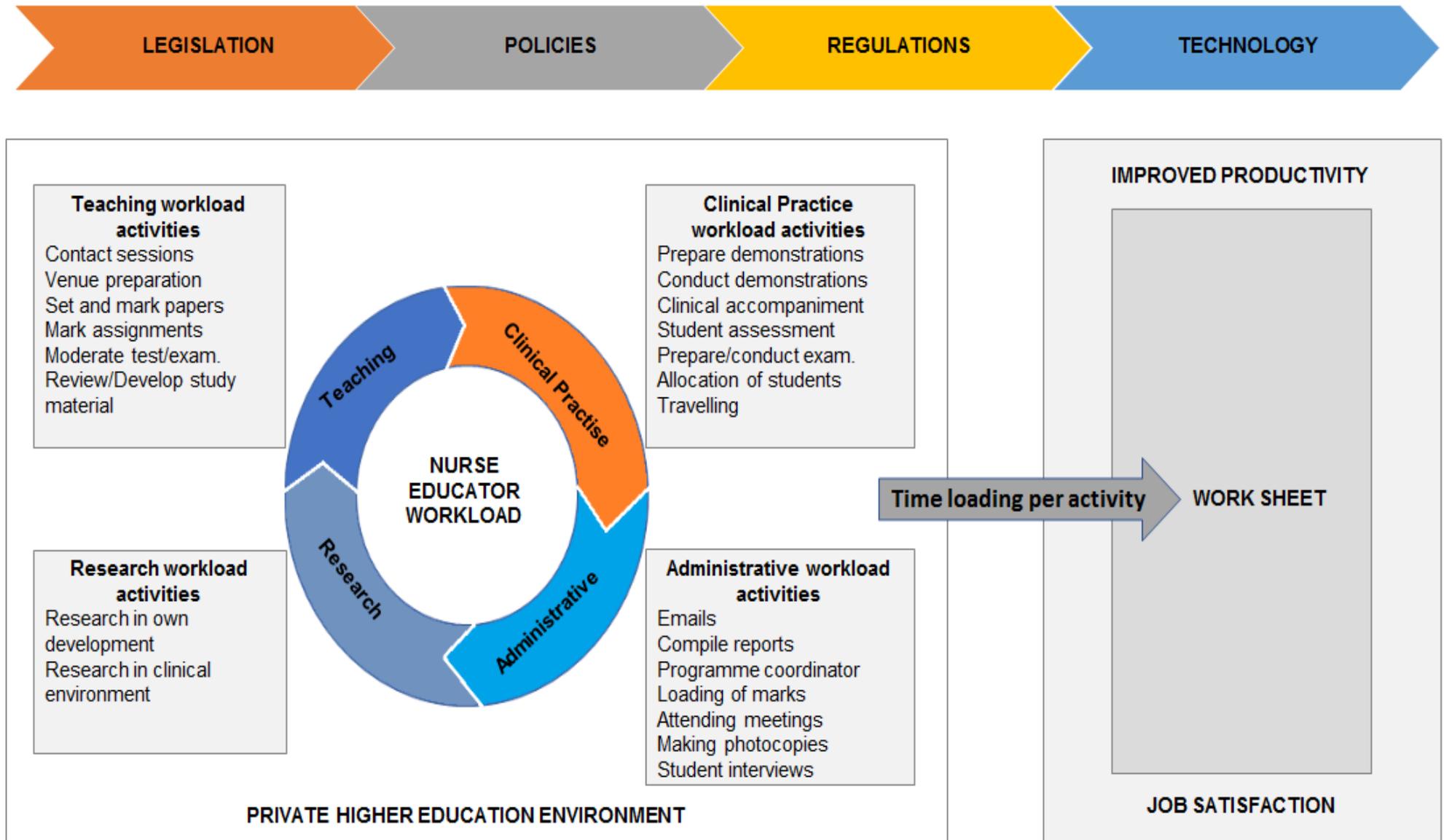
Figure 8.1: Nurse Educator workload model

The aim of the proposed workload model is to take into count as many factors as possible within nurse educator workload activities and allocate time to each activity in order to administrate the workload of nurse educators fairly, transparently and effectively. A copy of an Excel spreadsheet inserted below indicates the functionality of the proposed nurse educator workload model by using the same scenario illustrated in Table 7.10 of the applied findings (calculations) of the workload of one of the participants and applied to the relevant data referred to in Tables 8.1 to 8.4.

