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EXPERIENCES OF NEW NURSE GRADUATES REGARDING COMMUNITY SERVICE PRACTICE IN JOHANNESBURG

By

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DEDICATION

This study is dedicated to the Almighty God who has given me strength through the difficult times and He gave me hope where there was no hope. To my late husband Mr. Dingaan Daniel Mkansi who was brutally killed during the process of this study on the 16/10/12. May his soul rest in peace.

My late parents Mr. & Mrs. David & Leah Sebe who made sure that I attended school and who constantly supported me. To my mother in-law Mrs. Makhanani Mkansi who looked after my children to ensure that I could go to school and have a better future. May their souls rest in peace.

To my children, Tinyiko, Rhulani, Tsakani and Tintswalo who have encouraged me to hold on and to never give up. They have continuously stood by me during this journey and I will be forever grateful for their love and support.
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SUMMARY

The culture of nurturing the new nurse graduates during their transition from student nurse to professional nurse is introduced by Department of Health in all health professions. The new nurse graduates face negative experiences of having to handle shifts without the assistance of an experienced professional nurse. The new nurse graduates are continuously faced with the constant fear of making mistakes, and hence need the assistance or supervision of an experienced professional nurse whom they can rely on in problem-solving situations. The new graduate nurses are placed in clinical settings by the Gauteng Department of Health and they are neither supported nor mentored, which leaves them frustrated and lacking in the relevant expected experience.

The purpose of this study is to explore and describe the lived experiences of new graduate nurses regarding community service practice so as to be able to describe strategies to improve the practice of new nurse graduates in Johannesburg.

A phenomenological, contextual, exploratory, and descriptive qualitative research design (Burns & Grove, 2009:51) was used to explore and describe the experiences of new nurse graduates in clinical settings in Johannesburg. The target population was the new graduate nurses who completed their one-year community service practice in 2010 in a Johannesburg clinical facility and who were ready to register as professional nurses with the South African Nursing Council (SANC). A purposive, non-probability sampling method was utilised. An individual, semi-structured, interview data collection method was employed. Probing was done to encourage participants to share as much information as possible about the phenomenon under study. A qualitative, open coding method of data analysis was used. Conceptualisation of findings was made. Measures to obtain trustworthiness were ensured by using Lincoln and Guba’s (1985) four criteria, namely credibility, transferability, confirmability, and dependability. Ethical standards as outlined by DENOSA were followed. Three categories and their sub-categories emerged as: 1. Lack of teaching, guidance, and support, and the sub-categories are lack of teaching, supervision and support and fear/uncertainty from lack of experience.
2. Lack of management support, and the sub-categories are lack of resources, lack of conflict management, and poor communication. 3. Negative attitude of staff members, and the sub-categories are disrespect, name-calling, and intolerance. Strategies, limitations, recommendations, and conclusions were made.
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CHAPTER ONE
OVERVIEW OF THE STUDY

1.1 INTRODUCTION, BACKGROUND AND RATIONALE

Community service practice is undertaken by new graduate nurses who have completed the basic comprehensive nursing programme in terms of the Nursing Act (Act No. 33 of 2005) and who have met the requirements to qualify as professional nurses. These nurses must perform remunerated community service for a period of one year (SANC Regulation R765).

South Africa introduced a one-year community service requirement for health professionals in 1998. The first group of health professionals to do community service was doctors in 1999, this was followed by dentists in 2000, and pharmacists in 2001, and physiotherapists, occupational and speech therapists, clinical psychologists, dieticians, radiographers, and environmental health practitioners in 2003 (Reid, 2002:2,3). In 2004, the Minister of Health announced the introduction of community service for nurses. This government’s strategy was to:

- bridge the gap between theory and practice;
- cope with the problem of human resources in the health sectors;
- ensure that young health professionals provide service to the areas in need; and
- attract new graduates to work in rural areas in the longer term.

On 24 August 2007, in terms of section 40(3) of the Nursing Act, (Act No. 33 of 2005), and after consultation with the SANC, Regulation R765 concerning the undertaking of community service was established.

New graduates who perform community service must be registered in the category of community service with the SANC and are limited to practicing their profession in designated public health facilities. A person performing community service is subject to the rules and regulations of the professional conduct prescribed for the nursing profession in respect of which community service is performed (SANC Regulation R765).
The Gauteng Department of Health places final-year nursing students who have completed their studies at different types of clinical settings at convenient hospitals. These graduates start at a level of incompetence. They need full support and mentoring by experienced registered nurses to integrate theory and practice. The researcher has observed that during this period the new graduate nurses experience fear and anxiety. Because of their new responsibilities, they need support and mentoring to help them make the transition from student nurse to professional nurse. During training, learners concentrate more on achieving their learning outcomes so that they can be promoted to the next level of training. During the period of transition, the new graduate nurses require proper socialisation into the nursing profession and need to learn how to deal with challenging situations in practice, which requires problem-solving, decision-making, reflective and critical thinking skills (Billings & Halstead, 2009:95).

SANC’s Regulation R765 for community service nurses does not spell out their scope of practice, and this leaves them confused and without direction. They also have a confusing status, because in some instances they are referred to as community service nurses, and in other cases they’re referred to as professional nurses.

The mentoring of new graduates is supported by McConnell (2004:42) who emphasised that regardless of how much effort is put into making education practical, the gap between theory and practice remains huge until new graduates begin to practice as professional nurses, integrating theory and practice under supervision. New graduate nurses require significant support, even if they have the knowledge and skills that they acquired during their training.

The first month of practice can be chaotic, painful, and traumatic – fostering feelings of isolation, vulnerability and uncertainty. These feelings can result in low self-esteem, lack of self-confidence, and a sense of failure in new nurse graduates, as supported by Boychuck, Duchster, and Cowin, (in Lavoie-Trembly, Wright, Desforges, Gelinás, Marchionni Drevniok, 2008:291). O’Shea and Kelly (2007:1535) also suggest that while new graduate nurses experience problems with role transition, they perceive more potential problems than they actually experience in practice. New nurse graduates
experience stress, fright, and consider the situation to be an absolute disaster because they lack support, guidance, and mentoring in the nursing practice environment. Owing to staff shortages, the experienced professional nurses do not have time to orientate these new nurse graduates, and they are left to struggle on their own.

Mooney (2007:75) also indicated that the problems associated with the transition of student nurses to professional nursing have been acknowledged as being traumatic and stressful. Experienced professional nurses blame staff shortages and sometimes the learning institution for poor preparation of student nurses for practice as professional nurses.

According to Ahern and Kethy (2008: 911), many claims have been made regarding what graduates require in their first year of professional nursing practice, since the transition period is crucial in laying the groundwork for the integration of new graduates into the practice as professional nurses. The transition from education to the world of nursing practice can be distressing. The theory of nursing practice and the speed with which it has to be implemented or delivered in professional practice differs remarkably (Clutterbuck, 2004: 131).

One of the mechanisms designed and implemented to support new graduate nurses in the workplace are the transition support programmes, which are offered by most clinical settings in various formats. However, some clinical settings fail to implement the support programmes, while others have good programmes that senior managers are aware of but fail to communicate to professional nurses. Mentoring is a means of smoothing graduate nurses’ transition from an educational environment to a nursing practice environment. Mentoring helps the new graduate nurses to settle into the nursing practice environment comfortably (Clutterbuck, 2004:38). According to Sullivan and Decker (2005:270), getting an employee started in the right way is very important.

According to O'Shea and Kelly (2007:1534), professional socialisation is significant in shaping the new graduate nurses in their roles as professional nurses. The new graduate nurses who are not supported in the socialisation experience are less
satisfied, perform poorly, and are not committed to remaining within the organisation or nursing profession, which opposes the government’s intention to retain them. Much has been done to ensure the competency of newly qualified nurses (Lofmark, Smide & Wikblad, 2006:721), but little research has been done on their experiences during the transitional period from student nurse to a professional nurse. A study of the new nurse graduates’ experiences of community service will provide more in-depth information to the Gauteng Department of Health, and will encourage clinical facilities to implement strategies to improve community service practice in Johannesburg.

1.2 RESEARCH PROBLEM

The culture of nurturing the new graduate nurses during their transition from novice to expert professional nurse is traumatic (O'Shea & Kelly, 2007:1535). The new graduates are left alone to run the shift without the supervision of an experienced professional nurse. While these nurse graduates attempt to establish themselves in the nursing profession, they continuously face challenges that make them lose confidence in their ability to become future professional nurses. The number of staff allocated to these nurse graduates may well be adequate, but there is a lack of experienced professional nurses to provide guidance and support, which reduces the opportunity for new graduate nurses to seek advice from more experienced professional nurses (Saintsing, Gibson & Pennington, 2011:355).

The government will not meet its purpose of integrating theory into practice and to deal with staff shortages, which could result in new graduate nurses and other professional health care workers, such as assistant doctors leaving the profession after completing their one year community service practice contracts and seeking employment in private institutions or overseas. As a result, the goal of community service practice will not be achieved, and hence the need for a study to explore the experience of new nurse graduates regarding community service practice in Johannesburg.
1.3 RESEARCH QUESTION

Emerging from the introduction and the problem statement are the following research questions:

- What are the experiences of new nurse graduates regarding community service practice in Johannesburg?
- What should be done to improve the community service practice of new nurse graduates?

1.4 THE RESEARCH PURPOSE

The overall purpose of the study is to describe the strategies to improve the community service practice in Johannesburg.

1.5 THE RESEARCH OBJECTIVES

The purpose will be realised by the following research objectives:

- to explore and describe the lived experiences of community service nurses; and
- to describe strategies to improve community service practice for nurses at the Johannesburg Hospital.

1.6 DEFINITION OF KEY CONCEPTS

**Experience** – is the way in which people encounter situations in relation to their interests, purposes, personal concerns, and background understanding (Benner, Sutphen, Leonard & Day, 2010:186).

**New graduate nurse** – is a nurse who has completed all the requirements of a four-year basic comprehensive nursing programme. The Department of Health (DoH) places these nurses in clinical settings to practice as community service nurses for a full year before they can be registered with the SANC according to the SANC’s Regulation R425.
as a nurse (general, psychiatric, and community) and midwifery at diploma or degree level.

**Nursing** – is a caring profession practiced by a person registered with the SANC, who supports, cares for, and treats a healthcare user to achieve or maintain health (Mulaudzi, Mokoena & Troskie, 2010:2).

**Community service practice** – according to the SANC’s Regulation R765, community service practice refers to a practice rendered by any health related person who is a citizen of South Africa and who has met all of the prescribed requirements as a professional person, and who intends to register as such. These nurses must perform remunerated community service for a period of one year (SANC Regulation R765). In this study they will have completed community service in 2010.

**Practice setting in Johannesburg** – refers to the settings that provide opportunities to the new graduate nurses to practice the clinical skills that they require to become skilled professional nurses (Meyer, Naude, Shangase & Van Niekerk, 2009:112). In this study the setting is in a Johannesburg hospital.

1.7 **RESEARCH DESIGN AND METHOD**

1.7.1 **Research design**
A qualitative, phenomenological, explorative, descriptive design that was contextual in nature was employed. Burns and Grove (2009:51) note that qualitative research explores in-depth phenomena from people who have lived and experienced the phenomena. It is used to describe lived experiences and give them meaning. The main focus was to understand the lived experience of new nurse graduates during their community service practice.

