DURBAN UNIVERSITY OF TECHNOLOGY

AN EXPLORATION OF CLINICAL SUPPORT TO NURSING COMMUNITY SERVICE PRACTITIONERS IN UGU DISTRICT, KWAZULU-NATAL

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CLINICAL SUPPORT TO NURSING COMMUNITY SERVICE PRACTITIONERS IN UGU DISTRICT, KWAZULU-NATAL

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DECLARATION

I, Ignatia Tandiwe Malunga declare that **"Clinical support to nursing community service practitioners in Ugu District, KwaZulu-Natal"**

is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Ignatia Tandiwe Malunga February 2018

_____ _____

Signature of student Date

DECLARATION

I, Ignatia Tandiwe Malunga declare that "**Clinical support to nursing community service practitioners in UGu District, KwaZulu – Natal**", is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Ignatia Tandiwe Malunga December 2016

Signature of student Date

Approved for final submission

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6/3/2017
Date

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DEDICATION

This study is dedicated to all nurses doing compulsory community service in KwaZulu-Natal.

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ABSTRACT

Introduction: The shortage of skilled health professionals in public health care facilities is the main reason why compulsory community service was started by the South African government. The change in the disease pattern over the past two decades coupled with the mass exodus of health care professionals to overseas countries resulted in severe staff shortages especially in rural areas.

Nursing community service practitioners (NCSPs) lack experience in dealing with complex clinical problems especially at primary health care level. They need experienced health professionals to offer clinical support to them.

Aim of study: The aim of the study was to establish the degree of clinical support that is offered to NCSPs who are placed for compulsory community service within the Ugu district.

Methodology: A qualitative study was conducted using an exploratory-descriptive design. Purposive sampling was utilized to select eight NCSPs from a regional hospital and a community health centre. Semi-structured interviews were conducted and data was recorded verbatim for accurate analysis. Content analysis of data was employed where data was analyzed into meaningful themes.

Results: The study revealed gaps in the clinical support offered to NCSPs. Lack of clinical support was reported more in the hospital than at the community health centre. Organizational problems such as lack of orientation, absence of in-service education and lack of proper rotation to different departments were some of the main concerns that were reported.

Conclusion: Nursing community service practitioners need clinical support from experienced health professional to guide and teach them until they develop confidence.

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LIST OF ACRONYMS

AIDS: Acquired immunodeficiency syndrome

ART: Antiretroviral therapy

NCSP: Nursing community service practitioner

DoH: Department of Health (South Africa)

HIV: Human Immunodeficiency Virus

NHI: National Health Insurance

OM: Operational Manager

R425: South African Nursing Council Regulation 425 directs the education and training of a nurse in a four year nurse training programme (Government Gazette Regulation number 425 of 22nd February 1985 as amended) culminating in a qualification as a professional nurse with additional qualifications in Midwifery, Community and Psychiatric Nursing.

SANC: South African Nursing Council

TB: Tuberculosis

WHO: World Health Organization

UN: United Nations

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction

In the first chapter of this study, the concept of “compulsory community service” for health professionals is introduced. The chapter also highlights the need for clinical support needed for these practitioners to facilitate the success of compulsory community service implementation for all health professionals. This study was aimed at exploring the degree of clinical support that is offered to nursing community service practitioners (NCSPs) who were placed at a regional hospital and a community health centre in the Ugu district, KwaZulu-Natal. Background is provided with regard to the purpose of compulsory community service for health professionals and the reasons why clinical support is important for the successful implementation of this initiative by the Department of Health. The problem statement, aim, objectives, and operational definitions of this study are presented.

1.2 Background

Compulsory community service for health professionals is an initiative that was introduced in 2008 by the then Minister of Health, Dr. Mantombazana-Tshabalala Msimang, in order to deal with the staff shortages in government hospitals and clinics, especially in rural areas.

From the late nineteen nineties, a number of experienced health professionals left South Africa for better opportunities outside the country. Health workers who left the country were from different sectors of health care including doctors, pharmacists, dieticians and nurses. In a study by Breier, Wildschut and Mgqolozana (cited in Oosthuizen 2012: 49) the shortage of nurses in South Africa was estimated to be between 14 000 and 21 000 in 2008. The following are some of the reasons for the exodus of nurses from South Africa (HRH SA 2011: 31):

- Lack of vacant posts in the public sector;
- Increase in the number of patients admitted with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS);
- Unfavourable working conditions;
- Increased workload in the public sector;

- Lack of workplace security;
- Low morale in the workplace; and
- The risk of contracting tuberculosis (TB).

In 2013, 165 nurses requested their transcript of training to be verified and sent by the South African Nursing Council (SANC) to overseas countries so that they could be employed in other countries. Twenty six percent of these nurses were migrating to Australia, 13.9% to the United States of America and 12.7% to the United Kingdom (SANC 2013). The SANC is the professional body that regulates training and practice of nurses in South Africa. This figure shows a great decline compared to the 1 180 nurses who applied for verification of qualifications in 2008. Currently there is no statistics available that indicates the number of nurses who have left the country from 2014 to date, however a report by Makhubu (2016:2) indicates that nurses are still emigrating. The movement of health professionals contributes to a shortage of experienced health professionals to care for the sick. This has led to patients and clients having to wait in long queues waiting to be served by the few nurses at the clinics and hospital outpatient departments.

There was a rapid change in the disease pattern and HIV/AIDS was on the rise from the late nineteen eighties until free antiretroviral drugs were rolled out in April 2004. According to Oni *et al.* (2015: 2) the emergence of HIV/AIDS worsened the prevalence of other communicable diseases such as TB and malaria. The presence of diseases such as TB and malaria affected HIV positive patients due to their low immunity and vulnerability to opportunistic infections. According to Statistics SA the total number of people living with HIV in South Africa increased from an estimated 4, 02 million in 2002 to 6,19 million by 2015. In 2015 an estimated 11, 2% of the total South African population was HIV positive. Approximately one-fifth of South African women in their reproductive ages were HIV positive (Stats SA 2015). The Department of Health (DoH) national strategy for 2014 revealed that South Africa has the third highest number of people infected with tuberculosis after India and China (DoH 2012: 23). Van Rensburg (2014: 10) further argues that HIV/AIDS also contributes to staff shortages because of the increased deaths and illness among health workers and bereavement due to Aids-related death of family members. Shortage of staff contributes to heavy workloads, absenteeism, stress, burnout, demotivation, low morale and loss of productivity.

Staff shortages are even worse in rural areas. Rural communities in South Africa account for 46% of the total population and they have the same right as their urban counterparts to access quality health care (George, Gow & Bachoo 2013: 3). These communities, however, do not enjoy the benefits of quality healthcare due to chronic staff shortages.

The shortage of health care professionals could have prevented the realization of the Millennium Development Goals (MDGs) of ensuring health care to all citizens (UN, 2010: 3). The eight MDGs were developed by all member states of the United Nations to monitor development and how countries met the needs of their citizens (UN 2013: 1). The MDGs, that were to be achieved by 2015, included the following:

- Eradicate extreme poverty and hunger.
- Achieve universal primary education.
- Promote gender equality and empower women.
- Reduce child mortality.
- Improve maternal health.
- Combat HIV/AIDS, malaria and other diseases.
- Ensure environmental sustainability.
- Develop a global partnership for development (UN 2013: 3).

Achievement of the MDG's required a joint effort between all health care providers therefore staff shortages could have contributed negatively towards the achievement of MDG's and affected these efforts. Staff shortages might also affect the initiation of the National Health Insurance (NHI) scheme which has been piloted in twelve districts in South Africa and is now being adopted for implementation. This initiative aims to provide all South Africans with access to quality healthcare (South Africa 2011: 3). This ideal, however, cannot be met if health institutions continue to have staff shortages.

Health institutions in rural areas encounter difficulty recruiting and retaining experienced health professionals due to unattractive conditions of service such as poor infrastructure, inadequate medicine and equipment, poor human resource planning, political tension and upheaval (George *et al* 2013: 3). Poor living conditions

such as lack of clean water, poor road conditions, lack of electricity, and lack of telephone connections also make rural health facilities less attractive. Deteriorating work environments, gender discrimination, lack of personal security, HIV and AIDS, poor housing, lack of transport, and diminishing social systems are also some of the reasons that motivate health workers to leave rural public health facilities (Gaede & Versteeg 2014: 102). In rural facilities there is a shortage of experienced professionals who can mentor and support the community service practitioners. According to Roziers *et al.* (2014: 95), hospitals in rural areas lack permanent posts for experienced professionals who can mentor the newly trained professionals.

The problem of staff shortage in rural areas is a global problem. Various countries devised different strategies to attract health personnel to rural areas. In North Carolina, a well – planned placement and transition of newly trained nurses was introduced to achieve their competency, confidence and autonomy (Hofler 2016: 134). According to Maseko (2014:34) other countries like Zambia, started an incentive – based health workforce retention scheme which increased the number of health workers assigned to rural areas.

In South Africa, the DoH made it a requirement that all health professionals should render compulsory community service for a one year period at the end of their training (South Africa 1997: 11). Doctors were the first group of health professionals to commence with community service in 1998, followed by dentists in the year 2000 and pharmacists in 2001. Other health professions such as clinical psychologists, dieticians, environmental health officers, occupational health officers, physiotherapists, radiographers, and speech, language, and hearing therapists started their community service in 2003 (DoH, 2006). In 2004, the South African Health Minister stated that nurses would be included in the community service programme once the Nursing Bill was passed by Parliament (Mohamed, 2005 as cited by Beyers 2013:2). Section 40 of the Nursing Act, No. 33 of 2005 (South Africa 2005), defines compulsory community service for nurses. According to Section 40 of the Act, “A person who is a citizen of South Africa who intends to register for the first time to practice a profession in a prescribed category must perform remunerated community service for a period of one year at a public health facility” (SANC 2010). The South African Nursing Council (SANC) regulation of the Performance of Community Service, Regulation 765 of 2007 (SANC, 2008) further explains how

nurses should perform compulsory community service. In 2008, the first group of professional nurses started their compulsory community service. This applies to nurses who have completed a four year training diploma or degree as stipulated by the SANC (SANC Regulation R425 of 1985). The aim of compulsory community service is to reduce staff shortages in public health institutions especially in rural areas.

The College of Nursing in KwaZulu-Natal is responsible for nurse training in 11 campuses and 14 sub-campuses throughout the province. Ten of these campuses offer the diploma in nursing which leads to registration as a General, Psychiatric, Community nurse and Midwife (SANC Regulation R425). The curriculum for the four-year nursing diploma is designed in such a way that students learn General Nursing Science, Community Nursing Science and other fundamental courses for the first three years. Midwifery is done in the first semester of the fourth year and Psychiatric Nursing Science is done during the last six months of training. Nursing students get to practise in the general wards for three years. On their fourth year of study they only practise Midwifery and Psychiatric nursing respectively. This could have a negative effect on the clinical skills because by the time the student is allocated for compulsory community service, some of the learned skills may be forgotten. Horsburgh and Ross (2013: 1131) emphasise the need for clinical support to newly qualified nurses in spite of academic commitments.

At the end of the training period the student is not yet confident to practise independently and to manage complicated health emergencies since their exposure to clinical situations up until then has been limited. A study conducted by Roziers *et al.* (2014: 92) at the Western Cape, South Africa, further confirmed that students voiced concerns about deficiencies in the curriculum whereas the health institutional staff expected them to excel as newly qualified professional nurses. Curriculum deficiencies include limited periods of clinical exposure which leads to students not gaining sufficient clinical practice. According to Zonke (2012: 12) some complex conditions may not be available during the period of the students' clinical training and therefore the student may not get the required clinical practice.

Beyers (2013: 3) is of the opinion that clinical support by experienced health professionals could assist newly qualified nurses to become familiar with the health

environment, and the responsibilities and workload that allow them to gradually grow into their new role of professional nurses, while they are outgrowing the mind-set of a student who is constantly dependant on the professional nurse. Clinical support during a time of adjustment to the practical nursing milieu is critical for any new nurse, especially in a primary health care setting. In primary health care centres there may not be enough doctors therefore nurses need to be equipped with clinical skills and confidence to deal with complex clinical problems.

The researcher is a lecturer in one of the nursing colleges in KwaZulu-Natal. While doing clinical accompaniment and mentoring of nursing students at the hospital and clinics, the researcher noticed that the NCSPs were unsure how to deliver some forms of nursing care and they often asked for clinical assistance.

1.3 Problem statement

Compulsory community service for health professionals was a strategy to solve the problem of staff shortages within the public sector as explained in section 1.2. Nurses who are placed at public health facilities as NCSPs contribute to providing quality care to patients while they gain experience.

The transition from student nurse to professional nurse may be overwhelming to the NCSPs because of the added responsibilities. According to Beyers (2013: 68) NCSPs need clinical support by senior nursing personnel. The clinical support that NCSPs receive is sometimes not sufficient to help them build their confidence and sometimes not to the extent it should be. This may be due to shortage of professional nurses to supervise them.

Clinical support of NCSPs by experienced health professional nurses will reduce the anxiety due to inexperience and increase productivity (Horsburgh and Ross, 2013: 1132).

1.4 Purpose of the study

The purpose of the study was to establish the extent to which NCSPs receive clinical support from experienced nurses and other members of the multi-disciplinary team.

1.5 Objectives

The objectives of this research were to establish if:

- The NCSPs receive any support from the district trainers that are responsible for staff development within the district.
- Clinic managers, nurse managers and other senior nursing personnel provide any support to NCSPs.
- Other members of the multi-disciplinary health team, other than nurses, provide any clinical support to NCSPs.

1.6 Research question

This study aimed to answer the following research question:

- Do NCSPs receive any clinical support from experienced health professionals during their compulsory community service placement?

1.7 Research methodology

A qualitative study using an exploratory-descriptive approach was conducted. Semi-structured in-depth interviews with NCSPs placed at a Regional hospital and a Community Health Centre (CHC) in the Ugu district were conducted. The researcher chose a regional hospital because it serves as a referral hospital for the three district hospitals within the district and therefore deals with complex clinical cases. The researcher sought to establish if the newly trained nurses received any clinical support to help them cope with such complex cases. The study also aimed to establish what clinical support NCSPs received from experienced health workers in such a hospital. A CHC was chosen because it is located at primary health care level and the professional nurses work independently without relying on the doctor. The newly qualified nurses are expected to work independently without the necessary experience and therefore need clinical support. Interviews were continued until saturation of information was reached, which was after eight interviews. Research methodology will be discussed fully in Chapter 3.

1.8 Significance of the study

The researcher hopes that the study findings will be useful to health facilities where NCSPs are placed for compulsory community service. The study can help senior

staff in those facilities understand the challenges that NCSPs face and their need for clinical support. It is assumed that the findings will assist hospital and CHC managers to develop a plan to provide clinical support to NCSPs.

Future NCSPs will benefit since the hospitals and CHCs will have clear guidelines for providing clinical support to them.

The DoH will benefit because the findings may provide an insight into the clinical support that NCSPs receive and whether it is sufficient.

1.9 Definition of concepts

The following terms and definitions will be applicable for this research.