The simplicity of the model is demonstrated by the fact that the user is required only to select the applicable component activities relevant to the specific tasks of a month and enter the quantity portion of those activities into the model which will then calculate the projected combined workload of the nurse educator. The outcome of the model must then be compared with the identified company's policy benchmark of 168 working hours per month. It is the view of the researcher that the proposed nurse educator workload model provides nurse educators with a tool to individually micro manage their own workloads and to assist them in making on-the-job adjustments where necessary. It acts as guidance to administrators and managers of the nursing education sites in their decision making when they must deal with major deviations. The proposed model is flexible and can be adjusted to accommodate various nurse educator working scenarios.

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Table 8.5: Example of the proposed nurse educator workload worksheet

Component	Activity	Allocation (hrs)	Units	Quantity	Projected time (hrs)
Teaching	Preparing contact session	0.5	per class hour	48	24
	Preparing class venue or life support	1	Daily	0	0
	Facilitate contact sessions	1	per student week	12	48
	Set a 50-point test	2	per test	0	0
	Set a 100-point examination paper	20	per paper	0	0
	Mark a 100-point examination paper	0.5	per paper	0	0
	Mark a 100-point assignment	2	per student assignment	0	0
	Moderation of tests or examinations	8	monthly	0	0
	Invigilate tests or examinations	0.5	Weekly	4	2
	Format a test or examination paper	1	per paper	0	0
	Review study material	20	monthly	0	0
	Develop study material	30	per module	1	30
	Counselling of students	0.5	per student	0	0
	Student remediation	1	per student	0	0
	Sub-total				**104**

Component	Activity	Allocation (hrs)	Units	Quantity	Projected time (hrs)
Clinical practice	Prepare demonstration	2	per demonstration	0	0
	Conduct demonstration	2	per student	0	0
	Clinical accompaniment	6	per student	8	48
	Clinical assessment of students	1	per student	0	0
	Prepare for clinical examination	3	per examination	0	0
	Conduct clinical examination	1	per student	0	0
	Clinical allocation of students	1	monthly	0	0
	Travelling to and from hospitals	20	monthly	0.3	6
	Sub-total				**54**

Component	Activity	Allocation (hrs)	Units	Quantity	Projected time (hrs)
Administration	Emails	0.5	Daily	22	11
	Compile progress reports on 30 students	24	monthly	0	0
	Compile three-monthly reports	3	quarterly	0	0
	Role and function as programme coordinator	20	Weekly	0	0
	Compile clinical accompaniment planner	2	monthly	0	0
	Loading of marks, e.g., tests, examinations and assignments	3	monthly	0	0
	Closing out of students at end of course/programme	1	per student		0
	Attending meetings	2	Weekly	0	0
	Making photocopies	1	monthly	0	0
	Student interviews	6	monthly	0	0
	Sub-total				**11**

Component	Activity	Allocation (hrs)	Units	Quantity	Projected time (hrs)
Research	Research in own development	1	Weekly	4	4
	Research in clinical environment	1	Weekly	4	4
	Sub-total				**8**
Total monthly working hours					**177**

The researcher integrated elements contained in the systems and expectation theories when designing the proposed workload model demonstrated in Table 8.5. The model reflects the control the system has over the interactions with the environment which can lead to better performance and higher levels of quality (Friedman & Allen, 2011:8). It can be used as a feedback response mechanism (the systems theory) to reinforce and assist in correcting and minimising errors when optimising the nurse educator's workload. The proposed workload model addresses the key variables in the expectation theory as suggested by Nel and De Beer (2015:74) and Vroom (1995:17-22), namely expectation (a person's essential outcomes are possible), instrumentality (a person's credentials will be rewarded) and valence (a person's value or value towards how effective a specific outcome is). These variables can, according to the expectancy theory, be directly linked to the productivity of employees and the relationship between productivity and job satisfaction.

8.3.3   Implications for future research

The present study points to a number of items which can be added to a future research agenda related to nurse educator workload modelling, these include the following potential research topics.