1.7.2 **Research method**
Research method refers to the technique used to structure a study, and to gather and analyse information relevant to the research question (Polit & Beck, 2012:15). The
research method constitutes the population, sample and sampling method, data collection method, data analysis method, and the measures taken to ensure trustworthiness.

1.7.3  Population
The population comprised new graduate nurses who completed their one-year community service practice in 2010 in a clinical facility in Johannesburg and who were ready to register as professional nurses with the SANC. The researcher requested a list of all new graduate nurses who the Gauteng DoH had been placed in Johannesburg clinical settings, so that the researcher could easily locate them.

1.7.4  Sample and sampling method
Sampling was purposive, non-probability sampling. This type of sampling method is based on the researcher judgement regarding participants who are willing to participate and who the sample size was determined by data saturation, which is when the same data is repeated over and over again and no new data emerges (Burns & Grove, 2009:31).

1.7.5  Data collection
Polit and Beck (2012:341) describe the semi-structured, individual interviews as a conversational and interactive method where a researcher proceeds without a preconceived view of the content or flow of information to be gathered. The semi-structured interview gives the researcher and participant much more flexibility, because the researcher is able to follow up particular interesting lived experiences that emerge from the interviews, and participants are able to give a full picture of what they are experiencing (De Vos, Strydom, Fouche & Delport, 2013:296-297).

The researcher explained the purpose of the study to participants (Creswell, 2013:123-124). Using semi-structured, individual interviews, the researcher began with a broad question relating to the topic, such as “what is it like to work as community service nurse in this hospital?” Further questions were guided by the responses to the broad question. The researcher probed for more in-depth information and elaborated on ideas until the
experiences were thoroughly explored (De Vos et al., 2013:295). Interviews continued until data was saturated. The interviewer made field notes about verbal and non-verbal dynamics during the interview (De Vos et al., 2013: 298). The purpose of field notes is to enrich the data and thus increase the credibility of the data collected. Interviews were conducted on a date, time, and venue that were convenient for the participants to ensure a private and non-intimidating atmosphere. The envisaged time per interview was 45 to 60 minutes depending on the saturation of data.

1.7.6 Data analysis
Data collection and data analysis occurred simultaneously in qualitative studies (Polit & Beck, 2008:507). Data captured on the tape recorder was transcribed verbatim and analysed, using Tesch’s open coding, qualitative method of data analysis (Creswell, 2013:142-143).

1.7.7 Trustworthiness
Trustworthiness was maintained by using Lincoln and Guba’s (1985; 290-314) four criteria, which are credibility, dependability, confirmability, and transferability.

1.7.7.1 Credibility
Refers to the confidence in the truth of the findings. In this study, credibility was attained through prolonged engagement, triangulation, member checking, semi-structured interviews, and the researcher and supervisor’s authority.

1.7.7.2 Dependability
Refers to showing that the findings are consistent and could be replicated, and was attained through a thick and dense description of the study methodology.

1.7.7.3 Confirmability
Refers to the steps the researcher took to demonstrate that the findings emerge from the data and not the researcher’s own predisposition. It was attained by conducting a confirmability audit (triangulation and flexibility).
1.7.7.4 Transferability
Refers to showing that findings have applicability in other contexts. It was attained through a purposive, non-probability sampling method, saturation of data, and thick description of the research strategy and method of the study.

1.7.8 Significance of the study
Community service is mandatory to all nurse graduates in country as indicated in SANC Regulation R765. The purpose is to empower them and to curve the shortage of staff in the government hospitals. It is very pertinent issue in nursing, however the experiences of nurse graduates are integral in the improvement of the service.

1.8 ETHICAL CONSIDERATIONS

The following ethical standards as outlined by DENOSA’s Ethical Standards (Polit & Beck, 2008:320) for the nurse researcher were used.

1.8.1 Permission
Before commencing with data collection, permission to conduct the study was obtained from the University of Johannesburg, Faculty of Health Sciences Ethics Committee and Higher Degrees Committee, the Department of Health, participants, and the management of the participating in hospital in Johannesburg clinical.

1.8.2 Informed Consent
Prospective participants were invited to participate in the study. Participation was voluntary. The participants were not coerced. The researcher requested consent from the prospective participants to interview them and to audiotape the interviews for the purpose of capturing all the information before the study was undertaken. The participants were informed of the purpose, objectives, and the method of the research. Participants were briefed on their expectations before they signed the consent form.
Participants’ responses were recorded with their permission, and they were informed that the researcher would make notes during data collection process.

1.8.3 Termination

Participants were informed of their right to withdraw at any time or stage of the research without any intimidation.

1.8.4 Confidentiality and Anonymity

Confidentiality was ensured in that only the researcher, the interviewer, the co-coder, the supervisor, and co-supervisor had access to the research data. A co-coder is an independent person responsible for encoding the same data collected into categories to ensure consistency/reliability of the data analysis results. The audio taped data was kept in a safe place under lock and key, and will be destroyed five years after completion of the study. Anonymity was ensured by ensuring that the names of the participants and that of the clinical setting were not mentioned. The names were replaced by codes so that participants’ identities could not be linked to responses. The interviews were audio taped with the participants’ permission and transcribed verbatim.

1.8.5 Privacy

Privacy was maintained in that the interviews were directed by two research questions and probing emanated from the participants responses, to clarify information. The researcher did not coerce participants to disclose information they were not comfortable sharing. The interviews were conducted on the date, and at the time and venues that were convenient to the participants.
1.8.6 Harm

It was not the researcher’s intention to cause harm to participants. The right to protection from discomfort and harm was based on the principle of beneficence, which holds that one should do good and not do harm.

1.8.7 Benefit/Risk Ratio

According to Polit and Beck (2012:146), the degree of risk should never exceed the potential humanitarian benefits of the knowledge to be gained. In this study, the researcher did not envisage any risk because the date, time, and venue were determined by individual participants. The long-term benefit of this study is that strategies to improve the community service practice by new nurse graduates in Johannesburg were described.

1.11 DIVISION OF CHAPTERS

Chapter one – Introduction, background and rationale
Chapter two – Research design and method
Chapter three – Description of findings
Chapter four – Conceptualisation of findings
Chapter five – Strategies, limitations, recommendations and conclusion

1.12 SUMMARY

Chapter one focused on the background and rationale of the research study. The overview provided direction on how to approach the research study for the purpose of finding answers for the research questions. Emanating from the research questions and objectives, the research design and method were identified. Trustworthiness and ethical considerations were described. The research design and method will be described in chapter two.
2.1 INTRODUCTION

The purpose of this chapter is to describe the research design and method that gives direction to how the research study is going to be conducted.

2.2 RESEARCH DESIGN

The research design guides the investigation. It indicates the activities the researcher and participants will perform, and the order in which they will occur. This study utilised a qualitative, phenomenological, explorative, descriptive design that is contextual in nature. Burns and Grove (2009:51) note that qualitative research explores the in-depth phenomena from people who have lived experiences of the phenomena and gives them meaning. The main focus is to understand the new nurse graduates' experiences during their community service practice in Johannesburg.

2.2.1 Research Strategy

According to Burns and Grove (2009:22), the research strategy refers to the scientific method and procedure that will be used to ensure credibility in obtaining information, allowing for a full description and exploration of the research phenomenon as it occurs naturally in the empirical world.

2.2.1.1 Qualitative

A qualitative approach was used in order to make an in-depth exploration of the lived experiences of the new nurse graduates who have practiced as community service nurses in Johannesburg, and the approach gives these experiences meaning. The main focus is to understand the experience of the new nurse graduates during their first year of community service practice in Johannesburg. Burns and Grove (2009: 51) believe
that qualitative research is meant to offer in-depth insight and understanding of the phenomena from the people who have lived and experienced the phenomena.

2.2.1.2 Phenomenological
A phenomenological study describes the meaning of the lived experiences of individuals regarding a phenomenon (Creswell, 2013:51). A phenomenological approach considers human beings who live and make a sense of their experiences within their natural environment as being able to provide an understanding of the phenomenon being studied. According to Burns and Grove (2009:54), the purpose of phenomenological approach was to explore and describe the experiences of new graduate nurses as they are lived.

2.2.1.3 Exploratory
Exploratory design aims at establishing a richer understanding of the phenomenon of interest. In this study the exploratory approach was used to explore the unknown aspects and dimensions of the lived experiences of new nurse graduates when practicing community service in Johannesburg (Burns & Grove, 2009:131).

2.2.1.4 Descriptive
Burns and Grove (2009:231) define the descriptive approach as a strategy to describe and obtain complete and accurate information from the participants. The descriptive approach in this study provided the researcher with new information about the experiences of new nurse graduates’ during their community service practice. In-depth descriptions of the new nurse graduates experiences were made. The detailed descriptions of their experiences were captured on audio-tape during the semi-structured individual interviews and the observed non-verbal communications were written down as field notes. The descriptive approach provided the researcher with an in-depth description of the phenomenon as it occurs naturally. The researcher probed the participants during interviews until a clear picture of their lived experiences was captured.
2.2.1.5 Contextual

A context is characterised by a “specific set of properties pertaining to a phenomenon and a particular set of circumstances within which an action takes place” (Creswell, 2009:175). The environment where the study was conducted was clinical facility in Johannesburg.

The research study is focused on one of the clinical facilities and is aimed to explore and describe the new nurse graduates’ experiences when practicing as community service nurses. The purpose of a contextual study is to understand the clinical significance of the phenomenon of interest in relation to its environment. A contextual approach does not generalise the research findings but attempts to describe and understand the lived experiences of new nurse graduates in a clinical facility.

2.2.2 Reasoning strategies

According to Burns and Grove (2009:6), reasoning is the processing and organising of ideas in order to reach a conclusion. The researcher engaged in the reasoning process throughout the research study. The reasoning strategy utilised was guided by organising, reducing, and clustering the empirical data and conceptualisation. The following reasoning strategies were applied, namely analysis, inductive and deductive reasoning, synthesis, bracketing, derivation, and inference.

- **Analysis**

  Creswell (2013:154) describes analysis as a process of data reduction and interpretation that allows data to be reduced into themes for interpretation of the phenomenon. Analysis was utilised throughout the research so that the researcher could break up information into parts for better understanding.

- **Inductive reasoning**

  Burns and Grove (2009:6) describe inductive reasoning as a cognitive strategy whereby a particular phenomenon is observed and combined into a meaningful whole. The
researcher used the cognitive strategy to construct meaning from the new nurse graduates’ experiences on the research topic during their interviews.

- **Deductive reasoning**
  According to Chinn and Kramer in Burns and Grove (2009:6), deductive reasoning is a cognitive skill that allows one to move from general to specific conclusions. The researcher engaged in deductive reasoning to deduce from contextual data analysis and to conceptualise the research findings within related literature. The conclusion from the conceptualisation process formed the basis for the formulation of the strategies that will assist new nurse graduates to improve community service practice in Johannesburg.

- **Synthesis**
  Burns and Grove (2009:110) define synthesis as the strategy that involves clarifying the meaning obtained from different sources as a whole. The researcher used cognitive skills to synthesise the different information from the conceptualisation process and to draw the concluding statement that formed the basis for the description of strategies that will help new nurse graduates during their community service practice.

- **Bracketing**
  Polit and Beck (2012:495) describe bracketing as a means to maintain objectivity by identifying beliefs and opinion without preconceived ideas and ascending to open context. The researcher suspended what was known to her about experiences of new graduate nurses under study in order to take fresh perspective. All preconceived ideas and construct were bracketed to enhance objectivity. Participants’ different perspectives and opinions were allowed so that they could verbalise any possible dynamics related to the research phenomenon.