1.9.1 Compulsory community service

The term refers to the compulsory service that health care professionals are compelled to perform at public health care facilities, after they have successfully completed their diploma or degree course. The successful completion of the one-year community service is a requirement for entering the nursing profession as a professional nurse (SANC 2010). In this study the term community service shall be used to refer to compulsory community service.

1.9.2 Community service practitioner

Any person who is a citizen of South Africa intending to register for the first time to practise a profession in a prescribed category must perform remunerated community service for a period of one year at a public health facility (SANC 2005: 29). In this study such a person shall be referred to as a 'Nursing Community service Practitioner' (NCSP).

1.9.3 Mentorship

Wong *et al* (2016: 14) define mentoring as an interpersonal relationship in which a senior or more experienced person helps a junior or inexperienced person to succeed within the organization.

1.9.4 Professional nurse

According to the Nursing Act No. 33 of 2005, a professional nurse is “someone who is educated and competent to practice comprehensive nursing, assumes responsibility and accountability for independent decision making in such practice and is registered and licensed as a professional nurse under the Nursing Act”.

1.9.5 Experienced health professional

In this study an experienced health professional refers to any person registered by the SANC, the Health Professions Council of South Africa or any other professional statutory body and has been practising the profession for three years or more.

1.9.6 Student nurse

‘Student nurse’ refers to anyone who has passed matric and is pursuing a four year nursing degree or diploma as regulated by the SANC (R425). For purposes of the study the terms ‘nursing student’ and ‘student’ will be used to mean the student nurse.

1.9.7 Clinical support

In this study clinical support refers to the support that is offered to nursing community service practitioners which includes mentoring, training, orientation and guidance by experienced health professionals.

1.9.8 Sufficient clinical support

This term is used in this study to refer to clinical support that is enough to assist nursing clinical service practitioners to become competent and safe practitioners.

1.9.9 District trainer

In this study a district trainer refers to a professional nurse who is responsible for clinical training within the district.

1.10 Layout of chapters

Chapter 1: Overview of the study.
Chapter 2: Literature review.

Chapter 3: Methodology – research design, data collection.

Chapter 4: Data analysis, interpretation and discussion.

Chapter 5: Recommendations and conclusion.

1.11 Summary

This chapter gives an overview of the research process. It gives insight into the steps that were followed in establishing the clinical support that the NCSPs receive. The problem statement, research objectives and the significance of the study were discussed. In the next chapter, relevant literature that was used as a basis for the study will be discussed.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In the previous chapter, an overview of the study was discussed. In this chapter, literature relevant to clinical support and compulsory community service is discussed.

Grove, Burns and Gray (2013: 40) define a literature review as a broad, comprehensive, in-depth, systematic, and critical review of scholarly publications which enables the researcher to “build on the work of others”. It is an account of the published data accumulated by accredited scholars. The literature review further provides a foundation on which to base new evidence (Polit & Beck 2012: 58).

In this study the researcher embarked on an exhaustive database search for both national and international English-medium articles related to the experiences of and clinical support received by community service practitioners. Access to databases was mainly through the Durban University of Technology’s electronic library’s Summon search facility. The researcher mainly used EbscoHost which allowed her to search for other useful databases. Search engines that were accessed on EbscoHost include Academic Search Complete, CINAHL Plus with Full Text, Health Source: Nursing/Academic Edition and MEDLINE with Full Text. These databases were used to find articles in academic journals and other scholarly repositories. Key words such as ‘compulsory community service’, ‘clinical support’, ‘newly qualified nurses’ and ‘experiences’ were used to facilitate the search.

Links to the website of the KwaZulu-Natal Department of Health (www.kznhealth.gov.za) were utilised to access statutory regulations of the SANC and other relevant linked websites.

2.2 The rationale for compulsory community service in South Africa

2.2.1 Staff shortage

South Africa is faced with huge disparities in the health care system. This is the result of the previous apartheid government-led health care system that was characterised by fragmented and unequal health care services (Rispel 2016: 21). After 1994 when the democratic government took over, the health care system was unified under a single National Department of Health (DoH). The focus shifted from curative, hospital-based care to primary health care which emphasises preventive and promotive health (Mayosi and Benatar, 2014: 1344). According to Tin *et al.* (2016: 9), this approach was perceived by the elite members of society as providing inferior quality care. This led to the emergence of private hospitals and private clinics that rendered care mainly to medical aid-funded patients. The DoH is the main provider of health care in public health facilities which cater for 83% of the South African population. Private facilities, on the other hand, cater for the remaining 17% of the population (Coetzee *et al.* 2013: 169). There is a great discrepancy when it comes to human resources between the two types of health care. According to Mayosi and Benatar (2014: 1345) 30% of the doctors in the country provide medical care to more than 40 million people who do not belong to a private medical aid scheme and who constitute 84% of the general population. The remaining 70% of doctors are working full time in the private sector and provide health care to about 16% of South Africans (8 million). The Econex report (2014: 12) also revealed a great discrepancy in the distribution of medical specialists with private hospitals enjoying a larger percentage of specialists than public health facilities. According to the Health Systems Trust (2015), provinces that are mostly urban have a high number of medical specialists compared to provinces where the majority of communities are rural. In 2014 medical specialists in the Western Cape were 31.3 per 100 000 citizens followed by Gauteng with 20.5 per 100 000. Limpopo province rated the lowest with 1.8 per 100 000 citizens (HST 2015).

There is a trend among nurses to opt for private health facilities for employment. According to Cullinan (2015: 2), out of the 133 127 professional nurses registered with SANC, only 68 105 work in public health facilities. Coetzee *et al.* (2013: 170) state that 41.4% of nurses work in private institutions and only 58.6% work in public

health facilities. In the study by Labonté *et al.* (2015: 7), low remuneration, poor living and working conditions, lack of career development opportunities, high burden of HIV and MDR-TB, high cost of living, and job and economic insecurity were cited as primary reasons for nurses leaving the public sector. Rural health facilities with poor infrastructure are always the worst when it comes to staffing.

Malan (2012: 2) states that rural hospitals suffer an extreme shortage of medical professionals. In some instances, one doctor becomes responsible for medical care within the whole hospital with only the assistance of, maybe, two clinical associates. These are health professionals trained at a level higher than nurses, but ranked lower than doctors. They are not permitted to work without a doctor's supervision (Econex 2014: 16). Some of the challenges that are experienced by health workers in rural health facilities include:

- Lack of decent accommodation;
- Poor roads;
- Poor infrastructure; and
- Lack of decent schools.

These challenges all contribute to health workers being reluctant to take up positions at isolated rural hospitals (Malan 2012: 3).

The shortage of health workers in rural and remote areas often leads to relatively high mortality rates in such areas due to poor management at primary health care level (Buchan *et al.* 2013: 834). This also leads to rural residents seeking care at urban health facilities and thus to overcrowding and unnecessary depleting of the allocated budget for urban hospitals. The relatively higher levels of staff in urban areas and facilities may lead to the underutilization of skilled personnel, who may then consider emigration.

Nurses form the backbone of health care in South Africa. According to Swart, Pretorius and Klopper (2015: 1) nurses play a vital role in the delivery of quality health care. In rural areas where there is a shortage of doctors and other health professionals, nurses remain the main source of health care, providing preventive, curative and rehabilitative health care (Mayosi and Benatar 2014: 1349). According to Ndaba (2013: 22) professional nurses account for most of the human resources

within the health sector. They play a major role in the delivery of care in the health continuum, providing patient care 24 hours a day. For this reason, more skilled newly qualified professional nurses are required each year, especially in rural areas.

Tshitangano (2013: 2) conducted a study which found that the shortage of nurses was a global, ongoing problem which posed a challenge to retention of professional nurses but the conditions are worse in third world countries like South Africa. According to this study, nurses leave the country for reasons that include, among others, long working hours, increased workload, poor salaries and unfavourable working conditions. Staff shortages are likely to get worse in these countries due to population growth, aging of the existing workforce, an increase in the number of patients with complex and chronic conditions, and the expansion of health insurance to the underinsured and uninsured (Hofler 2016: 134) Retention of nurses in South Africa remains a big challenge. This is because South African nurses are continuously being lured by more affluent countries that have more to offer in terms of competitive incentives, better working conditions and resources, safety, and a lower prevalence of HIV/AIDS. Labonté *et al.* (2015: 7) point out that nurses continue to emigrate in spite of the government's introduction of the occupation specific dispensation (the remuneration policy that aims to attract and retain government employees by recognising their skills and experience). This movement of nurses contributes to a shortage of experienced qualified nurses to care for the sick. The shortage of nurses forces patients and clients to wait in long queues before being served by the few nurses at the clinics and hospital outpatient departments. This is supported by van Rensburg (2014: 13) who states that underdeveloped, mainly rural, communities have to be satisfied with an inferior quality of care provided by a smaller number of health care workers in racially segregated, poorly equipped and understaffed public facilities. It is for this reason that the DoH initiated compulsory community service by all health professionals including nurses. In a study conducted by Tshitangano (2013: 2) it was discovered that the shortage of nurses was a global, ongoing problem which posed a challenge to retain professional nurses but the conditions are worse in third world countries like South Africa. According to this study, nurses leave the country because of the reasons that include amongst others; long working hours, increased workload, poor salaries and unfavourable working conditions, which make retention efforts more challenging. Retention of nurses in South Africa remains a big challenge. This is because South African nurses are

continuously being lured by more affluent countries that have more to offer in terms of competitive incentives, better working conditions and resources, safety, and a lower prevalence of HIV/AIDS. Labonté *et al.* (2015: 7) emphasise that nurses continue to emigrate in spite of the government's introduction of the occupation specific dispensation (OSD). This is the remuneration strategy that aims to attract and retain government employees by recognising their skills and experience (Labonté *et al.*, 2015:12).

2.2.2 National Health Insurance

According to Watson (2015: 1) the shortage of nurses can negatively impact the implementation of the proposed National Health Insurance (NHI) scheme which puts great emphasis on the provision of primary health care.

The key goals of NHI are to:

- Provide universal coverage for all South Africans;
- Pool risks and funds;
- Improve negotiations with providers for supply of services and rational payment with quality assurance;
- Create one public fund with adequate reserves and funds for high-cost care;
- Promote efficient and effective service delivery in both public and private sectors; and
- Assure continuity and portability of NHI within the country (South Africa, 2015: 1).

The roll-out of NHI will require specialised nurses, particularly primary health care nurses, and advanced midwives (Watson 2015: 4).

According to the White Paper on the NHI (South Africa 2015: 21) primary health care should be the main pillar of health care in South Africa. The following are the principles of the NHI:

(a) Right to access health care

NHI will ensure access to health care as enshrined in the Bill of Rights, Section 27 of the South African Constitution, which states:

> Everyone has the right to have access to health care services including reproductive health care... The State must take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of these rights.
>
> No one shall be refused emergency medical treatment (South Africa 1996).

(b) Social solidarity

The NHI scheme will provide financial risk pooling to enable cross-subsidization between the young and old, rich and poor as well as the healthy and the sick.

(c) Equity

The NHI scheme will ensure a fair and just health system for all and that those with the greatest health needs will be provided with timely access to health services.

(d) Health care as a public good

Health care shall not be treated like any other commodity of trade, but as a social investment.

(e) Affordability

Health services will be procured at reasonable cost that recognises the need for sustainability within the context of the country's resources.

(f) Efficiency

Health care resources will be allocated and utilised in a manner that optimizes value for money.

(g) Effectiveness

This refers to the extent to which an intervention results in expected outcomes in every day settings. NHI will ensure that the health system meets acceptable standards of quality and achieves positive health outcomes.

(h) Appropriateness

The health system will adopt innovative service innovative service delivery models that are tailored to local needs of the population and delivered at appropriate levels of care (White Paper on the National Health Insurance scheme) (South Africa 2015).

The above principles can only be attained if there is sufficient and competent staff at all levels of health care, that is, at primary, secondary and tertiary levels of care. The Econex report (2014: 11) noted that the implementation of the proposed NHI remains under threat as long there is still unequal distribution of health professionals between public and private health facilities and between urban and rural health facilities. Based on the above observations there was a need for the government to balance the inequalities between public and private health care. This would ensure that people benefit from a fairly distributed, non-discriminatory health care irrespective of whether they can afford a medical aids scheme or not.

2.2.3 Changes in the disease pattern

Staff shortages in South Africa have been made worse by the changes in the disease pattern and the emergence of new infections like HIV/AIDS.

From the late 1980s there was a rapid change in the disease pattern in South Africa. The increase in the number of people who were suffering from HIV/AIDS increased the burden of health care in South Africa. According to the National Strategic Plan on HIV, STIs and TB: 2012-2016 (National Department of Health 2011: 22), the 2009 HIV prevalence in the adult population (aged 15–49) was estimated to be 17.8%. An estimated 5.63 million adults and children were living with HIV in 2009. Of these, 5.3 million were adults aged 15 years and older, 3.3 million were females and 334 000 were children. According to Oni *et al.* (2015: 2) the emergence of HIV/AIDS worsened the prevalence of other opportunistic communicable diseases such as tuberculosis and malaria that affect HIV positive patients due to their low immunity. Mayosi and Benatar (2014: 1349) argue that although death rates have declined since the launch of the Anti-Retroviral Therapy (ART) in 2003, the combination of HIV and tuberculosis remains the leading cause of maternal deaths in South African hospitals.

In 2011 the WHO estimated that South Africa ranked the third highest in the world in terms of the TB burden with an estimated 0.4–0.59 million cases, after India with 2.0–2.5 million cases and China who had 0.9–1.2 million confirmed cases. HIV was seen to be the most contributory factor fuelling the TB epidemic with more than 70% of TB patients also living with HIV. Approximately 1% of the South African population develops TB disease every year. The number of cases detected for all forms of TB has steadily increased from 148 164 in 2004 to 401 048 in 2010. The highest prevalence of latent TB infection, estimated at 88%, occurred among people in age group 30–39 years in township situations and informal settlements. Township and informal settlement conditions are characterised by overcrowding and low socio-economic status, all of which provide fertile ground for TB infection and disease. Rural communities have a high incidence of TB. According to the District Health Barometer 2015, TB is the leading cause of death among people between ages of 25 and 64 years with 24, 6% of the population being infected (HST, 2015:186).

The TB epidemic was further compounded by multidrug-resistant tuberculosis (MDR-TB), with almost 7 386 laboratory-confirmed MDR-TB cases and 741 confirmed cases of extensively drug-resistant TB (XDR-TB) in 2010 (WHO 2011: 21). According to the 2015 report of the UN (2015: 17), South Africa did not meet the 2015 target of reducing the TB prevalence and mortality rates by 50%. This means that the rate of TB infections and TB related deaths remains high in South Africa.

Sexually transmitted infections (STIs) including syphilis, gonorrhoea and trichomonas vaginalis also prevalent in South Africa. A study conducted by Naidoo *et al.* (2014: 30) showed that the risk of STIs is 20% higher among women below the age of 25 years. Women who were unmarried and non-cohabiting women were shown to be at highest risk for incident STIs. A study by Nel *et al.* (2012: 4) found that the rate of STIs is higher in KwaZulu-Natal compared to other provinces in South Africa. The contributory factors that were noted included migrant labour, low literacy rates and the high incidence of HIV/AIDS, to name a few.