Firstly, it remains questionable what percentage of his/her time a nurse educator should spend on research in a private higher education institution (cf. Ch. 7 sect. 7.2.2.3). There is thus a need to investigate this issue in more depth, considering that the training business and mission of any private health company is to focus on the teaching, clinical practice and administration of nurse educators. However, research by nurse educators is a legislative requirement which needs to be honoured and further investigated.

Secondly, this study aimed to analyse the current workload situation of a group of nurse educators within one private health higher education institution and to suggest a possible workload model within a private higher education domain. It would thus be useful to extend the study to other private nursing education institutions to determine whether there may be differences in workload activities among institutions and to

investigate if such differences might influence the 'ideal' workload model for nurse educators within private health training in South Africa.

Thirdly, there seems to be a need to inquire more deeply into nurse educator-student ratios to establish an adequate ratio for student support within clinical environments. This aspect has not been well explored in South African private nursing education institutions and might provide better insights into the effectiveness of nursing education.

Fourthly, the present suggested model has been based on the realistic time spent by nurse educators on various teaching, clinical practice, administrative and research activities (cf. Ch. 7 sect. 7.2.1 & 7.2.2). Although the proposed model is theoretically and empirically well-founded, it was not tested within the identified multi-campus private higher education institution; therefore, it needs to be tested in practice.

8.3.4   Limitations of the study

Despite the sound scholarly findings generated by the present study some of its limitations also need to be noted.

Notwithstanding the fact that the study was conducted at a private multi-campus higher education institution, , it may still be argued to be a limiting factor that the study covered only one higher education institution.

At the time of the study complex changes were still taking place in the South African national health and higher education contexts which severely impacted nurse training in general and subsequently the workload of nurse educators. The lack (limitation) of a clear understanding of final expectations made it very challenging designing an effective workload model for the future.

Limited relevant literature was available at the time of the study from a cross-reference point of view; current workload models available do not adequately address the diverse range of duties of the modern-day nurse educator in a highly competitive private health care industry.

The opportunity to test the proposed workload model during the study was limited due to a changing nurse training environment. It is envisaged the opportunity to test the workload model will present itself during the period of phasing out the old nursing courses and the full implementation of the new nursing programmes.

8.4   SYNTHESIS

This study revealed the complexity of the work situation of nursing educators at one multi-campus private higher education institution. There is little doubt that nurse educators of the identified private higher education institution are under pressure due to increased workloads within a rapidly changing national and international nurse education dispensation.

The study also showed that the private nurse education sector is faced with financial challenges and although private institutions acquire skills plan levies for the training of nurses in certain specialties, listed companies do not get any state subsidy for basic nursing education. These institutions are expected to carry the financial burden of the training of basic nursing students in a highly competitive world of medical care and education. The main value of the current study thus resides in a proposed workload model that is grounded in real workload complexities as reported by practicing nurse educators and experts within the field. This contribution may not only assist to address the needs of at least one private higher education training institution but also add value to the core business needs of the holding company and other similar nurse education contexts.

From a knowledge perspective, deeper insights and an improved understanding of the various factors contributing to the complex workload of nurse educators were

generated. This sets the scene for the future implementation and evaluation of the proposed workload model which may occupy a post-doctoral study.

In conclusion: This study represents the first known empirical research into the workload spectrum of nursing educators in a private higher education context in South Africa. It is hoped that this contribution would not only add to extending the knowledge in this field but also contribute to the implementation of a realistic and productive workload model for private higher education nurse educators.

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ADDENDUM A

Humanities approval notice

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

Approval Notice
Stipulated documents/requirements

04-Feb-2016

Coetzee, Catherina CM

Proposal #: SU-HSD-001795

Title: A workload model for nurse educators in private higher education: Perceptions of improved productivity and job satisfaction

Dear Mrs Catherina Coetzee,

Your Stipulated documents/requirements received on 29-Jan-2016, was reviewed and accepted.

Please note the following information about your approved research proposal:

Proposal Approval Period: 27-Jan-2016 - 26-Jan-2017

<u>General comments:</u>

Please take note of the general Investigator Responsibilities attached to this letter.

If the research deviates significantly from the undertaking that was made in the original application for research ethics clearance to the REC and/or alters the risk/benefit profile of the study, the researcher must undertake to notify the REC of these changes.