- **Derivation**
  Derivation refers to the formation or new formations of new word from the original (Walker & Avant, 2011:63). During data analysis the researcher derived new categories and sub-categories from the data collected and attached meaning to them from a
literature study of the same topic and during the conceptualisation process. During derivation the known words were redefined and assigned a new meaning for a better understanding of the research phenomenon.

- **Inference**

  Polit and Beck (2012:174) refer to inference as an attempt to reach conclusions based on existing information, using a logical reasoning process. The researcher used inferences of research phenomenon based on existing information gathered during data collected and from literature support.

### 2.3 RESEARCH METHOD

The research study was conducted in two phases. Phase one focused on the exploration and description of the lived experiences of new nurse graduates during their community service practice in Johannesburg. Phase two focused on the conceptualisation of findings within the relevant literature.

#### 2.3.1 Phase one

Phase one explores and describes the new graduate nurses’ experiences regarding community service practice in Johannesburg. The description is discussed under target population, sample and sampling method, data collection method, data analysis method, and trustworthiness.

#### 2.3.1.1 Target population

Burns and Grove (2009:343) describe the target population as all subjects that share the same characteristics that the researcher is interested in. In this study the researcher is interested in the new nurse graduates who have completed their one-year community service practice in 2010 in a Johannesburg clinical facility and have registered as professional nurses with the SANC. The researcher requested a list of all new graduate nurses who have been placed in a Johannesburg clinical settings from the Gauteng Department of Health so that the researcher could easily locate them.
2.3.1.2 Sample and sampling method
A purposive non-probability sampling method was used. The researcher chose a purposive sampling method because of the willingness of the participants to be included in the research project. This type of sampling method was utilised because the researcher required in-depth, insightful information from the participants who have experienced community service practice in Johannesburg, and who were willing to describe their rich experiences about the phenomenon (Burns & Grove, 2009:355). Data was saturated at the 11\textsuperscript{th} participant.

2.3.1.3 Data collection
The phenomenological, semi-structured, individual interviews were used to collect data in this research project. Polit and Beck (2012:341) described the semi-structured, individual interviews as a conversational and interactive method where a researcher proceeds without a preconceived view of the flow of information to be gathered. The semi-structured interview gave the researcher and participants much more flexibility, because the researcher was able to follow up particularly interesting lived experiences that emerged during the interviews and participants were able to provide a full picture of their experiences (De Vos, 2011:296-297).

- Preparation for semi-structured interviews
The researcher obtained the consent forms from the participants who indicated their willingness to voluntarily participate in the project within the ethical considerations. The participants were advised to select a venue of their choice, and the dates and times for the interview sessions. The participants were informed about the research study’s purpose and objectives so that they could make an informed decision about their participation in the research interviews. The participants were advised about the use of a tape recorder during the interview session and that field notes would be made during interviews to capture participants’ responses accurately. The researcher explained to the participants that anonymity would be maintained throughout the research project. The researcher explained to the participants that a code would be used to maintain anonymity. The environment for the interview was prepared in advance to make it welcoming, comfortable, and free from noise and distractions.
• **Conducting the semi-structured individual interviews**

The researcher created a friendly and open atmosphere and welcomed each participant during the interviews so that the participants could feel at ease. The researcher provided an environment that was non-threatening and non-authoritative. The seating arrangement was circular to facilitate interaction. The researcher and each participant agreed on the ground rules for the interviews and the proceedings. The researcher allowed the participants to ask questions related to the interviews so that there was mutual understanding of the envisaged experiences.

The two research questions asked were: What are your experiences during community service practice in health facility in Johannesburg? What should be done to improve community service practice of new nurse graduates? Further probing questions were guided by the participants’ responses. The researcher listened attentively and encouraged the participants’ responses by nodding. The researcher probed the participants for more in-depth, insightful information until the experiences were thoroughly explored (De Vos et al., 2013:295). Interviews continued until data saturation. The researcher paraphrased the participants’ responses to gain more clarity and understanding of what the participants were saying. The interviewer wrote field notes that captured the verbal and non-verbal dynamics during the interview so that the researcher could enrich the data collected, thus increasing the credibility of the data collection (De Vos, 2011: 298).

The interviews took about 45 to 60 minutes per interview. The researcher thanked the participants after the interview sessions. The researcher also used an audio-tape to record the interviews. The researcher maintained objectivity, neutrality, and openness to the participants’ experiences by bracketing her own experiences and feelings.

**2.3.1.4 Data analysis**

De Vos et al. (2013:397) describe data analysis as a process of bringing meaning to data collected. The researcher and the co-coder independently analysed the collected data (Polit & Beck, 2008:507). Data was captured on a tape recorder and field notes
were transcribed verbatim and analysed using Tesch’s open-coding qualitative method of data analysis (Creswell, 2013:142-143).

The researcher read through all of the transcriptions carefully and listened again and again to the tape recorded interviews to get a sense of the whole. As they came into her mind, the researcher wrote down ideas regarding the new graduate nurses’ experiences regarding community service practice. The researcher asked herself questions about the meaning of the information the participants offered, while noting her thoughts in the margin. A list of all topics was made and similar topics were grouped together and formed into columns that were arranged as major topics, unique topics, and leftovers. Topics were abbreviated as codes and these were written next to the appropriate segments of the text. The researcher found the most descriptive wording for topics regarding the new nurse graduates’ experiences regarding community service practice. Grouping the topics that related to each other reduced the total list of categories. Lines between categories were drawn to show interrelationships. A final decision was made regarding the abbreviation for each category, and these codes were alphabetised.

Data materials belonging to each category were assembled in one place and a preliminary analysis was performed. A co-coder analysed the data independently in accordance with Tesch’s protocol. A co-coder was purposefully selected by the researcher to code the categories and sub-categories independently. The criteria for selecting the co-coder were based on her knowledge in qualitative research. A consensus discussion meeting was held between the researcher and the co-coder to determine and agree on similar categories or sub-categories that were identified. The consensus discussion was essential so that the credibility of research findings was established. Follow-up interviews with four participants were conducted to verify the findings and to allow the participants to check the interpretation of their responses.

2.3.1.5 Trustworthiness

Several strategies for the assessment of the trustworthiness of qualitative research were used (Lincoln & Guba, 1985:301). Such criteria are discussed in relation to the specific strategies applied to increase the study’s trustworthiness. In this study,
trustworthiness was maintained by using the four criteria suggested by Lincoln and Guba (1985:290-314), which are credibility, dependability, confirmability, and transferability.

- **Credibility** – Credibility refers to the confidence in the truth of the findings. In this study, credibility was attained through prolonged engagement, triangulation, peer debriefing, and member checking.

  **Prolonged engagement** – where the researcher attended a research methodology class for one year. The researcher was emerged in the data by continuously listening to the tape recorded sessions. The researcher built and established rapport to develop the participants' trust. The researcher, supervisor, and co-supervisor are experts in qualitative research in order to provide appropriate direction in the study.

  **Peer debriefing** – was carried out by the researcher.

  **Triangulation** – phenomenological interviews, field notes, an independent coder, a tape recorder, and various references increased the credibility of data.

  **Member checking** – to verify the categories and sub-categories was carried out with four new nurse graduates who were participants in the main study.

- **Dependability**

  Dependability refers to the consistency of the research process (De Vos et al., 2013:420). The researcher kept an accurate record of how data collection was conducted. The researcher fully described the research process, observation, and the environment where the research process took place. Field notes and audio tapes were compiled during data collection, and data analysis and all events that occurred during the data collection process were kept confidential. The records were forwarded to an independent co-coder to analyse and interpret the findings independently.
• **Confirmability**

Confirmability refers to the objectivity or neutrality of data, bracketing researcher values, and the researcher distancing her emotions from the research inquiry. Lincoln and Guba (1985: 319) suggest keeping an audit track record. Therefore, the researcher:

- kept raw data obtained during data collection;
- summarised and condensed notes of data reduction and data analysis;
- processed field notes; and
- held a meeting between the co-coder and the researcher to reach consensus related to the results of the data analysis.

• **Transferability**

The data cannot be transferred or generalised from a representative sample from a clinical setting in Johannesburg to a population, because the entire group of new nurse graduates practicing as community service nurses are assigned across the country. The research provides sufficient descriptive data that is contextual in the research report so that a replication of the study can be made.

2.3.2 Phase two

Phase two focused on the conceptualisation of findings. According to De Vos, et al. (2013:29) conceptualisation is a process of categorising and labelling of information. The categories and the sub-categories that emerge during data analysis are conceptualised through relevant literature control. The main findings identified were conceptualised within relevant literature. The researcher made meaningful interpretations, and concluding statements were made on which strategies were described (Mouton, 2010:109).

2.4 SUMMARY

This chapter discussed the research designs and methods. The study used qualitative, phenomenological, explorative, descriptive, and contextual design to explore and describe the lived experiences of new nurse graduates in Johannesburg. The target populations were new nurse graduates who have practiced as community service
nurses and completed their community service practice in Johannesburg in 2010. A purposive, non-probability sampling method was used to select the participants. Phenomenological interviews were conducted, and qualitative, open-coding data analysis was made in accordance with Tesch’s approach to data analysis. Chapter Three will focus on the description of the findings.
CHAPTER THREE
DESCRIPTION OF FINDINGS

3.1 INTRODUCTION

This chapter focuses on the description of the study findings. Data was collected using semi-structured individual interviews regarding nurse graduates’ experiences of community service practice in Johannesburg’s clinical facility. The participants were purposefully selected to share their lived experiences on the research topic. Eleven newly qualified nursing graduates rendering community services were selected from midwifery, psychiatric and general nursing.

Field notes were taken of participants’ non-verbal behaviour during interviews to enrich the data collected. Permission was granted to conduct the interviews as arranged with the participants. All participants participated freely during their interviews and no participant terminated their participation. Data was collected using a tape recorder with their permission to ensure accurate capturing of data.

The research questions read as follows:

- What were your experiences of community service in your allocated clinical practice?
- What should be done to improve community service practice in Johannesburg’s clinical facility?

The researcher and the co-coder who was purposefully selected because of her knowledge and experience in qualitative research conducted data analysis independently. Tesch’s (Creswell, 2013:192) qualitative, open-coding data analysis method was utilised to analyse the data. The results of the analysis indicated three categories and six related sub-categories. The findings will be described in table 3.1.
TABLE 3.1 NEW GRADUATE NURSES’ EXPERIENCES REGARDING COMMUNITY SERVICE PRACTICE IN JOHANNESBURG

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>SUB-CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of teaching, guidance, and support</td>
<td>• Lack of teaching, supervision and support</td>
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<tr>
<td></td>
<td>• Fear/uncertainty resulting from lack of experience</td>
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<tr>
<td>2. Lack of management support</td>
<td>• Lack of resources</td>
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<td></td>
<td>• Lack of conflict management</td>
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<td></td>
<td>• Poor communication</td>
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<tr>
<td>3. Negative attitudes of staff members</td>
<td>• Disrespect, name-calling and intolerance</td>
</tr>
</tbody>
</table>

3.2 DESCRIPTION OF FINDINGS

The categories of new graduate nurses’ experiences regarding community service practice in Johannesburg included lack of teaching and guidance, lack of management support, and negative attitudes of staff members, and their sub-categories are indicated in table 3.1. Direct quotations from the participants’ lived experiences will be italicised.