The high incidence of HIV/AIDS also generated huge human resource wastage as many nurses were dying or getting extended sick leave due to HIV/AIDS-related illnesses. This further increased the workloads for the remaining staff leading to absenteeism, stress, burnout, demotivation, low morale and loss of productivity (van

Rensburg 2014: 10). Makhado and Davhana-Maselesele (2016:6) stated that 69% of nurses who nurse patients with HIV-related illnesses reported symptoms associated with burnout and depression.

According to Kerr (2014: 154) nurses between the ages of 20 and 30 were mostly affected by HIV/AIDS. This is supported by the National Strategic Plan for HIV, TB and STI 2012/16 (South Africa, 2012: 26) which observed that HIV and TB co-infection is high among people above the age of 20 and below the age of 49.

2.3 Benefits of compulsory community service

According to Beyers (2013: 2) compulsory community service provides the newly qualified nurse with an opportunity to gain “first-hand experience” in dealing with patients from underdeveloped communities and working in under-resourced clinical facilities. This can be a valuable experience because the nurse learns to be independent unlike in the bigger hospitals where the nurses always have to rely on the doctors and other senior nurses for clinical support. Hatcher *et al.* (2014) state that during compulsory community service NCSPs get a chance to develop professionally because of the guidance they receive from professional nurses. Community service can also be a fulfilling to the NCSPs as they feel that that they are making a difference to communities in need of care (Hatcher *et al.* 2014)

Haskins *et al*. (2016:180) state that ever since community service was introduced there has been reduced referral of patients from the outside clinics since these practitioners go out to the community. The waiting times for patients at outpatient departments have decreased since the NCSPs take off some of the workload from professional nurses. On the contrary, managers at regional hospitals complained that queues were very slow because NCSPs spend more time with each patient than the experienced health staff (Haskins *et al.*, 2016: 181). This could be attributed to lack of experience and skill of the NCSPs. It is for this reason that NCSPs require supervision and guidance so that they can grow professionally.

2.4 Transition from student to registered nurse

Transition is defined by Zaayman (2016: 45) as “the process of learning and adjustment that a new staff member undergoes to acquire the skills, knowledge and

values required to become an effective member of the health care team". Lagrimas-Botha (2015: 26) explains the transition from student nurse to community service practitioner as a period that contains different phases. Initially the NCSPs are excited about completing their training. During the second phase the initial excitement disappears as they start to realise that they are not adequately prepared for their new role as community service practitioners. Ndaba (2013:64) describes that phenomenon as reality shock. It occurs because community service practitioners get exposed to many challenges and expectations that they were not exposed to during their training. Some of the challenges experienced by community service practitioners are described by Hofler (2016: 134) as:

- An increased number of patients with complex critical illnesses;
- Lack of experienced clinical mentors;
- Fatigue due to professional and personal, including familial demands;
- Feelings of insecurity due to lack of experience; and
- Bullying by other staff members.

The study conducted by Govender, Brysiewicz and Bhengu (2015: 6) affirmed that newly qualified nurses encounter difficulties during the transition from student nurse to community service practitioner. Some of the reasons the researchers highlighted in the study included role expectations and increased workload.

According to Jones *et al.* (2014: 44), being exposed to the new environment requires a lot of learning and adjustment. These early experiences will have a direct impact on the future career development of the nurse. If these experiences are positive, nurses are likely to be happy and productive in their career but if the initial reception is stressful, nurses become frustrated and may seek other career choices. Beyers (2013: 46) attributes the initial stress experienced by newly qualified nurses to a number of factors including lack of clinical, managerial and organizational skills, whereas Tapping *et al.* (2013: 102) believe it is due to anxiety and lack of confidence. According to Whitehead and Holmes (2011: 21), the transition from student nurse to community service practitioner can be described as "moving between two different worlds" because the student moves from a sheltered environment to being exposed to the real clinical situation away from the protection of nurse educators.

During their training period nursing students are allocated to different clinical settings where they learn and practise under supervision. However, this time is not sufficient for them to gain confidence in dealing with clinical problems. According to Ndaba (2013: 78) shortage of experienced health professionals is the reason why the support and mentoring that NCSPs receive is sometimes not sufficient to help them build their confidence and sometimes not to the extent that it should be.

Compulsory community service can only be effective if it is be accompanied by a structured programme whereby the NCSPs will be supported by experienced personnel throughout the period of compulsory community service (Govender, Brysiewicz & Bhengu 2015: 7). According to Roziers *et al.* (2014: 98) community service is not a training period, but supervision and support helps the NCSPs to gain confidence in working independently and to deal with complex clinical situations. During this period they are not yet registered as professional nurses.

Proper support and guidance of NCSPs by experienced health professional nurses can reduce the anxiety due to inexperience and increase productivity. Tapping et al (2013: 103) argue that supervised community service is meant to reduce staff shortages and long queues within health institutions. Clinical support helps NCSPs to develop competence and prepares them for the changing health care environment.

2.5 Clinical competence

The training of professional nurses in South Africa is regulated by the SANC. The SANC Regulation R425 was promulgated on 22 February 1985 for the Diploma in Nursing (General, Community, Psychiatric) and Midwifery, and is the legislative basis for training of professional nurses in South Africa. This regulation stipulates that the nurses should be mature, skilled, confident and competent practitioners (SANC 1985). This regulation further stipulates that the trained nurses should be skilled to accept and execute the assigned responsibilities. To achieve this, the curriculum should be developed to allow for correlation of theory into practice. The time that the student nurses spend in the ward during their training period is limited by academic requirements that have to be met. SANC Regulation R2175 (SANC 1993: Section 7)

stipulates that during their first year, student nurses have to spend at least one thousand clinical hours in the general wards. This period is divided into medical, surgical, orthopaedic, paediatric and gynaecology departments with theory blocks in between. In a study conducted by Teoh *et al.* (as cited in Ndaba 2013: 26) students are rotated among various clinical areas so that they can get exposure to multiple clinical settings. The student, therefore, ends up spending about three weeks in one unit before moving to the next. This time does not allow the student to gain clinical competence that is required to work independently. According to Magerman (2015: 3) the levels of competence differ between degree and diploma students. NCSPs who have obtained a basic degree qualification are believed to be lacking in clinical competence compared to NCSPs who obtained a basic diploma qualification. This can be attributed to the differences in the amount of time that each group spends in the hospital. The diploma students enjoy more clinical exposure while the degree students have limited clinical exposure.

The curriculum of the College of Nursing in KwaZulu-Natal for a Diploma in Nursing (General, Psychiatric, Community) and Midwifery (SANC Regulation R425) is designed in such a way that Midwifery is learned in the first semester of fourth year for six months and Psychiatric Nursing is learned during the last six months of training. At the end of the six month period the student is not yet confident to practise independently and to manage complicated obstetric and psychiatric emergencies. For this reason, nursing students are allocated to general wards for the first three years of training. During the fourth year they only practise midwifery and psychiatric nursing respectively. Ndaba (2013: 23) found that by the time the students practise compulsory community service they have already forgotten some of the learned skills. The study conducted by Roziers *et al.* (2014: 92) further confirmed that the curriculum for nurse training does not equip them enough to be skilled practitioners. This creates frustration as the hospital staff expects them to excel as newly qualified professional nurses. According to Zonke (2012: 12) some complex clinical conditions may not be available during the period of the students' clinical placement and therefore the student may not get the required clinical practice. Some of the problems of clinical incompetence can be overcome by strengthening the programs of clinical accompaniment of nursing students (Rikhotso, Williams & de Wet 2014: 5). Whitehead and Holmes (2011: 23) suggest that clinical support of newly trained

nurses should be considered because the training they receive does not prepare them enough to be competent in the wards.

2.6 Clinical accompaniment

According to the Strategic Plan for Nurse Education, Training and Practice 2012/2013-2016-2017 (2012: 86), clinical accompaniment was identified as an important tool in improving nursing skills and improving the quality of nursing care. Beukes and Nolte (2013: 305) define clinical accompaniment as an intervention which is orientated towards helping the student to achieve personal and professional development. The purpose of clinical accompaniment is to develop students' knowledge and skills while imparting, at the same time, the culture and values of nursing. The SANC regulation for training of professional nurses (SANC Regulation R425) stipulates the number of hours that the student should spend in the clinical area. During that time the student should be accompanied by nurse educators. The SANC requirement is that nurse educators should spend not less than 30 minutes with the student (SANC, 1985). Xaba (2015: 53) states that lecturers and clinical facilitators sometimes do not meet this requirement because of work challenges. These challenges include, inter alia, the distance travelled between the nursing college/university and the hospital and the large number of students to be accompanied. Professional nurses in the ward or CHC also have an important role to play in the accompaniment of students. According to Kgafele, Coetzee and Heyns (2015: 223) during placement in the clinical area, the student is assisted to develop the required cognitive, psychomotor and affective skills. Rikhotso, Williams and De Wet (2014: 4) state that learning in the clinical area is a two-way process. The professional nurses in the ward as well the college professionals should create a supportive environment that will enable the student to grow and develop professional values. The student, on the other hand, should take the initiative to learn and gain new knowledge through active participation. Kgafele, Coetzee and Heyns (2015: 223) assert that during clinical accompaniment the student is encouraged to think critically, solve clinical problems and practise patient care in a safe and non-threatening environment. This is supported by Botma *et al* (2013: 38) who states that nurse educators provide effective support and supervision while they facilitate integration of theory in practice, and act as agents of socialization for the student.

NCSPs encounter clinical difficulties when they are placed for compulsory community service if clinical accompaniment was not done effectively. Roziers *et al.* (2014: 96) state that NCSPs are likely to undergo reality shock when they encounter difficult clinical situations therefore they need to be supported.

2.7 Clinical support within health care institutions

The environment where NCSPs are first placed for compulsory community service is crucial to a smooth transition. Whitehead and Holmes (2011: 22) found that staff shortages were a major contributor to the lack of clinical support given to newly qualified nurses rather than unwillingness from established members of staff. The pressures of a busy ward environment result in NCSPs being treated as part of the workforce and their learning needs not being attended to. According to Beyers (2013: 44) community service practitioners are sometimes left in charge of wards without the guidance of a senior professional nurse to direct and supervise them. This creates emotional stress and frustration among NCSPs. The study by Rikhotso *et al.* (2014: 2) found that professional nurses felt that providing guidance and support for the NCSPs is an extra workload as the wards are busy and understaffed. Due to the shortage of professional nurses in the wards, the NCSP's' guidance and clinical support becomes less important, and they become incompetent employees with inadequate skills as they are tasked to cover the shortage in patient care. Nkoane (2015: 41) also states that because of staff shortages, NCSPs end up performing non-nursing duties like collecting blood results from the laboratory and registering patients and they felt they were losing valuable time that could be used to gather clinical experience.

Staff shortages are worse in rural facilities. Health institutions in rural areas always encounter difficulty recruiting and retaining experienced health professionals due to unattractive conditions of service such as poor infrastructure (Makhubu 2016: 2). In those facilities there is a shortage of experienced professionals who will support the community service practitioners. According to Mayosi and Benatar (2014: 1345) hospitals in rural areas lack permanent posts for experienced professionals who can support the newly trained professionals.

The study conducted by Horsburgh and Ross (2013:1131) indicated that in cases where health professionals were supported, the transition from student to professional nurse becomes less stressful. They indicated that the experience helped them learn to become multi-skilled and to adapt to conditions in the real working world. In a study conducted by Holliwood (2011: 662) all newly qualified nurses interviewed agreed that support from experienced staff members was the key to alleviating anxiety and facilitating a smooth transition.

Lack of proper support and guidance leads to feelings of insecurity (Govender, Brysiewicz & Bhengu, 2015: 8). NCSPs who do not receive any clinical support feel frustrated and drained by the end of their compulsory placement, in spite of their initial enthusiasm (Holliwood 2011: 665).

2.8 Formal versus informal mentorship

Clinical support can be in the form of mentorship by experienced professional nurses. Mentorship is defined by Hnatiuk (2012: 3) as a reciprocal partnership between two individuals, the mentor and the mentee, with mutual goals and shared accountability for the success of the relationship. The mentor is an experienced professional and an expert in the specified field, who guides the new and less experienced mentee. In nursing the mentor can be a professional nurse who will guide the newly qualified nurse until he or she develops professional confidence. According to Rohatinsky (2012: 14) the following are the roles of the mentor in nursing:

- Teaching of new skills;
- Assessing learning needs;
- Arranging experiences;
- Evaluating outcomes;
- Challenging the mentee when necessary;
- Socializing the mentee to the role of the nurse and the nursing unit culture;
- Sponsoring the protégé for personal and professional advancement;
- Counselling the protégé by providing psychological support;
- Career advising by suggesting work and learning opportunities; and
- Role modeling unit culture and nurse behaviours.

Govender (2015: 8) distinguish between formal and informal support. In formal support, there is a well-defined program. The novice or mentee is assigned by the employer or supervisor to a mentor who could be a more experienced professional. Support occurs over a specified period and has to be evaluated from time to time to see if the mentee is benefiting from the program. Hodgson and Scanlan (2012: 390) indicate that the role of the mentor in formal support is to assist the mentee to identify their own learning needs and accomplish their professional goals. In some organizations both the mentor and mentee sign a contract or agreement and they both have to commit to the agreement. In nursing the program is designed to meet the educational needs of newly trained nurses during their transition to practice, instill confidence and improve their competence upon entering the clinical setting.

Informal support on the other hand occurs outside the formal arrangement by the organization (Haycock 2012:18). The mentee usually chooses his or her own mentor based on mutual interests, proximity or accomplishments. There is a relationship of trust between them. The mentee trusts that the mentor can help him/her achieve his/her goals and the mentor has faith in the mentee's capabilities. According to Hofler (2016: 134), mentorship provides a spontaneous relationship that is based on psychosocial factors. This form of support helps the mentee to develop self-esteem and confidence in the workplace by providing emotional support and sharing of common interests. According to Hogdson and Scanlan (2013: 390) the mentor provides an observable image that the mentee can imitate both professionally and personally. Kaihlanen, Lakanmaa & Salminen (2013: 418) further state that the role of the nurse mentor is to guide the graduate nurse in his or her clinical learning process and professional growth.

Clinical support can take the form of informal mentorship since the NCSPs do not have to be linked to a specific mentor but can be supported by any professional in the ward or at the CHC.

2.9 The value of clinical support in nursing

Literature shows that NCSPs experience challenges during their period of compulsory placement. Roziers *et al.* (2014: 96) state that some of these problems result from lack of clinical skills. According to Andren and Hammami (2011: 23),

newly qualified nurses described their experiences as “being abandoned” since they did not receive any support. Maseko (2014: 40) also state that staff shortages is the reason why most NCSPs do not want to be placed in rural areas. They feel that for them to grow professionally they need to practise in areas where there are enough experience professional nurses to support them. It is for this reason that various studies advocate for clinical support of NCSP’s. Lagrimas-Botha (2015:75) suggests that activities such as macro and micro-orientation and in-service education are some of the strategies that can promote clinical support in the clinical area of placement. According to Govender, Brysiewicz & Bhengu (2015: 6) orientation to the new working environment makes the transition easier and less stressful.