Please remember to use your **proposal number (SU-HSD-001795)** on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC 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.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2015 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

Sincerely,

Clarissa Graham
REC Coordinator
Research Ethics Committee: Human Research (Humanities)

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ADDENDUM B

Research approval

MEDICLINIC

PRIVATE HIGHER EDUCATION

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

10 November 2015

Ethical Committee

University of Stellenbosch

Private Bag x1

Matieland

7602

To Whom it Concerns,

RESEARCH APPROVAL

This letter serves to inform you that Mediclinic (Pty) Ltd grants Catherina Maria Coetzee (student nr. 14254654) permission to collect her research data at the learning centres of the Mediclinic Private Higher Education Institution .

The information will be collected and handled according to the Mediclinic Research policy.

Yours sincerely

Miss A.L. Stroh

(Training and Development General Manager)

ADDENDUM C

Research approval nursing education sites

From: van Zyl, Ann
Sent: 08 February 2016 10:18 AM
To: Coetzee, Kayline
Subject: RE: PhD Research

Dear Kayline

I support your research. You may conduct the research in the learning centres. It will add value to our Higher Education and Training Department.

Kind regards

Ann van Zyl
Higher Education and Training Manager

T +27 21 943 6000
www.mediclinic.co.ca

From: Coetzee, Kayline
Sent: 08 February 2016 09:50 AM
To: van Zyl, Ann
Subject: PhD Research

Dear Ann,

I am currently registered for a PhD degree at the University of Stellenbosch. The title of my research study, which has been approved by the university ethical committee, is "A workload model for nurse educators in private higher education: perceptions of improved productivity and job satisfaction".

I am requesting permission to conduct my research study in the learning centres of Mediclinic Private Higher Education Institution, which will directly benefit from the outcome.

Herewith a copy of my proposal and approval of the Stellenbosch University ethical committee

Please let me know if you require any further information.

Thank you for considering my request.

Kind regards

Kayline Coetzee
T +27 21 943 6143
M +27 82 898 0461
www.mediclinic.co.za

ADDENDUM D

Workload tracking

Learning Centre:		
Your highest qualification:		
Month		
Week start date		
Experience as Educator		
Age		

Indicate the total number of learners in each category of learners which was your responsibility during the month

Category	Classroom	Clinical

Teaching & related activities	Clinical & related activities	Administration & related activities	Other activities	Notes:
Actual facilitation/Teaching	Scheduling of schedules	Read & answer of e-mails	Traveling	* Recordkeeping: monthly reports/ three monthly reports/ extensions/terminations/ completions
Preparation for class	Accompaniment	Letters & monthly reports	Meetings	
Setting tests	Assessment	Photo copies	Workshops	
Invigilating test/exam	Demonstrations	**Recordkeeping** *	Congress	
Moderation tests/scripts/assign	Preparation for demonstration	Student counselling	Student interviews	
Marking tests/scripts/assign/ PoE	Practical examination	Traveling claims	**Work at home** *	* Work at home - please specify the activity you work on at home
Presenting life support	Preparation for examination	Audits		
Preparation for life support	Compiling clinical allocation	Review study guides	**Other** *	* Use other if activity is not listed but please specify what the other activity is.
Developing study material		Review procedures		

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After Hours Working

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ADDENDUM E

Original interview guide for nurse educators

Study participants

Nurse educators at the nursing education sites of the host Private Higher Education Institution who meet the sampling criteria for study participants

Introduction

The researcher is currently registered as a PhD candidate at Stellenbosch University. The title of her study is "**A workload model for nurse educators in private higher education: perceptions of improved productivity and job satisfaction**". Ethical approval was granted on 27 January 2016 number SU-HSD-001795 by the ethical committee of Stellenbosch University.

The aim of this study is to develop a workload model for nurse educators employed by Mediclinic Private Higher Education Institution.

Nurse educators who have been employed by Mediclinic for at least two years meet the inclusion criterion to participate in this study. Each nurse educator who meets this criterion will be invited to voluntary participate in this study.

Nurse educators who have agreed to participate in the study are expected to submit their workload diaries on a regular basis either weekly or monthly.

Commence the interview once informed consent has been obtained.