3.2.1 Category 1: Lack of teaching, guidance and support

Most of the participants highlighted the fact that there was lack of teaching and guidance in the clinical area, which left them with fear and uncertainty because of their lack of experience.

3.2.1.1 Sub-category 1.1: Lack of teaching, supervision and support

The participants stated:
“There was lack of teaching during our community service practice. We learned the hard way, and the little guidance we got was when we asked the enrolled nurses and enrolled nursing auxiliaries whose scope of practice differed from that of registered nurses.”
Participants further stated in this regard:
“It was a difficult moment because we were expected to practice as registered nurses while we were still community service nurses. We were expected to be accountable while we were supposed to be learning. It was not a good experience, yes we were no more students, we were qualified, but we still need to be taught and supervised, but supervision was very minimal. We formed part of the work-force, more than being community service nurses”.

The participant continued:
“If you have been given an opportunity to run the ward, there should be an experienced registered nurse to guide community service nurse[s] when clarity is needed.”

Showing great concern:
“I think that in nursing learning is a continuous process; when there is an experienced registered nurse, you feel comfortable and you learn a lot.”

Another participant stated regarding lack of guidance:
“We were supposed to practice under supervision until we were competent enough to practice on our own. We applied theory and practice that we got from the college, but there was no guidance from the ward sisters. Maybe it was because I used to try my best when I was a student, and it made some of the things much easier, putting up drips and interpreting blood results. Lack of guidance leads to pricking the patient more than five times trying to put up a drip and it was not a good experience.”

She continued to show her great concern about her experiences:
“Sometimes the registered nurses would guide you or become agitated, so most of the time the enrolled nurses guided us because they have been in the ward for a longer period. When I experienced a problem, I would consult enrolled nurses and went back to my book and studied so that I understand what was supposed to be done.”

“They must allocate time to teach us how to operate the ventilators because when we were allocated to the intensive care unit, we were allocated to nurse a baby on a
ventilator; and we didn’t understand how to record observations on the intensive care chart.

Another participant said:
“You are supposed to order ward stock on your first two to three weeks without supervision. They would say do the ordering and this is a stock room, blah, blah, blah. I mean I was new in the environment and I didn’t understand how ordering was done.”

She showed a great concern regarding being in charge of the ward:
“Oh! It was terrible because sometimes they would leave you with the ward and they would tell you that they were not going to babysit you anymore, you have to be responsible, and leave you with the ward keys. It was frustrating, because you have to take the responsibility of a registered nurse, and it was not fair because if there was a mistake you are blamed.”

She further explains the situation in an ophthalmic ward:
“I explained to them that I have done the conditions of the eye at the college and I don’t have enough first aid knowledge to manage a patient who has a bleeding eye. In this situation the enrolled nursing auxiliary have experience and knowledge, but they were not allowed to handle the situation, which was above their scope. Yes! I remember when I was doing night duty, there was a man who was bleeding profusely from the eye and the enrolled nursing auxiliary showed me how to pack the eye with a bandage and apply an adrenalin plug to stop the bleeding.”

Another community service nurse stated her experience whilst in charge of the ward during her community service practice:
“They don’t have time to teach us anything. I started running the ward when I was doing night duty during my community service [quietly laughing]. As I know that I have to be given guidance, and when you raise a concern, it was like you don’t want to work and you know too much. In most of the wards, community service nurses were replacing the permanent registered nurses who have resigned and those who were on leave.”
3.2.1.2 Sub-category 1.2: Fear/uncertainty resulting from lack of experience

The community service nurses felt insecure regarding managing the wards alone without experienced registered nurses. Their fear was to mismanage the patients. They described their fear follows:

“*We felt very insecure regarding managing of the wards alone without experienced registered nurses. The fear was to mismanage the patients. We need to ask questions while doing our duties from 07H00-19H00 from experienced professional nurses. To be alone in the ward without an experienced professional nurse creates fear, leading to lowered self esteem and confidence.*”

Another participant continues to state her concern:

“When they teach you something you have to grab it quickly because you become afraid and end up doing wrong things, or you don’t do it at all, because you are afraid to be called a dumb, or a slow learner.”

Another participant added:

“It was frustrating because you need experienced professional nurse to be there, and they were not there. It’s very frustrating because you are scared, what if I do the wrong thing to the patient, and what if the patient dies because of my wrong doing?”

The other community service nurse continues to state her fear by mentioning:

“*Yoh! Being a community service nurse was like you have entered the real world. In the college you learned about resuscitation on the doll, and in the ward it is a real situation where you have to apply the knowledge to the real patient and this is a scary situation, because when the patient dies you blame yourself. I thought I have failed the patient.*”

Another community service nurse expressed her fear of nursing premature babies:

“It was scary, even when I was on training. I didn’t have much time with the babies, because we were allocated for two weeks or a month, and went to other departments. It was scary to nurse those very small, premature babies where one could not even
handle them. The fact that you have to nurse them was difficult, by that time you didn’t have enough knowledge, and mothers would ask you questions about their babies which you could not answer, and you feel stupid in front of the mother.”

She continues to convey information as follows:
“The compounding situation was when one had to nurse very sick deformed babies. This situation made me not to fall asleep as I was thinking about those babies and it was too much for me, thinking about the parents and relatives. They were very sick and death rate was high”.

Another participant added:
“When it is your first day to nurse critically ill patients you become scared, thinking that you won’t manage. When no negative incidents happened to the patients, you feel good that you are becoming competent and gaining experience.”

She continues on a positive note:
“Going to work was a concern because you never knew how the day was going to unfold. It was tough, but it made me to develop professionally in a short period of time. When you went home after work you have to consult your books about anything that happened during the day.”

She continues to express her great concern:
“It was tough, it was tough. I remember in my ward there was an emergency; we were resuscitating a patient and I asked the enrolled nursing auxiliary to call the doctor from their room and she refused. [Crying] I had to go out myself to call the doctor, it was wrong because I left the patient alone and nobody was resuscitating the patient, fortunately the matron who was doing the rounds walked in and continued to resuscitate the patient. That was one of my bad experiences as a community service nurse.”
3.2.2 Category 2: Lack of Management Support

Most of the participants cited the lack of support from management, which created a poor working environment for the community service nurses. The community service nurses stated that they have to work under difficult conditions. Lack of management support was stated as the key contributing factor to community service nurses resigning after their community service period. The following sub-categories emerged: lack of resources, lack of conflict management, and poor communication.

3.2.2. Sub-category 2.1: Lack of resources

All participants reported that there was severe shortage of staff and equipments which has an impact on their daily practice. They felt that they were allocated to wards to replace nurses who have resigned from the institution.

They reported lack of resources as follows:

“There was severe shortage of staff which had an impact on daily practice. We were allocated to the wards to replace nurses who have resigned or retired and were not replaced. We believe that community service practice doesn’t solve problems of shortage because we also resign after we have served our one year community service practice contract. There was still a shortage of staff and others were still planning to leave, hence the Gauteng Department of Health were not reaching one of their objectives of maintaining human resource by allocating community service nurses for a year to curb the shortage and attract them to the service. Due to poor working conditions, we leave for better working conditions in private practice or outside the country.”

The participant explained that they were not doing quality care for patients but pushing the work because of shortage of staff:

“[Laughing] I didn't expect to be in a ward with a lot of patients. When I was doing general nursing, we were taught about nurse patient ratio. I was doing night duty, we were only five, one sister, one enrolled nurse and three enrolled auxiliary nurses. So for a professional nurse it was one nurse to 60 patients and it was difficult to give all
patients the nursing care they deserve because you want to finish on time. It was not that easy because professional nurses administer injections. During administration of intravenous injections, you have to fix drips that are not running first, a doctor would be looking for something, and you have to leave whatever you are doing and attend to the doctor. It was difficult, at least if it were three professional nurses so that every patient can receive quality nursing care. There was no quality nursing care, some would get that quality care but when you get to patient number 30 you would be exhausted, by the time you get to the last patient you would be agitated, and you don’t want to listen to what patients are saying. We tried our best though.”

The participant verbalised that:
“They would say you are there to add to the number of staff. In this institution we are short staffed, and I think this is a problem that causes the unit managers to move us from one ward to the other. When she said you must go to ward 30 you have to go, come back to ward 25, you have to go back, and you don’t know where you belong because you were changed from one ward to the other.”

Another participant commented:
“Where I was allocated, I was the only one who was supposed to relieve all the professional nurses. It was not fair for me because whenever there was a shortage in any ward I was the only one who was supposed to relieve them. The experienced, registered nurses were never allocated to relieve in other wards. Even in the ward I was working, whenever there was a registered nurse who went on leave from another shift, it would be me who would replace that registered nurse. It was not fair because I was having abnormal off duties. I also have a family and a life to live [shaking her head]”

Another participant explained:
“There were things that made me want to leave, shortage of staff, equipment, and the management. Even if you report to them, they were not handling our problems effectively, and they were having attitudes. So when you work with that type of management you become discouraged.”
Participants stated:
“Lack of material resources was a major problem which had an impact on daily practice. During an emergency we have to run around looking for equipment. Sometimes there would be one equipment to be used for a full ward and it was delaying the treatment, and the health of patients was compromised. The shortage of staff and equipment was above our control.”

Participant continued:
“There were a lot of problems, like patients not having beds, moving patients from one ward to another, and there was no policy in the institution to cover the transferring of patients without doctor’s approval. If something happens to the patient you are transferring to another ward, you will be responsible. The policy was not there in this institution, so we were not covered and you get blamed, that’s why patients fall, and get injured.”

Another participant remarked that:
“We have four cubicles, and in those four cubicles we had two movable blood pressure monitors that were working. You have to wait for other staff member to finish using the monitoring equipment. Even with the measuring scale, only two were working, those were the things which raised our stress level. Frustration was when you go to work, and there is no equipment. You have to run around looking for syringes, needles, and medications before you work, and that was most frustrating part of the job.”

The participant continues to give an account of information as follows:
“Sometimes I felt discouraged to go to work because there was lack of equipment, and I was going to be stressed anyway. You have to run around asking for equipment instead of working. It was so stressing when there was a baby who needed resuscitation and you have to run around looking for equipment. We didn’t have oxygen points, we used oxygen cylinders, which means if cylinders are empty you can’t administer oxygen to the patients, so that was the challenge I am talking about, because it means that a person would die without getting help and if it was my mom how would I feel when there was no equipment? I felt for them, because some of them had to bring their own food,
pyjamas, pillows, and blankets. For some of the patients it was bad because they did not have these supplies. They went to theatre with their own clothes, which was not allowed. It was very sad when they didn’t have pyjamas and the hospital was not having them, but the problem was beyond the nurses’ control.”

3.2.2.2 Sub-category 2.2: Lack of conflict management

Participants cited the inability to handle conflict as the cause of dissatisfaction of community service nurses. They didn’t know who could rescue them when they experienced conflict challenges. They explained the lack of conflict management as follows:

“Like late-coming and absenteeism, which makes other staff members not happy because they are always on duty and on time. When we complained, the culprit would say the supervisor knows and understands why he/she was always absent or late. When we asked, the supervisor would not give us a clear answer. He would say leave the person because I understand the situation. When asked further questions that demonstrate dissatisfaction, the supervisor would say this is her department and I won’t tell her how to run it.”