Clinical support for NCSPs gives them confidence to practise their nursing skills in a supportive environment until they become confident. In the study by Horsburgh and Ross (2013: 1127) newly qualified nurses who received support in the clinical area expressed their willingness to stay within the profession. It also helps to enhance the recruitment and retention of registered nurses in practice. The experienced professional nurse providing support can assist the NCSP to identify his or her learning needs and help him or her to meet those needs. This resonates with the views of Govender, Brysiewicz and Bhengu (2015: 7) and Roziers *et al.* (2014: 98) who state that clinical support helps to build the NCSPs’ confidence and boost staff morale. This can translate to improved quality of care and patient safety (Whitehead *et al.*, 2013: 23).

2.10 Summary

In chapter 2, literature relevant to clinical support was analyzed. The state of health care and the determinants of health in South Africa were discussed. Literature suggests that staff shortages in public health institutions have a direct influence on clinical support that is offered to NCSPs. Strategies to improve clinical support such as clinical accompaniment were discussed. Chapter 3 discusses the methodology that was employed in the study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

In the previous chapter literature relevant to the study was discussed. This chapter outlines the research design methods, techniques and strategies that the researcher used including the sampling and data collection.

Research design is defined by Creswell (2013: 12) as types of enquiry that provide specific direction to be followed in research. Researchers can use qualitative, quantitative or mixed methods.

A qualitative, exploratory-descriptive research design was used to establish if NCSPs placed at a regional hospital and CHC in the Ugu district, KwaZulu-Natal, received any clinical support.

3.2 Qualitative research design

Qualitative research is defined by Grove, Burns & Gray, (2013: 23) as a systematic, subjective approach used to explain the participants' lived experiences and give meaning to them. The aim of qualitative research is to observe everyday life with the purpose of describing and understanding the issue from the point of view of a participant (De Vos *et al.* 2011: 65). In qualitative studies, theories are generated by identifying relationships between emerging categories (Polit & Beck 2012: 62). The qualitative research method was identified as the best way to provide the researcher with an opportunity to establish the views of NCSPs on the clinical support offered to them.

3.2.1 Exploratory research design

The primary aim of exploratory research is to gather as much information as possible. It begins with a phenomenon of interest that is not just observed and discussed, but investigated in full in the manner that it occurs (Morake 2013:31). This design is used to "satisfy the researcher's curiosity and desire for a better understanding" (Beyers 2012: 80), which in this study is the experiences of NCSPs

at a rural health facility. According to Strydom (2013: 151), exploratory research allows for collection of large amounts of unstructured information in order to explore a new topic, or to respond to new concerns by breaking new ground through delving into new problem areas, to work on topics about which very little information is available, and to gain a broad understanding of a situation.

3.2 2 Descriptive research design

Most qualitative studies are descriptive in nature. They are used to observe, describe, and record aspects of a situation, such as the clinical support that is offered to NCSPs. According to Zonke (2012: 27), descriptive designs take less time to conduct.

3.2.3 Exploratory-descriptive research

In this method the researcher seeks to describe the topic of interest while exploring the problem area with the intention of finding a possible solution (Grove, Burns & Gray, 2013: 27).

3.3 Research Setting

Beyers (2013: 21) describes the research setting as the place where data collection takes place. Careful selection of the research setting is very important in qualitative research because participants have to feel safe and unthreatened. This study was conducted at a regional hospital and a CHC within the Ugu district. The province of KwaZulu-Natal comprises 11 health districts and UGu district lies on the southern part of the province on the borders of the Eastern Cape Province. This has a direct impact on the health institutions within the district because there is a lot of trans-border movement of patients from the Eastern Cape to the health facilities within the Ugu district.

The district has one regional hospital and three district hospitals. The regional hospital was chosen because it is in town and accessible to the researcher. The district has two CHCs which render primary health care services to the community but also serve as referral centres for smaller clinics. The researcher chose a community centre that served the larger rural communities.

3.4 Population

A study population can be defined as all the individuals who meet the sample criteria for inclusion in a study, and sometimes it is also referred to as the target population (Grove, Burns & Gray 2013:351). The target population comprised all nurses at the time of the study who were placed at a regional hospital and a CHC for compulsory community service. Those nurses had finished their four-year degree or diploma as regulated by the SANC (SANC Regulation R425).

3.5 Sampling and sampling techniques

A sample refers to a selected group of people or elements that are used in a study whereas the sampling method refers to the process of selecting a group of people or elements that best represent the population being studied (Gray, Grove & Sutherland 2017: 336). Sampling techniques or methods are classified as either probability or non-probability. Probability sampling is based on the notion that the probability of selection of each informant is known, while non-probability sampling is premised on the notion that the probability of selection is not known. Probability techniques include simple random, systematic sampling, stratified sampling, and cluster sampling. Non-probability techniques are convenience sampling, quota sampling, snowball sampling and purposive sampling (Gray, Grove & Sutherland 2017: 338). In this study purposive sampling was utilized.

3.5.1 Sampling of research sites

Convenience sampling of the health institutions was utilized. The researcher chose institutions that were within reach and were known to have NCSPs allocated to them.

3.5.2 Sampling of research participants

In selecting the research participants, purposive sampling was opted for by the researcher. In terms of this approach, the researcher's own critical judgement is important in determining the suitability and viability of the research participants to enhance the main objectives of the study (Polit & Beck 2012: 218). Purposive sampling of all NCSPs placed at Port Shepstone hospital and Turton CHC was accomplished. This sampling method was suitable since the subjects were readily available. According to Grove Burns and Gray (2013: 371), in purposive sampling

the researcher specifically select participants that they believe will enrich data collection and help provide insight to the study.

Purposive sampling procedures make demands on the researcher to carefully select participants who reflect the most salient characteristics or variables of the particular group being targeted. In this study, purposive sampling was opted for, as the researcher is knowledgeable about, and familiar with the research milieu to be studied (Polit & Beck 2012: 343). NCSP's were visited at their workplace where the researcher asked them to participate in the study. Information letters that contained the details about the study were given to them.

3.6 Sampling size

Interviews were conducted to the point of data saturation. The final sample consisted of eight participants.

3.7 Sample realisation

	Gender	Duration of community service	Institution where degree/diploma was completed	Currently placed for community service
R1	Male	6 – 12 months	KwaZulu Natal College of Nursing	CHC
R2	Female	3- 6 months	KwaZulu Natal College of Nursing	Hospital
R3	Male	3- 6 months	KwaZulu Natal College of Nursing	Hospital
R4	Female	6 – 12 months	KwaZulu Natal College of Nursing	Hospital
R5	Female	3- 6 months	KwaZulu Natal College of Nursing	Hospital
R6	Female	6 – 12 months	KwaZulu Natal College of Nursing	CHC
R7	Female	3- 6 months	University of KwaZulu - Natal	Hospital

R8	Female	3- 6 months	KwaZulu Natal College of Nursing	CHC
Total in %	**Male = 25%**	**3 – 6 months = 37.5%**	**KwaZulu Natal College of Nursing = 87.5%**	**CHC = 37.5%**
	Female = 75%	**6 - 12 months = 62.5%**	**University of KwaZulu –Natal = 12.5%**	**Hospital = 62.5%**

3.8 Sampling criteria

The sampling criteria refer to the extent to which the research participants do, or do not, meet the pre-selected traits or characteristics intended to advance the research objectives (Polit & Beck 2012: 218).

The research participants could either be included or excluded from participation in the study according to the pre-requisite criteria and involves selecting cases that meet a predetermined criterion of importance (Polit & Beck 2012:519).

3.8.1 Inclusion criteria

For inclusion in the study, the sampled participants had to comply with the following criteria:

- They must have completed a degree or diploma in nursing as regulated by the SANC (SANC Regulation R425).
- They should be performing compulsory community service as part of their induction into the nursing profession at the selected regional hospital and CHC.
- They must be willing to provide information by describing the support they have received during their compulsory clinical placement.

3.8. 2 Exclusion criteria

For purposes of this study, the following were excluded from participating in the study:

- Newly qualified professional nurses who had undergone the bridging course leading to registration as a professional nurse (SANC Regulation R683).
- Newly qualified professional nurses who had already completed compulsory community service.

3.9 Data collection

The process of data collection occurred concurrently with data analysis. This simultaneous process enabled the researcher to perceive and interact with the information to the point of data saturation (Burns, Grove & Gray 2016: 540). In order to minimise disruptions and enhance rapport between the researcher and the participants, the interviews were conducted in a private room agreed upon with the informant.

Three participants were interviewed during their lunch breaks. Two of them identified quiet rooms within their department where the interviews were conducted. The other one met with the researcher at the clinical teaching department during her lunch break. A quiet room at the clinical teaching department was organised and a “do not disturb” sign was placed at the door to ensure total privacy of the interviews. One participant volunteered to come during her day off. The interview did not pose any inconvenience to the participant since she stays about ten minutes from the hospital. The three participants working at the CHC were visited at the times convenient to them. Each interview lasted between 25 and 40 minutes.

The interviews were conducted In order to maximise spontaneity, the in-depth semi-structured interviews transpired within the parameters of two open-ended questions which were designed to obtain a detailed description of the experience of these practitioners and their interpretation of the clinical support they received during their placement as NCSP. These questions were asked with the view to identifying themes and/or sub-themes from the elicited responses.

During the semi-structured interviews, the informants were left to narrate their experiences with minimal interruption. Minimal responses and non-verbal cues such as nodding by the researcher were used to propel the informants to elicit more responses.

3.10 Data collection instrument

The research instrument that a researcher chooses is influenced by the research approach selected and must be relevant to the research question (Moule 2015: 99). The worth and scientific value of data collection relies mainly on the selection of a data collection instrument to broaden the understanding of the phenomenon's wider investigation. The instrument is mainly the means to an end, that is, the research is therefore not the data itself, but the means by which the sought data is collected.

The interview was based on the following open-ended questions:

- Please explain the clinical support you received as a community service practitioner.
- In your view, what clinical support do you require?

The above questions are open-ended and allowed for the participant to describe and detail a range of experiences. The researcher also prompted the informant to "say more" by asking follow-up questions, like "can you explain" and "what do you mean". The actual words of the participant and notes were audio-taped in order to maximise the capturing of all the valuable information.

3.11 Data management and analysis

The collection and analysis of data occurred concurrently, which enabled the process of theme and/or sub-theme identification (Polit & Beck 2012: 507).

Audio-taped and verbatim data from the informants was accurately transcribed and kept safely. As part of the data analysis process, the researcher read each participant's transcript with the view to a better understanding of meanings and descriptions of the data obtained.

Narrative data was broken down into smaller units and codes attached to each unit. The reductionist process was enhanced by means of clustering all related items for categorization. Data synthesis occurred with the grouping of information with common themes in order to gain further insight into the experiences of the NCSPs.

The researcher read all the data collected from the informants, obtained meaning from each unit which was then synthesised by transforming those units into statements referred to as “structures of experience” (Burns & Grove 2005: 531).

3.12 Ethical issues

3.12.1 Permission for the study

The researcher obtained ethical clearance from the Durban University of Technology Ethics Committee. Written permission was obtained from the Chief Executive Officer of the regional hospital where the study was conducted, and from the district manager of Ugu health district. This letter permitted the researcher to conduct research at the CHC. These letters were forwarded with an application letter to the provincial office of the National Health Research Database (NHRD) in Pietermaritzburg through an online application system. Permission was received from the NHRD before the interviews were conducted.

3.12.2 Consent

An information letter was given to participants. This letter detailed the research title, purpose and all the expectations of the researcher. This was done to ensure that participants understood what the study was all about and to protect their rights. Participants were required to sign consent before the interviews were conducted. The consent form included the following explanations:

- Participants would not be coerced into signing the consent form. Participants had a right to withdraw at any time and that would, under no circumstances, be used against them. Real names of participants did not appear on the research information except on the consent form.
- The researcher used codes, e.g. R1, R2 etc. instead of names to protect the identity of the participants.
- Throughout the study, participants were not exposed to any physical or emotional harm.
- Participants were free to withdraw from the study at any time if they wished to do so.
- Interviews were audiotaped and data will be kept in a locked cupboard for five years together with all the research records.

- After 5 years all records will be destroyed and electronic data will be cleaned and destroyed.

3.13 Data and design quality

The design and quality of data are invariably aspects of authenticating the scientific worth and trustworthiness of this predominantly qualitative study. Trustworthiness is the concept used to determine accuracy and quality in qualitative research, and is assessed mainly by these four variables: credibility, transferability, dependability, and confirmability in terms of Lincoln and Guba's 1985 data and design quality matrix (Polit & Beck 2012: 539).

3.13.1 Trustworthiness

Trustworthiness is the concept used to determine accuracy and quality of the study in qualitative research (Polit & Beck 2012: 539). The researcher used the following four criteria to evaluate trustworthiness of the study:

3.13.1.1 Credibility

This refers to the degree to which the researcher's interpretation of data can be justified in the data (Jolley 2013: 210). In this study, prolonged engagement with NCSP's and repeated interviewing was conducted until data saturation was reached.

3.13.1.2 Transferability

The use of the purposive sampling technique allowed for transferability of findings since the researcher used a specific group of nurses. According to Jolley (2013: 210) transferability refers to the degree to which concepts or theory generated by the analysis of the study can be applied elsewhere.

3.13.1.3 Dependability

The researcher conducted coding of data obtained to ensure that accurate themes were correctly captured and analyzed. Ndaba (2013: 39) states that coding enhances the dependability of the qualitative inquiry and helps the researcher gain a deep understanding of data patterns thus improving the presentation of participants' narrations.

3.13.1.4 Confirmability

The participants' views were verbatim recorded and analyzed. This ensured that the researcher accurately analyzed the correct data and that the findings and recommendations were supported by the data (Brink 2012: 127).

3.14 Strengths and limitations of the study

3.14.1 Strengths

The verbatim recordings and transcriptions provided an understanding of the study highlighting the need for extensive clinical support programs to assist the newly qualified professional nurses with a smooth transition.

3.14. 2 Limitations of the study

The study was limited to one district in KwaZulu-Natal. The relatively small sample of the study population affected the transferability of the findings although recordings, verbatim transcriptions as well as findings serve as a reliable source other studies could be based on.

3.15 Summary

This chapter presented the research design, population, sampling method that was used. The data collection method and instruments were discussed. The ethical issues that were considered throughout the data collection process were discussed.

CHAPTER 4: ANALYSIS AND PRESENTATION OF DATA

4.1 Introduction

This chapter focuses on analysis and systematic presentation and interpretation of data. Vosloo (2014: 355) describes qualitative data analysis as a process of making sense of the data from the participant's view and perceptions of the situation. It is a continuous process whereby the researcher carefully scrutinizes their data in search of meaning and understanding (Polit & Beck 2012: 557).