Questions

Section 1: Workload

I would like you to think about your workload

1. Tell me how you, as nurse educator, experience your current workload?

2. If applicable, what do you think might be helpful to better manage your current workload?

3. Will you please explain the issues that currently affect your workload as a nurse educator?

4. In your opinion, what tasks currently performed by nurse educators could be delegated to other categories of staff?

5. Do you have anything else to add that could assist nurse educators with their workload?

Section 2: Job satisfaction

I would like you to think specifically about job satisfaction

6. Tell me how you currently experience your job satisfaction?

7. If applicable, what would improve your current job satisfaction?

Section 3: Productivity

I would like you to think specifically about productivity

8. What do you think can be done differently to improve the following kinds of productivity at your learning centre?

    8.1 teaching productivity

    8.2   administrative productivity

    8.3 clinical productivity

Closing

Thank you very much for your participation in this interview. It is greatly appreciated.

ADDENDUM F

Consent to participate in research

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title of the study: A workload model for nurse educators in private higher education: Perceptions of improved productivity and job satisfaction

Nurse Educator

You are invited to participate in a research study conducted by Kayline (CM) Coetzee with a current MPhil degree in Higher Education, from the Faculty of Education, Department of Curriculum Studies at Stellenbosch University. The results will contribute to the researcher's dissertation presented for the degree of Doctor of Philosophy. You were selected as a potential participant in this study because of your experience and skills.

1. **PURPOSE OF THE STUDY**

The purpose of this study is to inquire into and redevelop a workload model for the nurse educators of the Mediclinic Private Higher Education Institution.

2. **PROCEDURES**

If you volunteer to participate in this study, you would be requested to participate in an individual interview at your Nursing Education Institution.

3. **POTENTIAL RISKS AND DISCOMFORTS**

This is a nurse educator workload study and there is no risk involved in your participation of this study.

4. **POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The development of a workload model for the nurse educators of Mediclinic Private Higher Education Institution

5. **PAYMENT FOR PARTICIPATION**

There will be no remuneration to the participants.

6. **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of no name of any participant will be mentioned in any report to ensure participant anonymity. Only the researcher will have access to the data. Audiotape recordings and data will be kept locked in a safe place. The results of the study will be published and presented in such a way that the respondents remain anonymous.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:
The Principal Investigator
Kayline Coetzee
Tijgerpark 1
Willy van Schoor drive
Bellville
Telephone number: 021 943 6143
Email kayline.coetzee@mediclinic.co.za

Supervisor
Prof Eli Bitzer
Centre for Higher Education an Adult Education
Stellenbosch University
Telephone number: 021 808 2297

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to the participant by Marina Clarke in English and the participant is in command of this language. I, the participant, was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____
Name of Participant

_____   _____
Signature of Participant   **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____. He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in Afrikaans/English.

_____   _____
Signature of Investigator   **Date**

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ADDENDUM G

Example of consent to participate in research - Delphi

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
Jou kennisvennoot · your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title of the study: A workload model for nurse educators in private higher education: Perceptions of improved productivity and job satisfaction

Dear Participant,

You are invited to participate in this Delphi survey conducted by Kayline (CM) Coetzee with a current MPhil degree in Higher Education, from the Faculty of Education, Department of Curriculum Studies at Stellenbosch University. The results will contribute to the researcher's dissertation presented for the degree of Doctor of Philosophy. You were selected as a potential participant in this study because of your experience and skills.

1. PURPOSE OF THIS SURVEY

The purpose of this survey is to reach consensus on the time spend on identified workload activities of the nurse educators.

2. PROCEDURES

If you volunteer to participate in this three round Delphi survey, you would be requested to do the following things:
- You will be asked to provide information about yourself and evaluate teaching-, clinical-, administrative-, research- and ad hoc activities
- You will need to agree or disagree with the statements and evaluate your answer according to a scale of 1 to 4
- You will receive feedback after each round

3. POTENTIAL RISKS AND DISCOMFORTS

This is a nurse educator workload study and there is no risk involved in your participation of this study.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The development of a workload model for the nurse educators of Mediclinic Private Higher Education Institution

5. PAYMENT FOR PARTICIPATION

There will be no remuneration to the participants.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of no name of any participant will be mentioned in any report to ensure participant anonymity. Only the researcher will have access to the data. Audiotape recordings and data will be kept locked in a safe place. The results of the study will be published and presented in such a way that the respondents remain anonymous.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:
The Principal Investigator
Kayline Coetzee
Corporate Office
25 Du Toit street
Stellenbosch
Telephone number: 021 861 1021
Email kayline.coetzee@mediclinic.co.za

Supervisor
Prof Eli Bitzer
Centre for Higher Education an Adult Education
Stellenbosch University
Telephone number: 021 808 2297

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to the participant by Kayline Coetzee in English and the participant is in command of this language. I, the participant, was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____   _____

Signature of Participant   **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____.
He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in Afrikaans/English.