She showed her concern on how conflicts where poorly managed by their seniors by saying:

“My matron was polite, but some of the matrons, when you tell them that you are having a problem with your off duties because the unit manager changed them without informing you, she will tell you that maybe she got a good reason for changing them. What is a good reason? I went to the matron because between my manager and me nothing was sorted out; I need her to be a mediator. She took sides even before I finished my statement, she would say she has a good reason for changing my off duties, and that was unfair for me. Maybe you did something wrong in the ward, and you are in the middle of the ward, she would be shouting at you in front of the patients, telling you how wrong you are.”
Another participant commented:
“At first it was difficult because experienced registered nurses were ill-treating us, they were sending our juniors to be rude to us, for example, when we arrive in the ward we find that the enrolled nurses were doing the duties of the registered nurses. We tried to correct it, but they were resistant to change, only to realise that they were sent by the registered nurses to be rude to us. We confronted them but they also sent us to be against them. They were promoting conflict between us so that there is no harmony in the ward.”

She continued to explain:
“When I was working in the cubicles I was working with enrolled nurses. Then they had this attitude that they would divide the work, saying they would be doing this and I would do that. Then I told them that I am a professional nurse, I was the one who supposed to supervise them. Then there would be this registered nurse who was causing conflict. She would be asking them for the report in cubicles. When the very people noticed that there was harmony they would divide us to work in different teams. They didn’t want us to feel free; they actually enjoy the conflict situation.”

3.2.2.3 Sub-category 2.3: Poor communication

Community service nurses cited communication as the most concerning challenge that they experience, and commented as follows:
“Maybe communication was not done to us because we were community service nurses and nobody recognises us. Ok, first the department of health didn’t inform us where we were going to be placed. We were surprised when the college gave us letters that we were going to be placed at such and such hospital or wherever. We were not given a choice of preference regarding clinical setting allocation or the opportunity to change if you don’t like the department.”
Another participant mentioned:
“I thought it was favouritism, because in that department, most of the information was given to auxiliary nurses and not registered nurses, by the unit manager. There was some information which was not disseminated to registered nurses from management”.

Another participant cited that:
“There were a lot of things, one of them was off duties being changed, the manner of approach. I am not saying the matrons were wrong, but if you want somebody to work to the best of their ability, at least you must tell them the good things that they do, not always telling them about wrong things. Even if a person was trying her best or I was wrong, they were supposed to approach them in a manner that you will understand, not shout at them.” [Looked angry]

### 3.2.3 Category 3: Negative Attitudes of Staff Members

The community service nurses explained that they experienced negative attitudes from the experienced nursing staff, which contributed to poor quality nursing care. They feared having to ask experienced registered nurses for clarity when experienced challenges during their clinical practice. These were unexpected attitudes and the community service nurses termed those attitudes as ‘reality shock’ and ‘real life’. The sub-category that support this category are as follows: disrespect; name-calling; and Intolerance

#### 3.2.3.1 Sub-category 3.1: Disrespect, name-calling, and intolerance

- **Disrespect**
  
The community service nurses explained that they were disrespected by all categories, namely managers, experienced registered nurses, enrolled nurses, enrolled auxiliary nurses, and radiographers.

  “The community service nurses are juniors to permanent registered nurses, but they are seniors to staff nurses. The senior sisters should change their attitudes and teach community service nurses. A registered nurse can teach an enrolled nurse. Not an enrolled auxiliary nurse teaching the community service nurse because at the end there
will be a problem of undermining. Like they look down on you, when they see that you know the work, and you didn’t ask them anything, they develop an attitude towards you”.

“Bad, you become de-motivated, telling yourself that you are not good and you start to doubt yourself. They said we don’t know nursing care in front of our juniors who are supposed to respect and take orders from you, it doesn’t motivate you anymore. When you think of going to work, you feel that you don’t want to go to the same ward anymore because you would be meeting those managers. You do not get motivated to go back to the ward to practice and learn as a professional nurse.”

One of community service nurse reflected:
“How can the matron shout at me in front of the patients, how are the patients going to have confidence in me? Because they will identify that was my matron because they wear a different uniform. They would lose trust in me and when I nurse them they loose trust, and they will not respect me because they will think that I’m going to kill them.”

Another participant added:
“Some experienced registered nurses were rude and some were willing to teach, but the enrolled nurses would never respect the fact that we were their sisters and seniors, they would not respect us, they would defy us and that’s what happened. When we delegated them they refused. In the first place the senior sisters have said the enrolled nurses will teach you, so you can’t delegate someone who has taught you.”

She continued:
“The staff nurses and the auxiliary nurses were undermining us. As I said they will say look at her and say “What does she know?” Even if you make a mistake, they won’t tell you that you have made a mistake, they will show each other instead of correcting you.”

She continued:
“The enrolled nurses didn’t respect us, when we delegate them they didn’t accept the delegation. They would say we must do the delegated responsibility, you have to ask
one of the enrolled auxiliary nurses from other cubicles to help, they didn’t respect us as their seniors, and it was difficult to tell them what to do. They were stating that they have been in the ward more than us, and that was what happened to me. [Raising the voice] to me that was undermining because I was a community service nurse. The person will change my off duties whenever she wants. She didn’t care how I feel, she didn’t consult me, and it was unfair and they were disrespecting us.”

Another participant added:
“No, moving around was not a problem, but the manner of approach. They were supposed to explain to me that they are allocating me to another ward. Managers should respect us and if there are any changes, I must be the first one to be informed”

Another participant continues to share her experiences:
“It was bad, the enrolled nursing auxiliary were not respecting me and not taking my instructions. They were doing duties which they feel comfortable with, not according to the needs of the ward. It is a hopeless situation because I ended up not delegating them, but developed a strategy of doing everything by myself, and at the end of the day I would be exhausted and stressed. Those were the attitudes we got. If it was not for the Gauteng Department of Health year contract to do community service in Gauteng, some of us would be gone.”

She continues by saying:
“We reported the disrespectful behaviour of some staff nurses to the unit managers and nothing was done to solve the problem and they continued to disrespect us.

- Name-calling
The participants felt unhappy and disappointed because they were called by different names, they said they were referred to as “community service nurse”, “the one who has just qualified”, “professional nurses”, “slow learners”, “just arrived”, and “Simakaleng” meaning always wandering and lost. The participants felt that name-calling is indicative of non-acceptance by the ward staff.
They stated their unhappiness and disappointment:

“Like they were having an attitude towards us, saying that we are slow learners or dumb. They said we don't learn fast and we end up feeling small and not asking further questions, instead we rather asked other community service nurses who don’t have experience because we don’t want to be undermined. We had to take 30 minutes doing a procedure, trying this and that. We avoided asking experienced registered nurses because they would say they have already taught us, and why don’t we know after a year.”

Another participant added:

“I feel that I had been used, I questioned myself that maybe I am not clever enough, because I was the only one from the ward who was relieving those who were absent. Sometime porters would tell me that I was a ‘spanner’, meaning that I’m the only one who is replacing all nursing staff who were absent, and I felt bad.

Another participant stated:

“There was this word they were using, ... ‘sethotho’ meaning you don’t know anything. I just told myself that they have been here for more than 20 years in the ward and I would never perform like them, but one day I will be like them. But there were some who didn’t accept to be called by that name and they resigned.”

She continues:

“For me this ‘community service nurse’ name should fall away, it should fall away because we are taken for granted because we are still learning and have no experience.”

Another participant commented:

“The experienced registered nurses called us ‘mafikizolo’ meaning we ... arrived yesterday in the ward, and we didn’t correct them because of fear of how they would react to us. It was bad and it was hurting”.
She continues to share her experiences:
“I remember last year when my colleague brought her father-in-law for cataract removal. She asked one of the registered nurse where I was, and the registered nurse said she doesn’t know me. After my colleague described me, she said “Oh, the one who has just arrived”. I was in the ward when she said those words, and I felt disappointed. I asked her why she called me ‘the one who has just arrived’ to my colleague, she said she forgot my name because she used the surname. I felt good because I told her and she apologised. The other one came looking for me; the very same person who said she doesn’t know me. I said “I know your name and surname and you don’t know me but I’m working with you. The first time you said I have just arrived, and now you say you don’t know me”. [The participant was angry, frowned, and shook her head]. It was not nice but she apologised again.”

Another participant added:
“I think all about the frustration and lack of supervision because we have been taken as ‘puppets’ meaning we are stupid jokes. They were undermining us because of the name ‘community service nurse’. Sometimes you will be in the ward with the unit manager, she will inform the matron that she is alone with the community service nurse. It was like you don’t exist, this ‘community service nurse’ name changes a lot of people’s perceptions and has become a stigma. Before they will graduate and be registered nurses, with us the problem is the name of ‘community service nurse’. We are just like others who graduated long ago, 2006, 2007, but because of the ‘community service’ name, we are treated like we don’t know anything.”

**Intolerance**
The community service nurses experienced significant intolerance from the nursing staff who were irritable when they were questioned. This contributed to poor quality nursing care because the community service nurses feared having to ask questions when there was a need for clarity. They commented as follows:
“When you asked them a question, they sounded very impatient, intolerant and very agitated, they were expecting you to be perfect and knowing better than them. You know when I asked questions, I didn’t get an answer I was expecting from them; they
would make you feel like you are useless, stupid, and telling yourself that I’m just qualified and I’m asking stupid questions. Next time when you are supposed to ask them, you have fears of asking because they are not approachable. The answers they give you show that they can’t tolerate you and you must be away from them.”

Another participant said:
“We felt very small because we were not getting information, even the enrolled nurses, when they were teaching us, they become angry and rude because you are asking too many questions. They felt that we are sisters and we must know everything, they didn’t consider that we are new in the ward and fresh from the college. That unit we are allocated, maybe we worked there three years ago while we were students. They got that attitude that you must feel it and it made us angry, but we had to overcome the situation.

Another participant showed her concern:
“The shouting happened when there was resuscitation; it’s the shouting that was confusing me, especially if you didn’t know what they need. For example, somebody said “give me Pneumolyte.” You have to ask others first because you don’t know where to get it, and how to mix it. When they need an endotracheal tube, you have to check one by one because you don’t know the sizes. They would be shouting at you before telling them that there were no endotracheal tubes in the ward.”

3.3 SUMMARY

This chapter focused on the description of the research findings. The categories and sub-categories pertaining to the experiences of community service nurses were described and enriched by relevant direct citations. Chapter Four will focus on conceptualisation of the findings within relevant literature.
CHAPTER FOUR
CONCEPTUALISATION OF FINDINGS

4.1 INTRODUCTION

Chapter Four focuses on the conceptualisation of findings described in Chapter Three. The findings are supported by relevant literature that provides an in-depth knowledge and understanding of community service nurses’ experiences. The following categories were identified, namely lack of teaching, guidance and support, lack of management support, negative attitudes of staff, and their related sub-categories (see table 3.1).

4.2 CONCEPTUALISATION

According to Mouton (2010:109) conceptualisation refers to the clarification and analysis of the study’s key concepts and the manner in which the research is integrated into the existing theory and research. Through conceptualisation, the themes identified by the research are supported by relevant literature and are interpreted by the researcher. Conclusions made will form the basis for the description of strategies to improve community service practice in Johannesburg. Conceptualisation will be in accordance to table 3.1.