Grbich (2013: 1) views qualitative research analysis as a comprehensive process that involves the three "Ps" namely:

- Person – the researcher, his or her views and choices, form an important tool throughout the research journey.
- Process – this relates to the design that has been used, the quality of data and how it has been managed.
- Presentation – the researcher's display of findings and interpretation of analyzed data.

4 .2 Qualitative content analysis

Qualitative content analysis, as described by Polit and Beck (2012: 564), is a system of breaking down raw data into smaller units while the researcher engages in coding and naming the content according to the content they represent. In this way the researcher engages with rich, in-depth information that could easily be missed if data was to be analyzed using "imposed themes" (Grbich 2013: 19). The aim is to identify prominent patterns or themes also known as clusters (Krippendorf 2005 in Polit & Beck 2012: 564).

In this study content analysis was employed whereby data that had been *verbatim* transcribed was carefully analyzed to pick up prominent tendencies.

4.3 Data analysis and management

Data that was collected from the eight participants was analyzed manually. Recorded interviews were listened to several times as the researcher transcribed them *verbatim.* Responses that had a similar meaning were grouped into categories. From those categories similar categories of data were further grouped into smaller groups until five themes were identified from the collected data.

Those themes with their relevant sub-themes will be discussed in detail below. The relevant *verbatim* transcriptions from the participants' transcripts are presented to support the themes.

4.4 Research findings

In this chapter the research findings are presented following the collection of data from the participants. The results illustrate the clinical support offered to NCSPs who are placed at a regional hospital and a CHC in the Ugu district of KwaZulu-Natal. Table 4.1 presents the themes and sub-themes which were identified from the analyzed data.

Table 0.1: Major themes and sub-themes

THEMES	SUB-THEMES
Theme 1: Clinical support	▪ Practice ▪ Administrative support ▪ Programs ▪ Orientation
Theme 2: Education	▪ In-service education ▪ Workshops
Theme 3: Providers of clinical support	▪ Operational manager ▪ Other senior and experienced health professionals ▪ District trainers ▪ Nursing managers ▪ Other members of the multi-disciplinary team
Theme 4: Challenges	▪ Insufficient clinical exposure ▪ Curriculum deficiencies ▪ Insufficient clinical accompaniment ▪ Bad ward experiences ▪ Staff shortage
Theme 5: Needs	▪ Teaching ▪ Orientation ▪ Mentorship ▪ Allocation plan ▪ Support by trainers

These themes and sub-themes are illustrated in Figure 4.1, and discussed below.

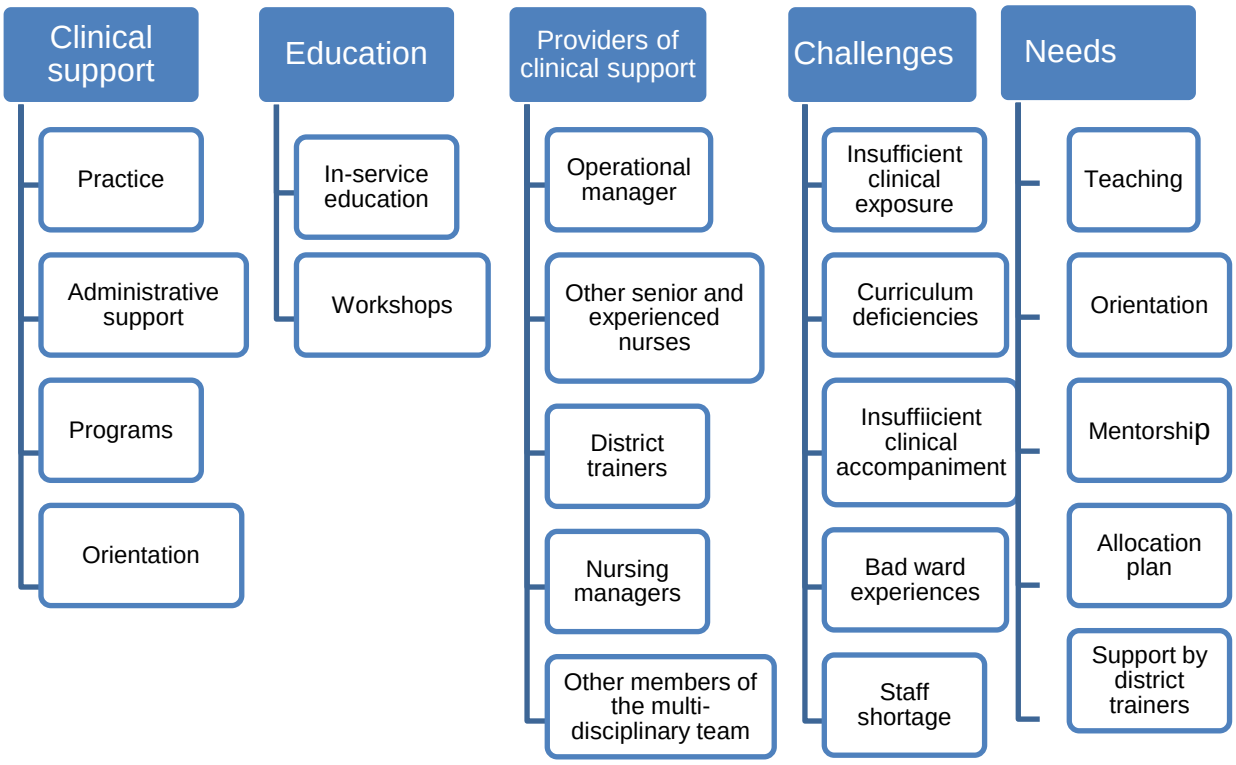

Figure 0.1: Illustration of major themes and sub-themes

4.4.1 Theme one: Clinical support

Clinical support refers to all the activities and processes that aim to assist the community service practitioners to cope with the new environment while they get acquainted with the role of newly qualified professional nurses. The NCSPs used different concepts to explain the clinical support that they have received or even lack thereof.

Only two of the five participants who were placed at the hospital reported to have received clinical support.

R1 (CHC): Basically I received clinical support in terms of what to do.

R3 (Hospital): Let me say I got supported in a sense, because if ever there was something I was not sure of, always had someone I could go back to and ask.

Participants who did not receive any clinical support had to rely on their embedded knowledge to cope with the pressures in the wards. Sometimes they had to elicit the help of junior professional nurses who had just completed community service.

R4 (Hospital): Luckily I still remembered stuff from training … Yea, like I have assisted during Doctors rounds as a student so I knew what I had to prepare for the rounds.

R7 (Hospital): What clinical support? In the wards you do what you still remember from College. What you do not know you have to ask from other junior sisters. No one has time for you.

Lack of clinical support had a negative effect on the performance of NCSPs. They verbalized that they were not sure what they were doing as they were inexperienced.

R4 (Hospital): There is no clinical support. I did not receive any guidance ... At first I was not sure where to start and what it was that I was supposed to do.

R5 (hospital): It is frustrating to do something you are not sure of. *You are just thrown in the deep end and the OM [Operational Manager] tells you to ask if you have a problem.*

One participant mentioned staff shortages as the reason for the lack of clinical support. This is supported by Whitehead and Holmes (2011: 22) who found that staff shortages was a major contributor to the lack of clinical support to NCSPs.

R5 (hospital): No one supports us. The wards are always are short staffed and the Sisters are always very busy, including the Operational Manager.

4.4.1.1 Sub-theme one: Practice

Participants who were placed in the hospital lacked experience in administration of intravenous therapy to patients and needed clinical support. According to one participant the reason for that lack of experience was because while they were student nurses procedures pertaining to venipuncture, that is drawing up of blood and putting up of drips, was done by professional nurses and doctors.

> *R2 (hospital): They showed me how to do administration of IVs, matron's report which I had no experience as a student doing*.

> *R4 (hospital): My main challenge was … even the putting up of drips was done by Sisters and doctors sometimes.*

> *R7 (hospital): At first I struggled especially with the IV therapy….*

> *R8 (CHC): I am getting used to it but I do not think I can be able to put up a drip on a baby.*

4.4.1.2 Sub-theme two: Administrative support

Nursing administration is defined as the act of managing nursing duties, responsibilities or rules (Basavanthappa, 2014: 45). The NCSPs appreciated the clinical support they received that enabled them to efficiently manage nursing duties. The study showed that community service practitioners who were placed at the CHC received more administrative support than their counterparts who were placed at the hospital.

> *R1(CHC): They showed me the clinic routine as well administrative support like the paper work, records that are kept at PHC.*

4.4.1.3 Sub-theme three: Programs

This sub-theme discusses the different components of nursing and services that are offered as primary health services.

Participants who were placed in primary health care were trained in different programs that would equip them with skills in primary health care.

> *R1(CHC): So I got trained in using the EDL [Essential Drug List – a book that contains guidelines for diagnosing and prescribing] and other diagnostic material for other programs like the STI [Sexually Transmitted Infections], EPI [Expanded Program of Immunization] and IMCI [Integrated Management of Childhood Illnesses].*

> *R6(CHC): I was mostly involved in a new program called the ICDM [Integrated Chronic Disease Management].*

Participants who did not receive any clinical support experienced difficulties in executing the programs available at the CHC. This is because clinical guidelines get updated regularly so even nurses who have been trained in those programs need to be trained on updated programs.

> *R6 (CHC): There are new vaccines that have been introduced so the immunization schedule is much different from what I learned at College. For that reason I needed someone to show me how things are done. Even the ARVs are now managed differently because of the changes in the HIV guidelines.*

4.4.1.4 Sub-theme four: Orientation

Six of the eight participants reported having received orientation into the ward or clinic routine and what was expected of them.

> *R3 (hospital): Orientation was given before I started working as to the routine, how the ward operates, what is expected of me***.**

> *R6 (CHC): Orientation was done when I first came but other than that I did not receive any support.*

R8 (CHC): She orientated me to the clinic routine and some of the records that are kept at the clinic.

The two participants who received no orientation reported feeling frustrated by not knowing what to do. They equate lack of orientation to being “thrown into the deep end”.

R7 (hospital): When I came I received no orientation, no guidance. If you are a com serve you are just thrown into the deep end. So you have to find your own way.

Two of the participants who practiced at the same regional hospital did not receive orientation because the professional nurses thought they already knew the hospital and ward routine.

R4 (hospital): The OM [Operational Manager] said since I have training here at this hospital, I do not need any orientation.

4.4.2 Theme two: Education

Education in nursing is very important both at basic and continuous levels. Sampson (2013: 2) argues that since the nursing profession is ever changing and new technology and innovations are continuously improved and introduced, nurses should engage in continuing education.

4.4.2.1 Sub-theme one: In-service education

This is education that is offered to personnel at the place of work.

R4 (hospital): We did in-service, once or twice a month depending on the number of patients.

R3 (hospital): We have routine in-service education within the department. People get allocated to conduct in-service education on different topics and it rotates among staff members.

R2 (hospital): During the in-service you get to reinforce some of the things and you get to ask your colleagues if you are not clear.

4.4.2.2. Sub-theme two: Workshops

R6 (CHC): Workshops are organized for a certain topic and one person from the facility would attend.

R1 (CHC): Recently we had a workshop on this new Hexavalent vaccine and all those new vaccines that were introduced.

One participant stated that she had attended in-service education that was conducted by another member of the multi-disciplinary health team.

R1 (CHC): She [the nutritional advisor] *conducted regular in-service training on how to deal with different nutritional problems].*

One participant mentioned staff shortages as the reason why NCSPs do not attend some of the planned workshops.

R2(hospital): Recently there was an HIV counselling and training course that I wanted to go to but I did not get a chance because the ward was busy and there was staff shortage at the time.

4.4.3 Theme three: Providers of clinical support

NCSPs rely on a variety of experienced health professionals to offer them clinical support. Experienced health professionals have a lot of knowledge that they can pass on to the inexperienced community service practitioners. The clinical support encounters take place as the NCSP is being assisted by members of the multi-disciplinary health team to facilitate the transition from student to professional nurse.

4.4.3.1 Sub-theme one: Operational managers

Four of the eight NCSPs interviewed said they received clinical support from the Operational Managers. The clinical support they received was in the form of orientation and teaching.

> *R1 (CHC): Basically when I first came here the Operational Manager made a lot effort in terms teaching me how to use the EDL, how to diagnose, how to treat patients and how to prescribe.*

> *R6 (CHC): The Operational Manager supported me a lot and showed me how things are done.*

A negative attitude was identified as one of the reasons why some of the community service practitioners were not supported. Some professional nurses did not see the need for orientating and supporting nurses who had practiced in the same hospital as students.

> *R4 (hospital): The OM said since I have been training here at this hospital I do not need any orientation.*

> *R7 (hospital): As I explained earlier, the OM [Operational Manager] and the older Sisters have never showed me any support.*

4.4.3.2 Sub-theme two: Other senior and experienced nurses

Professional nurses have a four-fold function, namely to nurse, administer, teach and conduct research (Stevens, 2012:65).

In this study, five participants acknowledged having received support from professional nurses in the ward and at the CHC.

> *R1 (CHC): The other professional nurses that I was working with, on the other hand gave me a lot of support … they are more hands on in supporting me. I would learn from them and ask from them.*

R3 (hospital): So, I personally got a lot of support from the professional nurses in the team where I was placed.

4.4.3.3 Sub-theme three: District trainers

According to Hendricks (2015: 60) decentalisation of health systems to the district level ensures rapid decision-making and improves employee morale since decision-making and implementation occurs closer to the actual workplace.
From this study it appeared that the main focus of district trainers lies with the primary health care nurses. Participants who were placed at the community health care centers agreed that they had received training organized by the district trainers.

R1 (hospital): Basically I would say I got enough external clinical support from the district trainers because there is a lot of facilitation and you learn a lot from these workshops.

Participants who were placed at the hospital did not receive any clinical support from the district trainers. They had no contact with the district trainers. The hospital departments organize their own in-service programs that do not involve the district trainers.

R2 (hospital): Within the hospital there is a department for human resource development. They organize orientation workshops for new employees within the hospital, more like an induction.

R3 (hospital): I have never received any clinical support from district trainers. We only have routine in-service education within the department.

This is against the WHO's mandate on the district health system that emphasizes "supporting countries in development of District Implementation Plan through availing training modules for district level health planning and training of trainers" (WHO 2014: 2).

4.4.3.4 Sub-theme four: Nursing managers

Nurse Managers have an important role to play in the clinical support of newly qualified nurses.

The results revealed that the nurse managers do offer clinical support to NCSPs. The nurse managers that were mentioned included the Deputy Managers (Matrons in-charge) Assistant Managers, Quality Managers as well Infection Control Managers.

> R1 (CHC)*: I would say she was supportive although she has a lot to deal with as the person who is managing the whole facility.*
>
> R2 (hospital): *She always makes time whenever she can to teach me.*
>
> R6 (CHC)*: You have to rely on the Assistant Manager if you encounter problems.*
>
> *R7 (hospital): The Quality Manager conducts in-service education on policies that need to be implemented. The Infection Control Manager also conducts inspections to check if the infection control policies are adhered to.*

One participant reported that there was no clinical support received from the nurse manager. Work overload was cited as the reason why some of the nurse managers do not offer clinical support.