_____   _____

Signature of Investigator   **Date**

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ADDENDUM H

Example of first round Delphi email

From: Coetzee, Kayline
Sent: 04 November 2017 10:40 AM
To:
Subject: Delphi survey

Dear ,

As you are aware, I am currently registered for a PhD degree at the University of Stellenbosch and have reached the final stage of the data collection phase of my research titled "A workload model for nurse educators in private higher education: Perceptions of improved productivity and job satisfaction".

Due to emphasis on high quality of data and your experience and skills you are selected as a subject matter expert and invited to take part in a three round Delphi survey. The purpose of the Delphi survey is to reach consensus on the time spend by you as educator to complete the workload activities as identified in the workload diaries received from you last year.

About the Delphi survey:
- The survey will be conducted over three rounds
- Feedback will be provided to you after each round
- You will receive an e-mail with a link as your unique access to the Delphi survey
- It is estimated the survey should take approximately 10 minutes to complete online
- You will be presented with 34 workload activities identified from the workload diaries received previously
- You will be asked to validate the activities in order to reach consensus on the time spend on each one of them
- Consensus for the purpose of this research study is define as 80% of participants vote on a specific item within the same value of the four-point scale
- Your answer remain anonymous and confidential to all other participants and will be known only by the researcher

Your voluntary participation up to this stage of my research is dearly appreciated and your contribution is vital to the outcome of this study. *A copy of the consent form to participate is attached to the e-mail for information purposes only; you do not have to complete the form as your consent to participate will be dealt with electronically during the Delphi survey stage.*

Please do not hesitate to contact me if you have any queries.

Here is your unique access to the Delphi survey link
http://surveys.ufs.ac.za/evasys/online.php?p=MM6KC

Have a nice day

Kayline Coetzee
T +27 21 861 1021
M +27 82 898 0461
www.mediclinic.co.za

ADDENDUM I

Example of second round Delphi email

From: Coetzee, Kayline
Sent: 23 November 2017 09:00 AM
To:
Subject: Delphi survey Round 2

Dear,

Thank you for completing the first round of the Delphi process, your participation is sincerely appreciated.

As mentioned in the previous e-mail, due to emphasis on high quality of data and your experience and skills you are selected as a subject matter expert and invited to take part in the second round of the three round Delphi survey. The purpose of the survey is to reach consensus on the time spend by you as educator to complete your daily teaching- clinical- service- and research workload activities.

More about the second round of the Delphi survey:

- The questionnaire for round two focusses on questions or statements where consensus/agreement was not reached in round one

- Details reflected in the questions have been aligned with feedback received from the participants in the first round

- A summary of the responses received in round one is attached for your reference

- You will be asked to validate the time spend on each activity to reach consensus

- Consensus for this research study is defined as 80% of participants vote on a specific item within the same value of the four-point scale (Larson and Wissman, 2000:45)

- You will have the opportunity to change your selection and make additional comments.

- Your feedback remains anonymous and confidential and will only be viewed by the researcher

- You have to follow the link below as your unique access to the Delphi survey

Your voluntary participation up to this stage of my research is dearly appreciated and your contribution is vital to the outcome of this study. *A copy of the consent form to participate is attached to the e-mail for information purposes only; you do not have to complete the form as your consent to participate will be dealt with electronically during the second stage of the Delphi survey.*

Please do not hesitate to contact me if you have any queries.

Here is your unique access to the Delphi survey
link: http://surveys.ufs.ac.za/evasys/online.php?p=UZJ28

Have a nice day

Kayline Coetzee
T +27 21 861 1021
M +27 82 898 0461
www.mediclinic.co.za

ADDENDUM J

Example of third round Delphi email

From: Coetzee, Kayline
Sent: 05 December 2017 09:58 AM
To:
Subject: Delphi round 3 (Final round)

Dear ,

Thank you for completing the first two rounds of the Delphi process, your participation is sincerely appreciated.