4.2.1 Lack of teaching, guidance, and support

The community service nurses are placed in clinical settings for one year before they can register as nurses with the SANC. The experienced registered nurses are expected to teach, guide, and support the community service nurses to further integrate theory into practice. The following sub-categories emerged, namely lack of teaching, supervision, and support, and fear/uncertainty. Dyess and Sherman (2009:403) state that new graduates enter practice with provisional licenses, and work with seasoned nurses for a number of months so that they can learn the practical skills from the experienced registered nurses. The community service nurse participants were neither guided nor supported, leaving them frustrated, and the Gauteng DoH could not reach
their intended goal of addressing staff shortages in the health sectors. In this study, the community service nurses were supposed to work under the supervision of experienced registered nurses for one year so that they could obtain clinical skills that would help them to give quality patient care. The health establishments where community service nurses are guided and supported become accountable and quality nursing care is improved. Because of the lack of support from experienced registered nurses, the community service nurses resign from the government health sector after they have completed their one-year compulsory community service practice to join private health sectors.

4.2.1.1 Lack of teaching, supervision, and support

The participants stated that learning is a continuous process and that the experienced registered nurses must teach community service nurses during their community service practice. Clinical teaching is necessary to ensure that new graduate nurses learn the practice of nursing to maintain and improve the standards of patient care and to produce competent practitioners (Mellish, Brink & Paton, 2009:207). When community service nurses are not taught in the clinical area, the patients receive poor quality nursing care, placing the patients’ health at risk. The researcher believes that if patients do not receive the correct treatment healing will be delayed, causing patients to experience prolonged hospital stays and will also impact on the hospital’s budget and the patients’ social lives.

It is the registered nurses’ responsibility to ensure that patients under their care receive quality nursing care by ensuring that community service nurses are capable of giving such quality nursing care by teaching them the practical nursing skills needed in the wards. The value of nurse-patient relationships must be reinforced to community service nurses.

Some of the participants felt that there was no supervision in the ward in which they were placed for community service practice, and this was not what they were expecting.
According to Mellish et al. (2009:161) supervision is when an expert practitioner in the art of nursing science guides and directs the work of someone who is less expert, in order to improve their performance and to facilitate work satisfaction so that the ultimate purpose of maintaining quality patient care is maintained. According to Siviter (2008:134), the expert nurse constantly uses her highly developed analytical skills to look for action, to make decisions, and to determine the best solution. In this study, the expert nurses are experienced registered nurses, and the less expert nurses are community service nurses because they have just graduated and they are newly faced with patient care in the real situation.

The community service nurses are there to learn and they must take advantage of the provided learning opportunities. The supervisor should create an environment that is conducive to learning. A conducive environment is an environment that enables nurses to engage in professional practice processes and relationships that are essential to quality nursing care (Kramer, Maguire, Schmalenberg, Halfer, Budin, Hall, Goodloe, Klaristenfeld, Teasley, Forsey & Lemke, 2012:569). When the environment is not conducive to learning, the community service nurses’ growth is arrested.

Participants indicated that as community service nurses, they were not given the opportunity to grow professionally by learning from experienced registered nurses. In order to create an environment where community service nurses experience continuous learning, the unit manager should have a planned teaching programme in the ward and allocate a person to teach according to their knowledge, skills, and scope of practice. Ward staff and community service nurses should be allocated topic according to patients’ disease profiles so that there is continuous learning in the ward. Community service nurses should attend workshops and in-service training. Community service nurses should be taught during ward rounds where they can learn different types of diagnoses and their management. Community service nurses should be involved in multi-professional meetings where patients’ cases are presented and discussed. Community service nurses should be allocated responsibilities under the supervision of an experienced registered nurse. According to Leggat, Balding, and Schifftan
(2015:1582) these activities could empower community service nurses with knowledge and skills to render adequate nursing care.

The participants cited that they have experienced many challenges during their community service practice in the clinical area, and lack of support was one of the challenges. Parker, Plank, and Hegney (2005: 304) stated that senior nurses do not provide support to new graduates in the clinical area. Support in the work place has vital implications for the institution (Newman, Thanacooda & Hui, 2011:170). During this transition the new graduate nurses need their decision-making and clinical judgement skills verified by senior registered nurses (Duchscher, 2008:446).

Guidance and supervision from more experienced registered nurses is valuable when clinical judgements are made by new graduate nurses. Because of their lack of experience, the community service nurses are unable to make correct decisions during practice. Poor decision-making leads to poor patient management. Therefore, the experienced registered nurses must guide community service nurses in decision-making by working hand-in-hand with them, and explain to community service nurses how they reach certain decisions and which principles are applied during decision-making. Horsburg and Ross’s study (2013:1125) revealed that new graduate nurses’ transition from novice to expert is a stressful experience, and one of the causes is lack of teaching, guidance, and support. The DoH has introduced a one-year community service practice to bridge the gap between theory of new graduate nurses by and their practice under the supervision of registered nurses in the clinical practices where they are placed.

Evans and Kelly in Maben et al. (2006:474) have identified that the high levels of stress experienced by new graduate nurses resulted from the theory-practice gap. Chang and Hancock (2002:155) define role stress as the consequence of the disparity between an individual’s perception of the characteristics of a specific role and what the individual currently performing that specific role is actually achieving. Oermann and Moffit-Wolf in Chang and Hancock (2002:156) found that stress experienced by new graduates is
caused by lack of experience, insufficient interaction with physicians, lack of organisational skills, and new situations and procedures.

Chang and Hancock (2002:155) added that nurses who are stressed have higher absenteeism rates, lower work satisfaction, feelings of inadequacy, self-doubt, lowered self-esteem, and are more likely to leave the organisation. The community service nurses experience feelings of inadequacy and self doubt because they are not sure whether or not the nursing care they are giving is correct. According to Komaratat and Oumantee in Chen and Lou (2014: 435) new graduate nurses have limited experience and skills to provide quality nursing care for patients. The community service nurses feel more secure when a senior person checks their actions. Therefore, during the transition period there should be registered nurses at all times with whom the community service nurses can verify their practice to minimise poor quality nursing care. The registered nurses must teach and guide the community service nurses on how procedures are done, by demonstrating to them first and then allowing them to practice under supervision until they are competent enough to practice on their own. Procedure manuals available in the wards can also be used for guidance.

The participants were planning to leave the hospital after they completed their one-year community service practice because of their dissatisfaction with the experienced registered nurses' uncaring attitude. The community service nurses find it difficult to approach the experienced registered nurses. Brier, Wildschut, and Mgqolozana (2009:101) stated that nursing is a caring profession but nurses do not execute the culture of caring to themselves and to their patients. The findings support this assertion, as community service nurses were subjected to uncaring experienced nursing staff. The community service nurses need caring experienced nurses who will support them during their transition. Caring nursing staff during the transition phase increases job satisfaction and commitment and decreases turnover and absenteeism (Newman et al., 2011:170)

O’Shea and Kelly (2007:1539) explained that stress might be caused by fear of litigation, staff shortage, poor relationships between multi-disciplinary teams, and
imperfect job descriptions. The community service nurses experience role confusion because their scope of practice is not well defined. Their job description states that they must work as professional nurses, yet they are community service nurses. They explained that they practice as professional nurses when it suits the ward staff and when it does not suit them, they are treated as student nurses. Without supervision and support, the community service nurses will not give quality patient care because they lack the necessary knowledge and experience. Therefore, there should be a support programme that runs for a full year for the community service nurses. According to Dyess and Sherman (2009:405) the theory-practice gap still exists. The nursing leaders’ concern about the theory-practice gap led to the development of a grant-supported Novice Nurse Leadership Institute programme in South Florida. The goal of the programme was to strengthen the new nursing graduates’ competency level by providing on-going support to reduce the high turnover in the first year of practice, and creating a pool of future nurse leadership to serve the community by developing a leadership mind-set in the first year of practice.

In the clinical area the community service nurses are exposed to stressful situations. Sherman and Bishop (2009:25) developed a plan of action to develop community service nurses. The plan was to provide a mentor to clarify issues of concern, so that new graduate nurses felt safe and could rely on mentors. The plan also sought to discuss the behaviour or performance that can derail a nursing career and correct the behaviour identified. It was proposed that new graduate nurses talent should be identified and developed at any early stage. The registered nurses should allocate some of the responsibilities to community service nurses according to identified talents. The unit manager must praise new graduate for a job well done in order to encourage them to continue with their good practice. Giving new graduate nurses feedback on their strengths and weaknesses will motivate them. New graduate nurses should be given responsibilities under supervision of the registered nurses who should teach them and send them on appropriate courses to build on their strengths and to improve their weaknesses. New graduate nurses should be allowed to attend leaders’ meetings and to give feedback at ward level with the support of the ward sisters who motivate them (Sherman & Bishop, 2009:25).
Nematollahi and Isaac’s study (2011:195) proposed the Graduate Nurse Program to assist newly graduate nurses to bridge the theory-practice gap. The aim of the programme was to support the newly graduated nurses during the period of adjustment, in which the graduates develops the skills, knowledge, and values required to become effective members of the multidisciplinary health care team.

Landers (2000:1551) mentioned that the clinical environment is changing and no matter how effective the theoretical input in the classroom is, it could never cater for the diverse complexities of the clinical situation. The complexity of the clinical situation is due to the high acuity level of patients, patient overcrowding in the wards, a shortage of equipment, and the use of technologies (Landers: 2000:1551). When new graduate nurses are faced with diverse cultures they become overwhelmed and psychologically affected, which leads to high stress levels. When working alongside experienced registered nurses as mentors, the community service nurses can observe how to manage diverse situations and they are able to apply practice-based knowledge at the bedside with real patients. The community service nurses can learn clinical skills and creativity through observing and practicing. Therefore, the community service nurses need experienced registered nurses or mentors to guide them so that they can correlate theory into specific care for each patient.

Supervision is concerned with helping the new graduates to make sense of the clinical situations, and to help them explore issues that they experience (Hole, 2009:67). The community service nurses lack clinical nursing judgement in the care of patients, professional ethics, and professional conduct (Dyess & Sherman, 2009:408). According to Billings and Halstead (2009:57), clinical judgment skills include the ability to identify, assess, and comprehend patients' conditions in order to solve the identified patient problems. Therefore, newly graduated nurses require constant supervision by experienced registered nurses to assist them to identify and solve patients’ problems.

The community service nurses should be exposed to different types of conditions in specific wards. According to Hillman and Foster’s (2010:54) study, new graduate nurses were given an assignment to collect data, work on data collected, analyse the data, and
create a plan of action related to their findings. These assignments should be repeated until the community service nurses can apply appropriate judgement in different conditions. Kilminster, Cottrell, Grant, and Jolly (2007:2) described supervision as providing guidance and feedback on matters of personal, professional, and educational development so that the new graduates can provide safe and appropriate patient care.

The participants expressed concern about lack of teaching and supervision during their community service practice. They mentioned that they have learned the hard way, and the little guidance they received was when they requested help from the enrolled nurses and the enrolled nursing auxiliaries whose scope of practice differs from that of registered nurses. The enrolled nurses and the enrolled nursing auxiliary nurses have minimum levels of training, and the skill and knowledge they have acquired are from their daily execution of duties. The scope of practice of enrolled nurses and the enrolled nursing auxiliary requires that they can only function under the supervision of registered nurses. Thus, it is impossible for them to supervise the community service nurses who are waiting to be registered nurses after their obligatory one-year community service practice. The scope of practice of community service nurses requires that they can only function under the supervision of the registered nurses. However, there are enrolled nurses and enrolled auxiliary nurses with wide experience who can give guidance to the community service nurses. Their knowledge is practice-based and not theoretically based.