> *R1 (CHC): The only challenge is that they are very busy. They only come to the ward to get the report and to do supervisory work*.

4.4.3.5 Sub-theme five: Other members of the multi-disciplinary team

The interdependent function of a nurse states that the nurse does not work in isolation but in cooperation with other health professionals from the multi-disciplinary health team. Nurses are part of the comprehensive health care team involved in patient care, they are part of the team that aims to provide quality, efficient and effective patient care (Ward 2013: 2)

From the study it appeared that the nurses work mostly with doctors as opposed to other health professionals. Participants stated that there was a good working relationship with the doctors although there were some personal differences that were mentioned.

> *R5 (hospital): It's mainly doctors that we work with. They do not trust me and they do not respect me*.

> *R2 (hospital): They only want to take rounds with the experienced Sisters. Maybe it's because I do not have epaulettes as yet so they think I am a junior student nurse.*

Participants stated that they had a limited encounter with the doctors so there was no significant clinical support.

From the study it appeared that most of the teaching occurred during the ward rounds, especially from senior doctors and consultants.

> *R3 (hospital): Doctors …we have a good working relationship with them. They only come to the ward for a specific time and leave, but I must admit there is a lot that I learn during those doctors' rounds.*

> *R6 (CHC): We have a good working relationship with ward doctors. At first they were not sure whether I am a student or not. Now they know me and we have good understanding.*

In the study it was clear that NCSPs placed at the hospital received more clinical support from members of the multidisciplinary team compared to their colleagues who were placed at the CHCs. Some of the reasons included the fact that most of the doctors at CHCs are community service practitioners.

> *R5 (hospital): In our case we do have doctors who work at the CHC but they only see certain patients who have been booked for them. So I wouldn't say there is any clinical support that they give to com serve practitioners because*

they see their clients while the nurses see theirs. It's like we are working parallel to each other.

In this study, there are other members of the multi-disciplinary team, other than doctors who also play a major role in offering clinical support to NCSPs.

R1 (CHC): We only have a nutritional advisor who was very, very helpful. I got a lot of support from her because she regularly taught us as staff how to deal with malnourished patients.

4.4.4 Theme four: Challenges

This theme looks at the challenges that are faced by NCSPs and explain some of the reasons that they lack clinical skills. Their lack of skills is the reason why they require clinical support.

4.4.4.1 Sub-theme one: Insufficient clinical exposure

Three participants stated that their clinical exposure was insufficient. They mentioned that they stayed in the wards for limited periods before being moved to other departments. One participant also mentioned that they only practiced general nursing for three years. In their fourth year they only practiced Midwifery and Psychiatric nursing which was done for six months each.

R2 (hospital): I came in hoping to learn most of the things here in the ward because some of the things, we did not get a chance to practice them as students. The training period is very short for you to learn and master everything.

R3 (hospital): You know when you are a student there isn't much time to practice because you are placed in different areas in a very short space of time. Also to be honest the main focus is on passing that module.

4.4.4.2 Sub-theme two: Curriculum deficiencies

Curriculum refers to an attempt to communicate the essential principles and features of an educational proposal which can be translated into practice (Ndaba 2013: 49). It

can be seen as means of achieving specific goals and objectives (Shao-Wen 2012: 154).

The curriculum of the College of Nursing where most of the participants were trained for a Diploma in Nursing (General, Psychiatric, Community) and Midwifery (SANC Regulation R425) is designed in such a way that students learn General Nursing Science, Community Health and other fundamental courses for the first three years. Midwifery is done in the first semester of the fourth year and Psychiatric Nursing is done during the last six months of training. This means that during the fourth year of training students do not practise in the general wards. This created a problem when they commenced compulsory community service because by that time they had forgotten some of the learned skills.

Participants mentioned that because in fourth year they never practised any general nursing, they experienced clinical challenges as NCSPs.

> *R2 (hospital): It was very scary because in our final year of training we were just doing our specialties which are midwifery and psychiatric and we didn't have much practice in the general, like going back to general nursing.*

4.4.4.3 Sub-theme three: Insufficient clinical accompaniment

All participants felt that the clinical exposure they received was not enough. They said the number of clinical lecturers was not enough which meant that most of the time they were practicing without any clinical supervision.

> *R2 (hospital): Personally I didn't think we had enough clinical support as students. We were always mostly on our own.*

> *R5 (hospital): Accompaniment in the hospital setting was not so much. With us there weren't many clinical tutors.*

Two participants stated that during the training period the main focus was on passing the modules and not on competence.

R3 (hospital): We are examined on clinical skills but you learn that component just to pass the clinical examination and you progress to the next level. You do not get to practice for competence.

4.4.4.4 Sub-theme four: Bad ward experiences

Bad ward experiences during training were identified as one of the reasons that can cause tensions leading to the student not meeting the set objectives.

R2(hospital): *Like in some department you had a bad experience as a student, now you are thrown in there as a com serve you will go in there looking at it in a bad light.*

4.4.5 Theme five: Needs

In response to the question of what clinical support do community service practitioners require, the following sub-themes emerged.

4.4.5.1 Sub-theme one: Teaching

Participants mentioned that there was insufficient teaching and learning during the period of compulsory community service. Three of them stated that they needed to be taught how to work since they are learning to be professional nurses.

R1 (CHC): There is a lot of teaching that the community service practitioner needs. You need someone to teach you how to use all the clinical guidelines, how to diagnose, how to prescribe, how to do the statistics.

4.4.5.2 Sub-theme two: Orientation

Community service practitioners mentioned the need to be properly orientated. Five of the eight participants expressed the need for orientation. Three of those responses were from participants who were placed at the CHC.

R5 (hospital): If we could be properly orientated and be made to understand our role because as it we are not sure.

R6 (CHC): Proper orientation into the PHC routine is also very important so that you can learn to work efficiently

4.4.5.3 Sub-theme three: Mentorship/Guidance

Jones, Benbow and Gidman (2014: 44) state that newly qualified nurses experience transitional shock when they are exposed to an environment that is different from the training environment and therefore fail to perform as expected. They may feel intimidated by the added responsibilities and expectations of having to care for patients independent of the college and tutorial staff. They need someone to support and guide them.

R7 (hospital): If I had maybe a mentor, say for the first three months things would be much easier.

R8 (CHC): For the next group of com serves, maybe it would help to actively mentor them until they develop the confidence of working as professional nurses.

4.4.5.4 Sub-theme four: Allocation plan

Allocation refers to the systematic placement of nurses to meet the learning needs. It is also done to meet the staffing needs of the department.

R3 (hospital): Every person is unique so I think if people were to be allocated to their area of interest I personally feel that people would adjust much easier as professional nurses.

R5 (hospital): We would appreciate proper allocation. Here there is no allocation plan for com serves. You are just taken to cover wherever there is a staff shortage.

4.4.5.5 Sub-theme five: Support by clinical lecturers

One participant voiced a need for clinical lecturers to continue supporting the NCSPs even after completion of training.

R2 (hospital): Personally, I would have loved a little bit of clinical support from college itself to bridge us through the transition of student to professional nurse. Like clinical tutors coming to help us and explain some of the things.

Two of the participants said NCSPs need someone who will liaise on their behalf. That person would liaise between them and the facility management.

R4 (hospital): I wish there could be somebody to liaise with com serves. Someone who will be responsible for our affairs.

R6(CHC): Yes, like a person who will talk on behalf of com serves and guide them on matters pertaining to their practice like their leave, allocation and things like that.

4.5 Summary

In this chapter an analysis of the research data was presented. The themes and their sub-themes that were derived from the analyzed data are presented. Direct quotations from the *verbatim* transcription were presented to further illustrate the themes. In the next and final chapter of the dissertation, the researcher discusses the research findings and makes recommendations in relation to the research findings.

CHAPTER 5: FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In this chapter the findings of the study will be discussed, based on the data that was analyzed in Chapter 4. Concluding remarks will be detailed and the researcher's recommendations will be discussed.

5.2 Summary and interpretation of research findings

The researcher was prompted by her encounters with NCSP's to find out more about the clinical support that is offered to them during their period of compulsory placement.

5.2.1 Research findings

The research aimed to meet the set research objectives, namely, to establish if:

- The NCSPs receive any support from the district trainers that are responsible for staff development within the district.
- Experienced nursing personnel provide any clinical support to NCSPs.
- Other members of the multi-disciplinary health team provide any support to NCSPs.
- Guidelines for clinical support of newly qualified nurses can be developed and sent to the Department of Health, KZN.

To meet these objectives the researcher asked semi-structured questions that would accomplish the set objectives.

5.2.1.1 Clinical support

In this study NCSPs had different interpretations of clinical support. The NCSPs measured the presence or lack of clinical support in terms of the orientation that they received. From this study, orientation helps nurses to reduce stress and improve the confidence and performance levels. The orientation of new staff members to the environment facilitates the smooth running of the department and prevents unnecessary hazards (Ndaba 2013: 45).

Lack of clinical support, on the other hand, can result in stress on the newly qualified nursing community practitioners (Whitehead & Holmes 2011: 21).

The participants who did not receive any clinical support had to rely on what they were taught at college. Others reported having to ask for support from other newly qualified professional nurses. That can have a negative influence on the quality of health care rendered to the patient or client. Junior professional nurses lack clinical experience and therefore cannot deal with complex clinical health problems. Newly qualified nurses still lack managerial as well as organizational skills and can therefore not be relied on to give clinical support to NCSPs (Roziers *et al.* 2014: 96).

5.2.1.2 Clinical support from the district trainers

According to Rispel (2016: 3) a well-functioning district health system is expected to perform the following key functions:

- Ensure the delivery of quality, equitable PHC services;
- Improve health outcomes for all South Africans;
- Address the social determinants of health, involve communities; and
- Change the power relations between the province and the district.

District trainers are professional nurses responsible for the development of nurses within the district. They organize in-service education and workshops for nurses within the district. According to the Health Systems Trust (2014: 2) district trainers are responsible for the provision of technical assistance to health personnel within the district and the strengthening of primary health care programs.

In this study it was evident the district trainers focus only on clinics and primary health care centres. They provide training and in-service workshops for nurses at primary health care institutions only.

The NCSPs who were placed at the CHC were aware of the services of the district trainers. They had attended training and workshops organized by them.

The results also showed that different departments within the hospital organize different ways of providing in-service education. Some departments allocate staff members to take turns providing in-service education to their colleagues. This involves discussing work-related topics.

The hospital also has a human resource department that is responsible for the professional development of staff members. They organize orientation and induction workshops for all staff members including nurses.

This study showed that there was no uniformity in terms of the nature and frequency of in-service education among the different departments. In some departments regular in-service education was reported whereas in some it was occasional.

Staff shortages and workloads were mentioned as a cause for some community service practitioners to not receive any in-service education. If the ward was busy then it becomes impossible to attend any form of in-service education.

5.2.1.3 Clinical support from Operational Managers

Operational Managers are professional nurses who are the unit managers in-charge of the smooth running of operations in the nursing units. The Department of Public Service and Administration's occupation specific dispensation (South Africa 2007: 1) prescribes the following key result areas for an Operational Manager:

- Supervision, co-ordination and delegation of the provision of effective and efficient client care through adequate excellent quality care.
- Maintenance of constructive working relationships with nursing and other stakeholders (i.e. inter-professional, inter-sectoral and multi-disciplinary teamwork).
- Effective and efficient management of all resources.
- Co-ordination and monitoring of the implementation of nursing care plan and evaluation thereof and ensuring that participation in research related activities are evident in the practice.
- Maintenance of professional growth and ethical standards and promotion of the quality of nursing care.

- Management of the hospital after-hours and rotation on night duty when the need arise.

Quality nursing care can only be maintained if the nursing personnel in the Operational Manager's unit are adequately skilled and competent.

This study revealed a lack of support to NCSPs by the Operational Managers. Operational Managers are unit managers who have administrative influence over the functioning of their units. They have a responsibility to efficiently manage all human resources allocated to their wards (Armstrong *et al.* 2015: 30).

In this study the NCSPs stated that they were not orientated when they first arrived. One of the reasons that were cited for not receiving any orientation was the fact that some of the community service practitioners had done their student practise in the same hospital. The operational managers therefore did not see the need to orientate nurses who had been students in the same hospital. That resulted in them not knowing what to do.

Staff shortages also contributed to the lack of clinical support for NCSPs. The wards were always busy therefore the Operational Managers could not orientate the NCSPs. According to Whitehead and Holmes (2011: 22) staff shortages is a major contributor to the lack of clinical support to NCSPs.

Even at the CHC, NCSPs did not receive any orientation and guidance. They were just given the clinical guidelines to manage clients. That caused a lot of confusion because they were not familiar with those guidelines. Community service practitioners experienced difficulty practicing the primary health care programs like Intergrated Management of Childhood Illness (IMCI) and Expanded Program of Immunisation (EPI) on their own because most of the guidelines had changed since the last time they practiced primary health care as students.

Community service practitioners expected operational managers to mentor and teach them. In the units where they were taught, NCSPs mentioned that their confidence has improved. They are able to manage complex situations, even working on night duty on their own.

In the units where they were not taught NCSPs equated this to being thrown into the deep end. They had to rely on their embedded knowledge which was sometimes insufficient.

5.2.1.4 Clinical support from other senior and experienced nurses

The study revealed that nurse managers such as assistant nurse managers did give clinical support to the NCSPs. They always made time even though they were very busy with their administrative duties. They had a lot of meetings to attend therefore they only visited the wards and clinics to conduct supervision and inspection. They were consulted whenever there was a crisis. For that reason they did not offer sufficient clinical support to the newly qualified nurses.

Professional nurses, on the other hand, were mentioned as the main source of clinical support. The study revealed that the NCSPs relied on professional nurses that they work with for teaching and guidance. They ask from them where they are not sure and they learn from them as they practice.

At the CHC the community service practitioners stated that the experienced professional nurses taught them the different programs that are offered at primary health care. They taught them how to use the different clinical programs.

Enrolled nurses and enrolled auxiliary nurses at the CHC provided clinical support to NCSPs. They are experienced in the primary health care programs and therefore the newly qualified nurses learned a lot from them. The study revealed that the NCSPs even learned from the lay HIV/AIDS counsellors.

At the hospital, though, the NCSPs experienced a lot of resistance from the enrolled nurses and enrolled auxiliary nurses. These nurses did not carry out duties delegated to them by NCSPs. They only carried out duties that were delegated by the Operational Manager or other senior professional nurses. Even the off-duties that were drafted by NCSPs were not acceptable to enrolled nurses. They always had complaints and wanted the off-duties to favour their preferences. At times the Operational Manager had to intervene and talk to them.

5.2.1.5 Clinical support from other members of the multi-disciplinary team

This study showed that NCSPs work mainly with doctors. It showed that there was a good working relationship between doctors and NCSPs. There was mutual respect among them but there was no clinical support. The doctors only visit the wards to check on specific patients. They do not stay long in the ward and therefore do not offer any clinical support.

Community service practitioners, however, mentioned that they learn a lot during the ward rounds, especially rounds that are conducted by consultants.