As mentioned in the previous e-mail, due to emphasis on high quality of data and your experience and skills you are selected as a subject matter expert and invited to take part in the third round (last round) of the Delphi survey. The purpose of the survey is to reach consensus on the time spend by you as educator to complete your daily teaching- clinical- service- and research workload activities.

More about the third round of the Delphi survey:
- The questionnaire for round three (final round) focusses on questions or statements where consensus/agreement was not reached in round two

- Details reflected in the questions have been aligned with feedback received from the participants in the second round

- A summary of the responses received in round two is attached for your reference

- You will be asked to validate the time spend on each activity to reach consensus

- Consensus for this research study is defined as 80% of participants vote on a specific item within the same value of the four-point scale (Larson and Wissman, 2000:45)

- You will have the opportunity to change your selection and make additional comments.

- Your feedback remains anonymous and confidential and will only be viewed by the researcher

- You have to follow the link below as your unique access to the Delphi survey

Your voluntary participation up to this stage of my research is dearly appreciated and your contribution is vital to the outcome of this study. *A copy of the consent form to participate is attached to the e-mail for information purposes only; you do not have to complete the form as your consent to participate will be dealt with electronically during the second stage of the Delphi survey.*

Please do not hesitate to contact me if you have any queries.

Here is your unique access to the Delphi survey
link: http://surveys.ufs.ac.za/evasys/online.php?p=A958U

Have a nice day

Kayline Coetzee
T +27 21 861 1021
M +27 82 898 0461
www.mediclinic.co.za

ADDENDUM K

Quicksheet

Workload Diary – Quick tip sheet

Thank you for participating in this project. We realize that this is going to take effort on your part to complete and with that in mind we tried to design a simple and easy way for you to track your activities.

1   Use the Drop-downs to complete the Demographic section

The demographic section is found on the top left corner of the sheet.

All the cells that are shaded gray contain drop down selectors. Click on the cell and select the most appropriate option.

Drop downs will be displayed to the right of the cell.
Click on the drop down and then click an option to select it.

Use the scroll bars to move up or down through the options

2   Complete the demographic section and save the workbook

Complete the demographics once and then save the file.

Every week, open the template and save as a new sheet or book with this section already completed.

· *Use Save As .. and save a new workbook;*

Important: There is a **Tracking Key** field on top of the page. Please assign a unique random word and ensure that the key is on every submitted sheet. This will allow us to tie your weekly entries together.

3   Copy, Paste and Autofil

To complete the calendar activities, copy the appropriate activity from the various categories and tasks listed. Paste the task in the start day/time cell and autofil it for the duration.

ADDENDUM L

Consent to participate in research study – workload diaries

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
Jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title of the study: A workload model for nurse educators in private higher education: Perceptions of improved productivity and job satisfaction

Nurse Educator

You are invited to participate in a research study conducted by Kayline (CM) Coetzee with a current MPhil degree in Higher Education, from the Faculty of Education, Department of Curriculum Studies at Stellenbosch University. The results will contribute to the researcher's dissertation presented for the degree of Doctor of Philosophy. You were selected as a potential participant in this study because of your experience and skills.

1. **PURPOSE OF THE STUDY**

The purpose of this study is to inquire into and redevelop a workload model for the nurse educators of the Mediclinic Private Higher Education Institution.

2. **PROCEDURES**

If you volunteer to participate in this study, you would be requested to do the following things:
- Keeping a daily workload diary on a prepared document. You have to submit the completed document monthly to the researcher.
- Your activities will be observed in the field for a full 8-hour shift.
- You will have to participate in a group interview at your Nursing Education Institution.

3. **POTENTIAL RISKS AND DISCOMFORTS**

This is a nurse educator workload study and there is no risk involved in your participation of this study.

4. **POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

The development of a workload model for the nurse educators of Mediclinic Private Higher Education Institution

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5. PAYMENT FOR PARTICIPATION

There will be no remuneration to the participants.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of no name of any participant will be mentioned in any report to ensure participant anonymity. Only the researcher will have access to the data. Audiotape recordings and data will be kept locked in a safe place. The results of the study will be published and presented in such a way that the respondents remain anonymous.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:
The Principal Investigator
Kayline Coetzee
Tijgerpark 1
Willy van Schoor drive
Bellville
Telephone number: 021 943 6143
Email kayline.coetzee@mediclinic.co.za

Supervisor
Prof Eli Bitzer
Centre for Higher Education an Adult Education
Stellenbosch University
Telephone number: 021 808 2297

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to the participant by Kayline Coetzee in English and the participant is in command of this language. I, the participant, was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____   _____

Signature of Participant   **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____. He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in Afrikaans/English.