One of the participants reported that he was left to run an ophthalmic ward without any supervision from an experienced registered nurse. One patient who was bleeding from the eye, and the community service nurse was unable to manage the patient and the enrolled nurse demonstrated eye plugging. Due to the shortage of registered nurses, the community service nurses find themselves having to be guided by enrolled nurses, therefore there should be a special training programme for enrolled nurses to enable them to give appropriate and safe guidance.

According to Smith and Pilling in Fitzgerald, Moores, Coleman and Fleming, (2014:13) new graduates nurses are required to demonstrate professional competency by having
the relevant knowledge, skills and attitudes to perform the work. Although new graduate nurses achieved SANC professional requirements of minimal competency to ensure practice, studies indicated that many new graduate nurses lack the clinical skills and judgement needed to provide safe, competent practice (Dyess & Sherman, 2009:403). Developing nursing skills requires applying, verifying and clarifying learned theoretical knowledge through practice under supervision, which assists new graduates in internalizing, translating, and applying knowledge more effectively in practice (Chen & Lou, 2014:435).

When new graduate nurses practice without the supervision and guidance of an experienced registered nurse, it will lead to poor nursing care and it may damage the image of the profession because patient and community will lose trust in nurses. It may also damage the image and confidence of the new graduate nurses who are still trying to build their nursing career because whatever decision and action they will be taking might put the life of patients in danger due to lack of experience. Therefore new graduate nurses require guidance from senior nurses to guide them to apply their knowledge to real life situations. Community service nurses should be given opportunities to practice nursing skills so that they can gain specific clinical skills. Simulations can be used to provide an opportunity for development of decision-making skills through critical thinking skills, technical skills and self-confidence in a safe and controlled department (Ackerman in Hillman & Foster, 2010:54).

Transferring theoretical knowledge that has been acquired in an education programme to a work place setting might be difficult because of differences in the context, culture and mode of learning Eraut (in Hatlevik, 2011:869). The experienced registered nurse use their past experience to identify patient problems and be able to execute treatment and new graduate do not have past clinical experience. The community service nurses should be exposed to different types of conditions in specific wards with the help of experienced registered nurses so that they can gain experience. Because of lack of experience the community service nurses may misdiagnose patient which may lead to wrong treatment given to patient or delay treatment of the patients which may lead to complications or death. Therefore the experienced registered nurses must guide the
new graduate nurses by pointing out relevant information necessary to identify patients’ problems and guide the new graduate nurses to pay attention to underlying signs in order to contextualise the assessment of the patients as they care for them. Contextualisation means taking into account the response of the particular patient in the situation, including the patient history, interrelationships between physiological systems, social interaction with others and responses to the particular environment (Benner et al. 2010:46-47).

The participants explained that they find it confusing that different training institutions have different procedures. Although procedure methods differ from one institution to the other, the principles are the same. Every institution has their own different methods they prefer because the methods have been effective. Organisational culture is the combination of the symbols, language, behaviour, and skills that are openly manifested in the values and norms of an organisation; it is a pattern of behaviour that has worked in the past and is taught to new graduates as the correct way to perceive feel and act (Roussel & Swansburg, 2009:223). The community service nurses have to learn the ward’s philosophy, vision, and mission, their impact on the organisation, and how to apply them during their daily practice. They must also learn how to communicate with the multi-professional team. Nurses use the bleep method when there is an emergency, especially when they cannot reach the doctor. One of the participants stated that she left the patient she was resuscitating unattended to, to call the doctor from doctors’ resting rooms. The participant’s action put the patient at risk of death, which was caused by the participant’s lack of knowledge of resuscitation. Therefore the community service nurses need to be taught the different lines of communication that are used during emergencies.

The participants mentioned that they were not given opportunities to meet and share their experiences with their colleagues. Benner in Hatlevik (2011:869) use the word ‘share’ to mean reflection. Developing new graduates reflective skills could help them to perceive coherence between the theoretical and practical components of their educational programme. Kember et al. in Hatlevik (2011:870) define reflection as a careful re-examination and evaluation of experiences, beliefs, and knowledge, and it
involves looking back or reviewing past actions. Observing coherence between theoretical and practical components during their initial training can be considered as a vital step in bridging the gap between the newly graduated nurse’s theory and practice. Coherence is defined as the connection between theory and practice (Hatlevik, 2011:870). If the community service nurses learn reflective skills during their transition, this will have a positive impact on their practice. The community service nurses could identify their own mistakes and rectify such mistakes with the help of reflection and mentoring. Reflection promotes new graduate nurses’ professional development, and improves patient care (Hatlevik, 2011:869). The institution should develop in-service training because of the gap identified during the period of reflection.

Community service nurses were not given opportunities to reflect on their clinical experiences in order to help them to identify their mistakes during patient care to prevent the same mistake from reoccurring. In this study, the community service nurses stated that they shared their clinical experiences during tea and lunch times, which indicates that they need formal time to reflect on their clinical experiences. Developing new graduate nurses’ reflective skills will help them to develop professional expertise. Therefore, developing a reflective skills programme might be beneficial for community service nurses to promote quality patient care during their transition. Hatlevik (2011:876) suggested developing a reflective skills programme for nursing graduates, which could emphasise the clinical development of new graduate nurses. Forneris and Peden-McAlpine (2007:412) identified the following reflective programmes, namely narrative reflective journalling, individual coaching, and preceptor coaching.

A narrative reflective journalling programme is a six month programme that engages the novice nurses in the reflective thinking process as they recall and document their narrative stories to be discussed with colleagues in the presence of an experienced registered nurse.

In individual coaching the new graduate nurse is given a scenario that resembles a real life situation that requires critical thinking whereby the problem identified and resolved. The registered nurse may allocate a patient to a new graduate nurse and the new
graduate nurse is required to interview the patient to obtain subjective and objective data, to identify problems, and with the aid of a coach they should be able to solve or manage identified problems.

Preceptor coaching should take place in the first three months. Preceptors should engage the novice nurse in contextual learning on a daily basis to help the novice nurse, with the aid of a coach, to incorporate critical thinking into their daily practice experiences.

The institutions should establish a clinical department with trained mentors who will guide new graduates to develop critical thinking skills by encouraging them to reflect on their past experiences. Therefore, a formal guided programme should be implemented to allow new graduate nurses to reflect on their practice once a week. Dyes and Sherman (2009:407) recommended extended support throughout the first year that respects the graduate nurses’ skill development and allows for honest reflection on practice in group discussions with other new graduate nurses.

The participants stated that the wards were chaotic, that they have to run up and down looking for equipment that was not available, and they were unable to operate machines. Maben et al. (2006:474) found the entry into professional practice chaotic. Most newly qualified nurses are in the late adolescent stage and require support, especially in the challenging arena of nursing practice. During this life stage, adolescents are battling with their identity and want to explore every situation. Most of the community service nurses are in the adolescent stage and they are busy trying to secure accommodation for themselves, preparing for stable relationships, or they are engaged. They find nursing practice scary, confusing, and chaotic, and receive little to no supervision and support from experienced registered nurses (Siviter, 2008:132). The chaotic nursing environment is characterised by personnel shortages, shrinking resources, incompetency in advanced technologies, and unending documentation. Additionally, they must work with the largest number of co-workers of different occupations, and they are expected to be professionally accountable for the provision of
care and management of diverse clinical situations (Kramer et al. 2012:567). In the midst of chaos, new graduate nurses feel overwhelmed and professionally isolated.

The community service nurses become disorganised when they work in a chaotic environment. They are unable to complete the tasks allocated to them because they become confused due to the busy environment. Due to a lack of experience they are unable to prioritise. At the end of the day they feel exhausted and overwhelmed by unfinished task or with of the large number of mistakes they have made. To allow community nurses to work in a chaotic ward without supervision or guidance from experienced registered nurses is a recipe for heightened emotional stress, which will cause high absenteeism, nurses leaving the nursing profession, or resignations immediately after completion of the one-year community service period. At this early stage of their careers, they can change jobs easily if they are not satisfied with their current job. Lack of professional and collegial support during this transition phase can seriously affect both short- and long-term performance and could determine whether or not the new graduate remains in the nursing workforce. Therefore, guidance and supervision from more experienced registered nurses is important for the retention of the new graduates, and for the adequate provision of safe nursing care by community service nurses.

According to Dyess and Sherman (2009:406) and Duchscher (2008:442), new graduates move through the three stages of doing, knowing, and being during their first 12 months of practice. The doing stage is the initial stage of entry into professional practice; the new graduates work through the process of discovering, learning, performing, adjusting, and accommodating. Their discovery is when they realise that all was not as they expected. They discover new ways of performing skills that differs from what they have learned at college (Duchscher, 2008:444). Benner in Nematollahi and Isaac (2011:196) identifies the doing stage as involving novices, who are new graduate nurses, entering a clinical setting and being limited to the novice level of performance when they have had no experience in dealing with the patient population and are unfamiliar with the procedures, policies, protocols, and tools used for delivering patient care. The novice can perform and further learn the required skills under the watchful
eyes of experienced registered nurses, because at this stage they lack clinical knowledge and confidence in skill performance, relationships with colleagues, workload demands, organising, and prioritising when they make decisions (Duchscher, 2008:448).

During the doing stage the community service nurses manage correct procedures when they are supervised and supported by experienced registered nurses. The community service nurses stated that they were not guided or supported during their initial stages of transition. They were given the full responsibility of running the wards without being supervised by experienced registered nurses, which was scary and frustrating to them because of their lack of experience.

During the doing stage, the community service nurses require directions about what should be done in particular clinical situations, because if they are not supervised or directed they may harm the patients. Therefore the new graduates should be guided, assisted, and supported by experienced registered nurses during the doing stage. Duchscher (2008:442) stated that new graduate nurses, if properly supported, will reduce the workload, and they should therefore be given dependable access to a consistent, experienced clinical colleague who will give them adequate guidance and support.

The second stage is the stage of knowing. During this stage the newly graduate nurses have progressed from a novice level of competence into the stage of knowing or an advanced beginner level (Duchscher, 2008:448). Benner in Nematollahi and Isaac (2011:196) stated that advanced beginners are nurses who demonstrate marginally acceptable performance for delivering safe patient care, someone who has dealt with enough real situations to identify the recurring, meaningful situational components. These real life situations help them to develop principles, which then guide their actions. They are comfortable with the ward routines and they are familiar with the roles and responsibilities that have been established by the experience gained during their initial months of transition. At this stage, the new graduates can predict and respond to the presenting situations. The new graduates are slowly introduced to challenging situations
to advance their thinking and practice under supervision of a mentor. The new graduate nurses are ready to be introduced to a more unstable patient population. New graduate nurses should be assisted in taking responsibility for complex decisions and making clinical judgements related to changing patient situations under the guidance of advanced clinicians (Duchscher, 2008:448).

The final stage is the stage of being. New graduate nurses seek to establish a separation that distinguishes them and allows them to unite with the practitioners in their larger community (Duchscher, 2008:448). During the transition period the community service nurses require support, guidance, and constant supervision by experienced registered nurses to ensure that they develop both personally and professionally.