At the CHC doctors consult on patients that have been referred to them by nurses. There is no clinical support because doctors work in a different consulting room while the nurses are busy with other clients.

The study also revealed that the doctors who visit the CHC are mainly community service doctors who are inexperienced. For that reason they do not offer any clinical support to nurses. Even other members of the multi-disciplinary team like physiotherapists and occupational therapists were also community service practitioners.

5.2.2. Challenges faced by NCSPs

In this study NCSPs voiced a number of challenges that they faced during their compulsory placement. These challenges include:

- Insufficient clinical exposure;
- Curriculum deficiencies;
- Insufficient clinical accompaniment;
- Bad ward experiences;
- Staff shortages; and
- Difficulty in executing primary health care programs.

5.2.2.1 Insufficient clinical exposure and curriculum deficiencies

The study revealed that the clinical exposure that nursing students received was not enough to develop them into proficient practitioners.

The curriculum of the KwaZulu-Natal College of Nursing allows nursing students to learn General Nursing and Community Nursing Sciences for three years. In their fourth year of study they do Midwifery and Psychiatric nursing during the first and last semesters respectively. The study showed that students tend to forget the skills they learned during the first three years. This causes a challenge when they are allocated to general wards and CHCs for compulsory community service.

Another challenge that was found by the study is that the four-year course is packed with a number of outcomes that have to be achieved in a short period of time. For that reason, students are allocated to a nursing department for a short period. The maximum stay in any department is four weeks. This causes frustration because the student has to move to another ward without having mastered the required skills.

The Royal College of Nursing (2014: 3) defines nursing as “the use of clinical judgement in the provision of care to enable people to improve, maintain or recover health, to cope with health problems and to achieve the best possible quality of life, whatever their disease or disability, until death”. This is in line with Virginia Henderson’s view that nursing is a science and an art (REFERENCE). From this definition it is evident that nurses need a certain level of knowledge and practical skills to be able to render quality nursing care. Nursing community service practitioners are newly qualified nurses who lack practical experience and need clinical support to improve their clinical skills.

5.2.2.2. Insufficient clinical accompaniment

Clinical accompaniment is an integral element in the training of nurses. It helps learners to practice their clinical skills in a supportive environment (Motsilanyane 2015: 74). Insufficient clinical accompaniment leads to frustration and jeopardizes patient care because nurses do not get supported during their learning period (Roziers *et al.* 2014: 64).

In this study the NCSPs stated that they did not receive sufficient clinical accompaniment. The following *verbatim* quote emphasizes this:

R2: “*Personally, I didn’t think we had enough clinical support as students. We were mostly on our own*”.

Shortage of clinical lecturers was mentioned as the major cause of insufficient clinical accompaniment.

According to the study there is no clinical accompaniment that is conducted by the professional nurses in the ward since there is no mention of them.

5.2.2.3 Bad ward experiences

Sometimes NCSPs have bad ward experience during their clinical allocation in the wards. Bad attitudes of the trained staff towards student nurses contribute to student nurses not achieving their clinical learning outcomes. Bad experiences can result from personality clashes, reality shocks when the student comes into contact with different illnesses, and many other types of experiences (Ndaba 2013: 46).

5.2.2.4 Staff shortages

Shortage of staff was mentioned as a reason for the lack of clinical support. The NCSPs were not orientated properly because the wards were very busy. Operational Managers did not have time to orientate and teach the newly qualified nurses allocated to their wards. Community service practitioners were left alone to be in charge of the wards without the supervision of experienced professional nurses. This is supported by Whitehead and Holmes (2011: 22) who found that staff shortages were a major contributor to the lack of clinical support to NCSPs.

Shortage of staff was also mentioned as a reason for why community service practitioners did not receive sufficient in-service education. They could not attend workshops because most of the time the wards were busy and short staffed. This resulted in them not getting up-to-date information on nursing procedures.

The study also revealed that some NCSPs were not exposed to various departments because of staff shortages, while others stayed in one ward for nine months or more. They voiced their frustration with that arrangement because they expected to be exposed to different departments so that they could improve their clinical skills. Their

main cause of frustration was that they had forgotten some of the learned skills and they needed to be guided on them before they gain employment as permanent professional nurses.

Another concern that was raised in the study was the allocation of NCSPs as relief nurses. They were allocated to any ward that was experiencing staff shortage. They did not have any clinical support and were given the responsibility of managing nursing units. They were even allocated as “night sisters”, which meant they were managing the units on night duty.

5.2.2.5 Difficulty in executing primary health care programs

According to Dookie and Singh (2012:3), primary health care is regarded as the first point of entry to the health system and is directed towards health promotion and disease prevention. In primary health care the professional nurse is the main provider of health care as she/he executes preventive, promotive as well as curative health care.

There are different programs which are designed to meet this objective. Oni *et al.* (2015: 7) reiterate the need for various services or programs to meet the challenge brought about by the emergence and prevalence of different diseases. These diseases include TB, HIV/AIDS and chronic diseases like diabetes and hypertension. These diseases require primary care nurses to be skilled to execute the pertinent programs.

At the CHCs NCSPs were expected to diagnose and manage clients on their own. They had to rely on clinical guidelines that they were not familiar with. This created frustration for both the community service practitioners and their clients. Clients lost confidence in the standard of care they were receiving. Community service practitioners had to keep asking from other professional nurses in other consulting rooms for guidance and they felt embarrassed by that.

5.3 Conclusion

International and national studies have been conducted on the lived experiences of newly qualified nurses but very few, if any, have focused on the clinical support that they receive.

In this study, data was collected from NCSPs using semi-structured interviews. The challenges that were highlighted by the study included insufficient clinical exposure, curriculum deficiencies, insufficient clinical accompaniment and staff shortages.

5.4 Recommendations

Recommendations are made with the aim of improving support that is offered to NCSPs. Recommendations are based on the findings of the study. Some of the recommendations are derived from the concerns that were highlighted by the research participants.

5.4.1 Practice

- The SANC should develop a scope of practice for community service practitioners. This will help to clarify their role and limitations. This follows the findings of this study that revealed that NCSPs perform professional nurses' duties without any supervision.
- Nurse Managers should develop an induction programme that is specific to NCSPs. This will reduce frustration as they will be aware of what is expected of them.
- Mentorship programs for NCSPs should be developed by the nurse managers. Each community service practitioner should be allocated a mentor who is an experienced professional nurse. The mentor will work closely with the NCSP providing guidance and training. Most importantly the mentor will model good clinical practice for the NCSP.
- An allocation program should be developed by nurse managers that will ensure that the learning needs of nursing community practitioners are met. The allocation program should be designed in such a way that community service practitioners gain exposure to different areas of clinical practice.

- A plan of rotation between the different departments should be designed in a way that promotes development of competence in clinical skills. Three months should be the maximum time that NCSPs spend in any one department. In that way they get enough experience in all departments.
- Hospitals and CHCs should allocate senior professional nurses who will be the liaison officers for NCSPs. These professional nurses will liaise with the nursing managers on matters that concern NCSPs. This follows a complaint by the participants that they do not know who to talk to within the hospital. The liaison officer will be responsible for the social and professional welfare of NCSPs, like allocation of leave.

5.4.2 Nurse training

- Curriculum of nursing colleges should be revised to integrate Midwifery and Psychiatric nursing into the general nursing practice from the third to the fourth year of study. This recommendation comes from the complaint that nurses tend to forget what they learned in general nursing if their fourth year only focuses on Midwifery and Psychiatric nursing. Participants stated their concern that it is difficult to remember the things they have not practiced for the whole year. This is further support by Zonke's (2012: 52) findings.
- More innovative teaching strategies to be utilized to allow students to correlate theory and practice.
- Skills laboratories to be well equipped to allow for better simulation of skills.
- The curriculum should be revised to allow the students to spend longer in the wards. In that way they can get to learn the clinical skills under the guidance of professional nurses.
- Clinical examination should be comprehensive to help the learner to integrate various skills.

5.4.3 Clinical accompaniment

- Clinical accompaniment strategies should be strengthened in hospitals and CHCs. The number of clinical lecturers should be increased as the shortage of clinical lecturers was discovered to be the cause of poor clinical accompaniment.

- Lines of communication should be open between the nursing campuses and the clinical facilities. This will allow professional nurses in the wards to become aware of the clinical objectives that learners should meet.
- The clinical teaching model as suggested during the 2011 Nursing Summit (Nursing Strategy 2012) should be adopted. This model advocates for preceptorship as a means of providing clinical support to nursing students. The preceptors will conduct clinical accompaniment to nursing students on a regular basis since they will be based in the hospitals and CHCs.
- Clinical Teaching Departments should be strengthened with full time managers who are responsible for co-ordination of clinical learning programmes.
- Lecturers should develop a plan of clinical accompaniment. They should assist nursing students to correlate the theory that they teach with practical clinical practice.

5.5 Limitations of the study

The following limitations of the study were identified:

- The study was conducted in one regional hospital and one CHC. This limits the generalizability of the findings.
- The study was conducted on NCSPs who were trained in campuses of the KwaZulu-Natal College of Nursing only. The two community service practitioners who were trained at Durban University of Technology and University of KwaZulu-Natal were on night duty and vacation leave, respectively. The researcher failed to get hold of them.
- Some of the interviews were conducted inside the ward in a private room. That caused a lot of interruptions and banging of doors. That partially affected the quality of the recorded interviews.

5.6 Concluding remarks

Compulsory community service is an important program of the Department Health that is designed to reduce staff shortages especially in the rural health facilities. This study discovered that NCSPs were faced with a number of challenges that affect

their clinical competence. All these challenges are caused by the lack of a program for clinical support of community service practitioners.

Recommendations have been made to improve the clinical support to nursing students and to NCSPs. Effective implementation of these recommendations will improve their clinical competence and reduce their frustration as well as that of other health professionals who work with them.

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ANNEXURES

Annexure A: Letter to Turton CHC

P.O. Box 47684
Sea Park
4241
01 June 2015
Chief Executive Officer
Turton CHC
Private Bag X 07
Hibberdene
4220

REQUEST TO CONDUCT RESEARCH

Dear Sir / Madam

My name is Ignatia Tandiwe Malunga. I wish to request permission to conduct nursing research within your institution. The details of the study are contained below. I am currently working at Port Shepstone Nursing Campus as a lecturer and am a Master of Technology- Nursing student at the Durban University of Technology.

Title of the Research Study

Clinical support to nursing community service practitioners in Ugu district, KwaZulu-Natal.

Principal Investigator/Researcher: Mrs. Ignatia Tandiwe Malunga- B. A. Cur.

Co-Investigator/ Supervisor: Dr. Petro Magdalena Basson – PhD

Brief Introduction

According the Nursing Act No. 33 of 2005 (South Africa 2005: 40) at the end of their training, nurses, like all other health professionals must serve for a period of one year at public health facilities including hospitals, CHCs and clinics. During this

period they are registered with the South African Nursing Council as community service practitioners.

Compulsory community service for nurses is an important strategy towards solving the problem of staff shortages especially in rural hospitals, CHCs and clinics; however these practitioners are not yet experienced and skilled enough to deal with complex clinical situations.

Purpose of the Study

The purpose of this study is to establish the experiences of nursing community service practitioners that are allocated to hospitals and CHCs on the clinical support offered to them.

Research Design

This is a qualitative study that uses an exploratory-descriptive approach. Semi-structured in-depth interviews with nursing community service practitioners allocated at Port Shepstone Regional Hospital and Turton CHC will be conducted.

Outline of the Procedure

- The researcher is conducting interviews so that participants can share their lived experiences as community service practitioners.
- The interviews will be recorded using a tape recorder.
- No names will be used when analysing data, therefore the participants' identity will be protected.
- On completion of the study, once all the relevant permission has been obtained, participants will be informed of the findings of the study and recommendations.

Risk or Discomfort to Participants

- There will be no risk or discomforts
- The participant is expected to dedicate twenty minutes of his/her time to answer the interview questions.

Benefits

- The study will be used to improve mentorship programs for community service practitioners.
- The results will assist during the induction of junior professional nurses.
- District trainers will benefit when planning their training programs for nurses.
- Other researchers will benefit from the study since a copy will be made available to the Durban University of Technology library as a source of reference.
- It would also assist the researcher to gather accurate data and complete the study and gain her qualification.

Reasons/s why a Participant May be Withdrawn from the Study

- The researcher foresees no reason for withdrawing the participant.
- Participation is voluntary, so the participant may withdraw at any point if he/she so wishes.
- A participant who is ill in any way and is unable to sit for the interview may withdraw from the study.

Remuneration: None

Cost of the Study: All costs of the study will be incurred by the researcher. There are no costs that the participants will have to endure.

Confidentiality

- Will be maintained as there will be no use of participants' name.
- The name of the CHC will not be mentioned.
- All data will be kept in a secure place; no unauthorised persons will have access to this information.
- The tapes will be stored in a metal safe for a period of five years.

Research- related Injury

- This is a non-experimental study; so there will be no physical harm to participants.
- Confidentiality will be maintained so psychological harm will be prevented.

- There will be an instruction letter distributed to participants before the interviews to reduce queries but should there be any problems the researcher will be available to answer any questions.

Person to Contact in the Event of any Problem or Queries

- Should there be any enquiry please contact the researcher: Mrs. I. T. Malunga – 0736142522
  E-mail: ignatia.malunga@kznhealth.gov.za
  thandiwe.malunga@gmail.com
- Should you still not be satisfied please contact my supervisor: Dr. Petro Magdalena Basson
  031 -3732606; e-mail petrob@dut.ac.za

Thank you for your assistance

Yours sincerely

Ignatia Tandiwe Malunga

Annexure B: Letter to Port Shepstone Regional Hospital

P.O. Box 47684
Sea Park
4241
01 June 2015
Chief Executive Officer
Port Shepstone Regional Hospital
Private Bag X5706
Port Shepstone
4240

REQUEST TO CONDUCT RESEARCH

Dear Sir / Madam

My name is Ignatia Tandiwe Malunga. I wish to request permission to conduct nursing research in your facility. The details of the study are contained below.
I am currently working at Port Shepstone Nursing Campus as a lecturer and am a Master of Technology- Nursing student at the Durban University of Technology.

Title of the Research Study

The extent of mentoring and support offered to nursing community service practitioners.

Principal Investigator/Researcher: Mrs. Ignatia Tandiwe Malunga- B. A. Cur.

Co-Investigator/ Supervisor: Dr. Petro Magdalena Basson – PhD

Brief Introduction

According the Nursing Act No. 33 of 2005 (South Africa 2005: 40) at the end of their training, nurses, like all other health professionals must serve for a period of one year at public health facilities including hospitals, CHCs and clinics. During this period they are registered with the South African Nursing Council as community service practitioners.

Compulsory community service for nurses is an important strategy towards solving the problem of staff shortages especially in rural hospitals, CHCs and clinics; however these practitioners are not yet experienced and skilled enough to deal with complex clinical situations.

Purpose of the Study

The purpose of this study is to establish the experiences of nursing community service practitioners that are allocated to hospitals and CHCs on the clinical support offered to them.