_____   _____

Signature of Investigator   **Date**

427

ADDENDUM M

Research invitation workload diaries

From: Coetzee, Kayline
Sent: 10 February 2016 06:52 PM
To:
Subject: Research

Dear Nurse Educator,

I am currently registered for a PhD degree at the University of Stellenbosch. The title of my research study, which has been approved by the university ethical committee, is "A workload model for nurse educators in private higher education: perceptions of improved productivity and job satisfaction".

You are selected as a potential participant and invited to take part in this study because of your experience and skills. The purpose of this study is to inquire into and redevelop a workload model for the nurse educators of the Mediclinic Private Higher Education Institution. I have embarked on this study to investigate and develop an optimum workload model for nurse educators under various conditions. The data collection phase will take place over a period of 12 months.

Your voluntary participation will be dearly appreciated and is vital to the outcome of this study. Kindly complete the attached "consent to participate in research" to confirm your participation and forward it to me on or before 1 March 2016. On receipt of the document a signed a copy will be forwarded to you.

If you volunteer to participate in this study the attached workload tracker sheet will take you 20 -25 minutes to complete the first time and there after 10 minutes if done regularly. For your convenience follow the instructions on the attached workload tracker quick tip sheet.   Please forward your workload tracker sheet weekly to: workloadproject@portalmediclinic.co.za

Please do not hesitate to contact me if you have any queries.

Have a nice day

Kayline Coetzee
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ADDENDUM N

Confidentiality agreement - transcriber

CONFIDENTIALITY AGREEMENT

I, the undersigned Leigh Story

1. herewith undertake that all information disclosed or submitted, either orally, in writing or in other tangible or intangible form by Kayline Coetzee to me, or made available to me, or details of Kayline Coetzee' business or interest of which I may become aware of in respect of transcriptions being done by myself for Kayline Coetzee, to keep confidential and not to divulge to anyone for which Kayline Coetzee did not give written consent;

2. guarantee that I will apply the information, detail or knowledge in **clause 1** only for the purpose of the intended research;

3. indemnify Kayline Coetzee against any claims that may be instituted against Kayline Coetzee, amounts that may be claimed or losses that Kayline Coetzee may suffer in consequence of a violation by me of any provision included in this agreement.

SIGNED at Cape Town on 10th October 2017

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ADDENDUM O

Editor certificate

Suzette M. Botes

FULL MEMBER: Professional Editors' Guild

28 August 2018

TO WHOM IT MAY CONCERN

I, Suzette Marié Swart (ID 5211190101087), confirm that I have edited the noted PhD thesis:

A suitable workload model for the nurse educators in private higher education towards improved productivity and job satisfaction

The accuracy of the final work remains the responsibility of the student.

STUDENT:
Ms C.M. Coetzee
INSTITUTION:
Stellenbosch University

Editing guide used:
STELLENBOSCH UNIVERSITY LANGUAGE CENTRE
MAKE SENSE OF REFERENCING
The Harvard, APA and Vancouver methods and the Footnote system (3rd edition)

The edit included the following:
- Spelling
- Vocabulary
- Punctuation
- Grammar (tenses; pronoun matches; word choice etc.)
- Consistency in terminology, italisation etc.
- Sentence construction
- Suggestions for text with unclear meaning
- Logic, relevance, clarity, consistency
- Checking reference list against in-text sources

Thank you

Suzette M. Botes (not signed – sent electronically)
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Email: suzette.botes.21@gmail.com

LANGUAGE PRACTITIONER/EDITOR/FACILITATOR:
Aston University (UK)
Consortium for Language and Dimensional Dynamics (CLDD)
Health Advance Institute (HAI)
Milk Producers' Organisation – Institute for Dairy Technology
Milpark Business School
Sefako Makgatho Health Sciences University (formerly known as Medunsa)
South African Civil Aviation Authority (SACAA)
Stellenbosch University (US)
Tshwane University of Technology (TUT)
University of Johannesburg (UJ)
University of Pretoria (UP)
University of South Africa (Unisa)