Research Design

- This is a qualitative study that uses an exploratory-descriptive approach. Semi-structured in-depth interviews with nursing community service practitioners allocated at **Port Shepstone Regional Hospital and Turton CHC** will be conducted.

Outline of the Procedure

- The researcher is conducting interviews so that participants can share their lived experiences as community service practitioners or as professionals who work directly with them.
- The interviews will be recorded using a tape recorder.
- No names will be used when analysing data, therefore the participants' identity will be protected.
- On completion of the study, once all the relevant permission has been obtained, participants will be informed of the findings of the study and recommendations.

Risk or Discomfort to Participants

- There will be no risk or discomforts
- The participant is expected to dedicate twenty minutes of his/her time to answer the interview questions.

Benefits

- The study will be used to improve mentorship programs for community service practitioners.
- The results will assist during the induction of junior professional nurses.
- District trainers will benefit when planning their training programs for nurses.
- Other researchers will benefit from the study since a copy will be made available to the Durban University of Technology library as a source of reference.
- It would also assist the researcher to gather accurate data and complete the study and gain her qualification.

Reasons/s why a Participant May be Withdrawn from the Study

- The researcher foresees no reason for withdrawing the participant.
- Participation is voluntary, so the participant may withdraw at any point if he/she so wishes.
- A participant who is ill in any way and is unable to sit for the interview may withdraw from the study.

Remuneration: None

Cost of the Study: All costs of the study will be incurred by the researcher. There are no costs that the participants will have to endure.

Confidentiality

- Will be maintained as there will be no use of participants' name.
- The name of the hospital will not be mentioned.

- All data will be kept in a secure place; no unauthorised persons will have access to this information.
- The tapes will be stored in a metal safe for a period of ten years.

Research- related Injury

- This is a non-experimental study; so there will be no physical harm to participants.
- Confidentiality will be maintained so psychological harm will be prevented.
- There will be an instruction letter distributed to participants before the interviews to reduce queries but should there be any problems the researcher will be available to answer any questions.

Person to Contact in the Event of any Problem or Queries

- Should there be any enquiry please contact the researcher: Mrs. I. T. Malunga – 0736142522
  E-mail: ignatia.malunga@kznhealth.gov.za
  : thandiwemalunga6@gmail.com
- Should you still not be satisfied please contact my supervisor: Dr. Petro Magdalena Basson
  031 -3732606; e-mail petrob@dut.ac.za

Thank you for your assistance

Yours sincerely

Ignatia Tandiwe Malunga

Annexure C: Letter to KZN Department of Health

Annexure: A

P.O. Box 47684
Sea Park
4241
08 April 2015

The Head of Department
Private Bag X9051
Pietermaritzburg
3200

REQUEST TO CONDUCT RESEARCH

Dear Sir / Madam

My name is Ignatia Tandiwe Malunga. I wish to request permission to conduct nursing research within the district. The details of the study are contained below.
I am currently working at Port Shepstone Nursing Campus as a lecturer and am a Master of Technology- Nursing student at the Durban University of Technology.

Title of the Research Study

Clinical support to nursing community service practitioners in Ugu district, KwaZulu-Natal.

Principal Investigator/Researcher: Mrs. Ignatia Tandiwe Malunga- B. A. Cur.

Co-Investigator/ Supervisor: Dr. Petro Magdalena Basson – PhD

Brief Introduction

According the Nursing Act No. 33 of 2005 (South Africa 2005: 40) at the end of their training, nurses, like all other health professionals must serve for a period of one year at public health facilities including hospitals, community health centers and clinics. During this period they are registered with the South African Nursing Council as community service practitioners.
Compulsory community service for nurses is an important strategy towards solving the problem of staff shortages especially in rural hospitals, community health centres and clinics; however these practitioners are not yet experienced and skilled enough to deal with complex clinical situations.

Purpose of the Study

The purpose of this study is to establish the experiences of nursing community service practitioners who are allocated to hospitals and community health centres on the clinical support offered to them.

Annexure D: Letter of information

LETTER OF INFORMATION

Dear Participant

Warm greetings to you and thank you for participating in this study. My name is Ignatia Tandiwe Malunga. I wish to request permission to conduct nursing research within the district. The details of the study are contained below.

I am currently working at Port Shepstone Nursing Campus as a lecturer and am a Master of Technology- Nursing student at the Durban University of Technology.

Please take some time to read the information presented hereunder, which will explain the details of the study. It is important that you fully understand the process of this study and how you will be involved. Your participation is voluntary. Please read this information letter and if you agree to participate then proceed to sign the consent form.

Title of the Research Study

The extent of mentoring and support offered to nursing community service practitioners.

Principal Investigator/Researcher: Mrs. Ignatia Tandiwe Malunga- B. A. Cur.

Co-Investigator/ Supervisor: Dr. Petro Magdalena Basson – PhD

Brief Introduction

According the Nursing Act No. 33 of 2005 (South Africa 2005: 40) at the end of their training, nurses, like all other health professionals must serve for a period of one year at public health facilities including hospitals, CHCs and clinics. During this

period they are registered with the South African Nursing Council as community service practitioners.

Compulsory community service for nurses is an important strategy towards solving the problem of staff shortages especially in rural hospitals, CHCs and clinics; however these practitioners are not yet experienced and skilled enough to deal with complex clinical situations.

Purpose of the Study

The purpose of this study is to investigate the extent to which the nursing community service practitioners allocated to hospitals and CHCs are being mentored.

Research Design

This is a qualitative study that uses the phenomenological approach. Semi-structured interviews with nursing community service practitioners allocated at Port Shepstone Regional Hospital and Turton CHC will be conducted. The following health officials will also be interviewed:

- Nursing Managers of the above institutions
- Doctors who are working directly with nursing community service practitioners
- District trainers who are responsible for training at the above institutions.

Outline of the Procedure

- The researcher is conducting interviews so that participants can share their lived experiences as community service practitioners or as professionals who work directly with them.
- The interviews will be recorded using a tape recorder.
- No names will be used when analysing data, therefore your identity will be protected.
- On completion of the study, once all the relevant permission has been obtained, you will be informed of the findings of the study and recommendations.

Risk or Discomfort to Participants

- There will be no risk or discomforts.
- You are expected to dedicate twenty minutes of his/her time to answer the interview questions.

Benefits

- The study will be used to improve mentorship programs for community service practitioners.
- The results will assist during the induction of junior professional nurses.
- District trainers will benefit when planning their training programs for nurses.
- Other researchers will benefit from the study since a copy will be made available to the Durban University of Technology library as a source of reference.
- It would also assist the researcher to gather accurate data and complete the study and gain her qualification.

Reasons/s why a Participant May be Withdrawn from the Study

- The researcher foresees no reason for withdrawing your participation.
- Participation is voluntary, so you may withdraw at any point if you so wish.
- If you happen to be ill in any way and are unable to sit for the interview, you may withdraw from the study.

Remuneration: None

Cost of the Study: All costs of the study will be incurred by the researcher. There are no costs that the participants will have to endure.

Confidentiality

- Will be maintained as there will be no use of your name.
- All data will be kept in a secure place; no unauthorised persons will have access to this information.
- The tapes will be stored in a metal safe for a period of ten years.

Research- related Injury

- This is a non-experimental study; so there will be no physical harm to you.
- Confidentiality will be maintained so psychological harm will be prevented.
- There will be an instruction letter distributed to you before the interviews to reduce queries but should there be any problems the researcher will be available to answer any questions.

Person to Contact in the Event of any Problem or Queries

- Should there be any enquiry please contact the researcher: Mrs. I. T. Malunga – 0736142522
  E-mail thandiwe.malunga6@gmail.com
  or ignatia.malunga@kznhealth.gov.za
- Should you still not be satisfied please contact my supervisor:
  Dr. Petro Magdalena Basson 031 -3732606; e-mail petrob@dut.ac.za

Thank you for your assistance
Ignatia Tandiwe Malunga (Researcher)

Annexure E: Consent form

CONSENT FORM

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Mrs. I. T. Malunga, about the nature, conduct, benefits and risks of this study.
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth and initials will be anonymously processed into a study report.
- In view of the requirements of the research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____ _____ _____ _____

Full Name of Participant Date Time Signature

I, Ignatia Tandiwe Malunga hereby confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Ignatia Tandiwe Malunga _____ _____ _____

F**ull Name of the Researcher Date Signature**

Annexure F: Permission letters from research sites

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

PORT SHEPSTONE REGIONAL HOSPITAL
Private Bag X5708, PORT SHEPSTONE 4240
11 Bazley Street, PORT SHEPSTONE 4240
TEL: 039 688 6208
FAX: 039 682 1514
Mreesi.rakaki@kznhealth.gov.za
www.kznhealth.gov.za

Reference: 2/7
Enquiries: Mr. GBC Khawula
Telephone: (039) 688 6208

28 July 2015

Chairperson: Research Committee
KZN Department of Health
Private Bag 9051
PIETERMARITZBURG
3200

RE: PERMISSION FOR RESEARCH TITLED: "CLINICAL SUPPORT TO NURSING COMMUNITY SERVICE PRACTITIONERS AT PORT SHEPSTONE HOSPITAL

OBJECT

To grant permission for Mrs. I.T Malunga to do research on the clinical support to nursing community service practitioners at Port Shepstone Regional Hospital.

SUPPORTING DOCUMENTS

Appended hereto is documentation received.

OFFER OF SUPPORT

This office wishes to inform that the proposed research to be conducted by Mrs I.T Malunga is wholly supported. There are no financial implications.

RECOMMEDATION

In view of Mrs. I.T Malunga request I recommend the necessary authority be granted by the Research Committee for her to continue with her research.

Submitted for your attention and further action.

Yours sincerely

28/7/2015

MR GBC KHAWULA
CHIEF EXECUTIVE OFFICER
PORT SHEPSTONE REGIONAL HOSPITAL

HEALTH
KwaZulu-Natal

UGU HEALTH DISTRICT OFFICE
Private Bag X 735, Port Shepstone, 4240
41 Bissett Street, via Main Entrance of Nelson Mandela Drive
Tel.:039 688 3000,
Fax.:039 682 6296
Email.:veeran.chetty@kznhealth.gov.za

www.kznhealth.gov.za

Enquiries: Mr C Nguza
Ref: UGUDHO research
Date: 28 July 2015

Principle Investigator: Mrs I T Malunga

Re: PERMISSION TO CONDUCT RESEARCH AT TURTON CHC

I have pleasure in informing you that the permission has been granted to you by the District Office/Facility to conduct research on "Clinical support to nursing community service practitioners in Ugu district, KwaZulu- Natal".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.

2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.

3. Please ensure this office is informed before you commence with your research.

4. The District Office/Facility will not provide any resources for this research.

5. You will be expected to provide feedback on your findings to the District Office/Facility.

Thanking you.
Sincerely

Mr Comfort Nguza
Acting District Manager
Ugu Health District Office

Annexure G: Permission letter from KZN Health Research Committee

KwaZulu-Natal Health Research Committee

APPLICATION DETAILS

Title of Research Project

Clinical support to nursing community service practitioners in Ugu District, KwaZulu - Natal

Status of Application

Approved

Status of Project

On-Going

Proposal Submission Date

2015/07/31

Comments

You will find a list of all comments made on the selected research application. The list below displays comments visible to both the Applicant and Research Committee

Comment	Comment Date	Comment By

Research Staff assigned to Project/Proposal

Title	Name	Surname	Role	Institution	E-Mail	Phone No.	Mobile No.	CV/ Resume
Mrs	Ignatia Tandiwe	Malunga	Investigator	Durban University of Technology	ignatia.malunga@kznhealth.gov.za	0393155322	0726141522	No File

Aim and Objectives

The purpose of this study is to establish the experiences of nursing community service practitioners that are allocated to hospitals and CHCs on the clinical support offered to them.

Study Area(s)/Field(s)

Description

Public Health

Quality of Care

Study Design(s)

Description

Exploratory

Data Collection Method(s)

Method Category Method Description

Qualitative Interview

Sample

Purposive sampling of all nursing community service practitioners placed at Port Shepstone hospital and Turton CHC will be done.

Data Analysis Tool(s)

Tool Description

Content analysis

Information / Data Request?

No

Information / Data request details.

No Data Requested

Locations(s) where study will be conducted

Facility

---- Port Shepstone Hospital

Anticipated Start Date

2015/08/10

Anticipated Completion Date

2015/08/31

Institution(s) which gave ethical approval

Institution

DUT - Durban University of Technology Faculty of Health Sciences Research Committee

Ethics Approval Number

REC 46/15

Date of Ethical Approval

2015/05/21

Date Ethical Approval Expires

2015/11/21

If Clinical Trial, MCC Approved

No

National Clinical Trials Registry Number

Funding source

None

Budget (in ZAR)

0

Back to List

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Annexure H: Interview questions

Interview Questions

Two main questions will be asked from Nursing Community Service Practitioners:

- Please explain the support that you received when you arrived at this institution.
- In your view, what kind of support do you require?

Annexure I: DUT IREC Provisional Approval

Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

21 May 2015

IREC Reference Number: **REC 46/15**

Mrs I T Malunga
P O Box 47684
Sea Park
4241

Dear Mrs Malunga

Clinical support to nursing community service practitioners in Ugu district, KwaZulu-Natal (KZN)

I am pleased to inform you that Provisional Approval has been granted to your proposal REC 46/15 subject to:

- Obtaining and submitting the necessary gatekeeper permission/s to the IREC.

Full approval is subject to meeting the above condition.

The Proposal has been allocated the following Ethical Clearance number **IREC 043/15**. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Professor J K Adam
Chairperson: IREC

DUT DURBAN UNIVERSITY OF TECHNOLOGY
2015 -05- 21
INSITUTUTIONAL RESEARCH ETHICS COMMITTEE
P O BOX 1334 DURBAN 4000 SOUTH AFRICA

Annexure J: DUT IREC Full Ethics Approval

Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

1 October 2015

IREC Reference Number: **REC 46/15**

Mrs I T Malunga
P O Box 47684
Sea Park
4241

Dear Mrs Malunga

Clinical support to nursing community service practitioners in Ugu district, KwaZulu-Natal (KZN)

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC

DUT DURBAN UNIVERSITY OF TECHNOLOGY

2015 -10- 01

INSITUTUTIONAL RESEARCH ETHICS COMMITTEE
P O BOX 1334 DURBAN 4000 SOUTH AFRICA

Annexure K: Editing Certificate

DR RICHARD STEELE

BA, HDE, MTech(Hom)

HOMEOPATH

Registration No. A07309 HM

Practice No. 0807524

Freelance academic editor

Associate member: Professional Editors' Guild, South Africa

110 Cato Road

Glenwood, Durban 4001

031-201-6508/082-928-6208

Fax 031-201-4989

Postal: P.O. Box 30043, Mayville 4058

Email: rsteele@telkomsa.net

EDITING CERTIFICATE

Re: **IGNATIA TANDIWE MALUNGA**

Master's dissertation: **CLINICAL SUPPORT TO NURSING COMMUNITY SERVICE PRACTITIONERS IN UGU DISTRICT, KWAZULU-NATAL**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at UCT was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University

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16 March 2017

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