Maben et al. (2006:475) stated that there should be a formal mentorship programme for new graduate nurses and that the mentors should attend a formal programme for mentorship. Mentoring is a way of overcoming professional isolation and a way of providing support for health care workers such as community service nurses. A mentor acts as role model and provides clinical supervision for new graduate nurses in the clinical area (Nematollahi & Isaac, 2011:197). Myrick and Yonge in Nematollahi and Isaac (2011:198) propose that mentor support empowers new graduates nurses to learn in the clinical settings.

Horsburg and Ross (2013:1131) stated that expert nurse mentors should be provided and job satisfaction should be measured. Leggat et al. (2015:1578) state that the mentoring programme consisted of three face-to-face workshops for mentors and new graduate nurses and included training in mentorship skills and action learning, educational sessions on clinical leadership, and opportunities for reflection and feedback. Monthly face-to-face or telephone mentoring meetings are organised by mentors. There is monthly email contact with the programme facilitators. Facilitators need feedback from both mentors and new graduate nurses. The programme facilitator attends one meeting of each mentor pair to observe the interaction and to provide feedback.
The mentorship programmes facilitate the smooth transition of new graduate nurses and improves safe patient care. The mentorship programme assists new graduate nurses to achieve clinical competency and develop critical thinking during their community service practice. Kowalski and Cross’s study (2010:102) found that mentorship programmes improve clinical competency, decrease levels of feeling threatened, and improve communication, leadership, and professional development.

Ballem and McIntosh (2014:384) are of the view that managers should pair mentors with new graduate nurses and ensure that mentors remain consistent throughout the mentorship programme. Organisations that implement mentorship programmes must select and match mentors and mentees, provide training programmes and opportunities for discussion, and set objectives and time frames for completion (Berezuik, 2010:n.p). According to Berezuik (2010:n.p) mentoring programmes can be formal or informal. Formal mentoring programmes and guidelines must be formulated to ensure that the relationship between mentors and mentees meet the organisation’s expectations. According to Nematollahi and Isaac (2011:298), the mentors are the key influence in reducing the high turnover of nurses in their first year of practice, and they provide clinical supervision for new graduate nurses in the clinical area.

The participants mentioned that they were part of the workforce but experienced minimal supervision. Role models provide clinical supervision for new graduate nurses in the clinical area. The mentorship role includes regular interaction, explicit sharing of ideas, clarity of expectations, and focus on areas of strength, as well as those areas requiring improvement. According to Maben et al. (2006:474) staff shortages, a poor skill mix, and an overstretched workforce contributed to the lack of good role models and support. Learning is a continuous process and new graduates need support when entering clinical settings. The community service nurses mentioned that they need experienced registered nurses who can supervise and support them.

Community service nurses need mentors to teach and support them during their community service practice until they can stand on their own or when they are competent. Nematollahi and Isaac (2011:197) describe a mentor as a more experienced
colleague who stands alongside a less experienced colleague or a mentee to facilitate their professional development through teaching, counselling, support, and guidance. Professional development is a process of increasing the level of knowledge and broadening the scope of practice (Duchscher, 2008:442).

Dyess and Sherman (2009:403,406) stated that having a mentor reduces the frustration that new graduate nurses feel when they attempt learning organisational policies and procedures. Dyess and Sherman (2009:406) further suggest that new graduates nurses would benefit from long-term support that includes further development of clinical judgement, debriefing opportunities, and skill set enhancement. This suggestion for long-term support is in consistent with the theoretical stage of acquiring clinical competence that acknowledges that novice nurses do not have an explicit understanding of the brand new situation in which they are expected to perform (Benner in Nematollahi & Isaac, 2011:196). Horsburg and Ross (2013:1131) suggest that there should be new graduate nurse support groups that meet regularly during and after transition to share their experiences.

Improvements in the support of new graduate nurses is required to ensure that patient safety will not be compromised and that poorly supported new graduate nurses are retained in the nursing profession (Parker et al. 2005:300). Support and supervision is vital to any new professional recruit in helping new graduates make sense of the difference between their professional ideals and the bureaucratic reality (Maben et al. 2006:474). Maben et al. (2006:473) define professional ideals as the principles governing professional practice. A gap may exist between the ideals and values taught and adopted by new graduate nurses during college education and those in the practice settings where they are allocated as community service nurses. In the real situation they have their own style of performing procedures and managing the ward.

The participants were concerned that they were expected to be accountable while they were supposed to be learning. This statement was supported by Burns and Poster in Dyess and Sherman (2009:403) who stated that new graduates were deployed into clinical settings where they assume professional responsibilities that are potentially
beyond their capabilities. Experienced registered nurses need to give new graduate nurses opportunities and space to grow in the profession so that they can transfer the skills and clinical judgements learned to their daily practice to achieve quality nursing care (Benner et al. 2010:42-43).

Community service nurses expressed concern about their ability to function in intensive care units (ICU). Their concern was due to their lack of knowledge and skill to operate ventilators, manage patients on ventilators, and record observations on the ICU chart. An ICU is a specialised area for patients with complex needs and patients who require high-level decision-making skills. Patients in ICU are critically ill, are nursed on ventilator machines, are unable to communicate, and their treatment is highly complicated. Community service nurses have undergone a basic nursing training whereas ICU requires highly skilled nurses who have undergone ICU training.

Historically, new graduate nurses were initially assigned to general medical-surgical wards. Today, for a variety of reasons, new graduate nurses are assigned to ICUs without any background of ICU care. The new graduates are unable to make reasoned judgement that is logical (Dyess & Sherman, 2009:408). One of the participants stated that she was asked to fetch Pneumolyte and she didn’t know where to get it or how to mix it. The community service nurses feel unprepared to meet such challenges. The finding is supported by Dyess and Sherman (2009:408) and Missen, Mckenna, and Beauchamp (2014:2428) who stated that the new graduate nursing profession and the health of the patients will be at stake. Therefore, community service nurses need extensive training before they can be assigned to specialised areas, and they must be assigned to ICU facilities with trained mentors who can teach and supervise them during the management of patient care.

The findings are supported by Missen et al. (2014:2428) who stated that specific programmes must be designed to assist new graduate nurses in the highly specialised areas. Dyess and Sherman (2009:408) stated that extensive speciality education related to technology and disease management needs to be provided to new graduate nurses. There should be two weeks of formal training of specific specialised areas
before the community service nurses practice in any specialised area. Mentors must be assigned to community service nurses to teach and guide them during the transition period. Formal, monthly debriefing programmes should be implemented by qualified counsellors for community service nurses allocated to the neonatal ICUs; these qualified counsellors should understand what the community service nurses can expect to experience and help them to anticipate the effect of nursing very sick neonates. According to Mellish et al. (2009:320), counselling is a person-to-person form of communication where a problem that is real to a person seeking counselling is the focus of the counselling. Counselling aims at helping or enabling the person in need of counselling to reach a decision, to make up their own mind, and therefore the choices open to them must be clarified. Counselling allows the new graduate nurses to explore personal concerns, especially after a traumatic experience. If counselling is not carried out after traumatic experiences, the community service nurse might avoid dealing with a similar situation in the future, which would delay patient treatment and affect the quality of patient care. Lack of support during the transition phase can seriously affect the community service nurses’ performance, self-esteem, and confidence, and place patient health at risk.

Community service nurses lack experience in nursing critically ill neonates and yet they are expected to counsel frustrated parents. If the health institution does not take care of the new graduate nurses who are traumatised by working in the neonatal ICU, they may lose them after they complete their one-year community service to other departments or health institutions. Hospital management should design specific teaching programmes to assist community service nurses in highly specialised areas (Dyess & Sherman, 2009:408). Healthcare facilities and education providers should offer educational strategies such as programmes, mentorships, and workshops, all aimed at guiding the development of new graduate nurses (Parker et al. in Missen et al., 2014:2420). Dyess and Sherman (2009:408) recommend formal learning sessions that are held every Friday for 20 days.

Participants recommended that the Gauteng DoH should carry out continuous check visits of community service nurses in their assigned areas so that they can identify what
they are going through during community service practice. The Gauteng DoH representatives must interview the community service nurses so that they can obtain accurate information about their experiences and the management support they need.

The above recommendation is supported by Nematollahi and Isaac (2011:198), who stated that the success of the Emiratization Graduate Nurse Programme was due to the high level of commitment and support received from the government authorities. Horsburg and Ross (2013:1131) stated that the expert nurse mentors should be provided and the job satisfaction should be measured and monitored. Missen et al. (2014:2424) recommended specific year long programmes of mentorship that includes a 12-month programme that integrates patient simulation, social and professional reality, 10-day scheduled education seminars according to the need of patients, 14 to 16 week mentor programmes that provide clinical competence and develops confidence, and a 6-month of Intensive Care programme.

4.2.1.2 Fear/uncertainty resulting from lack of experience

Community service nurses indicated that they feared harming the patients due to the community service nurses’ lack of experience and not having an experienced registered nurse to ask for guidance when there was a need for clarity. Louw and Edwards (2011:454) define fear as the situation in which there is the likelihood of doing harm. The community service nurses fear harming patients due to their lack of clinical skills. New graduate nurses may avoid performing certain procedures because they fear harming the patients, and this may lead to patients not receiving prescribed treatment and may delay patient healing and death may occur. When new graduate nurses lack confidence in what they are doing, they are likely to feel stressed, absent themselves from work, and overwork those who are on duty. Continuous absenteeism will lead to lack of knowledge about nursing care, and will impact on the future of nursing profession since the profession will be populated by professional nurses who are unknowledgeable.
In order to build the nursing profession, new graduate nurses must be guided by experienced registered nurses so that they can clarify any misunderstanding until the new graduate nurses gain confidence in practicing quality nursing care. Healthcare institutions and education providers should offer educational strategies such as workshops to develop and guide new graduate nurses during their transition from novice to advanced beginner practitioner (Missen et al. 2014:2420).

The participants stated that they felt insecure when managing the ward without the assistance of experienced registered nurses. Tingle and Gildberg’s study (2014:535) showed that for new graduate nurses the transition is accompanied by feelings of stress and uncertainty, and they find it difficult to deal with the responsibilities that are placed on them. The strain of professional accountability is caused by managers and colleagues’ unclear practice expectations and inaccurate assumptions. Duchscher (2008:448) further explains that the new graduates fear assuming the responsibility of managing wards because they are unsure of whether or not they are practicing correctly. To assign the responsibility of managing the ward to community service nurses without the assistance and guidance of experienced registered nurses puts the health of patients at risk, which may lead to severe complications or death. It also places a significant responsibility on the community service nurses who are still adjusting to the role change. When significant responsibility is placed on new graduate nurses, they experience physical exhaustion that will likely lead to poor productivity. Therefore the community service nurses should not be allocated the sole responsibility of managing the ward, but there should be experienced registered nurses to clarify any issues to prevent poor patient care and productivity.

Gennep in Lee, Hsu, Li, and Sloan (2012:790) define transition as the period during which people experience drastic life changes by heading into an unknown future that may cause stress and uncertainty because they do not know what to expect in their new role. The community service nurses have moved from the student nurse role to the unknown future of being a professional nurse. This finding is supported by Mooney (2005:1612), who state that during training, the community service nurses are unaware of what is happening in the ward and feel unsure about the professional nurses’ role.
Mooney (2005:1612) further explains that community service nurses are familiar with doing the observations, making beds, and bathing the patients, and they are under the misapprehension that is all a nurse has to do. These feelings can result in low self-esteem, lack of confidence, and a sense of failure in new graduate nurses. Lack of confidence is caused by limited experience with the application of the skills and knowledge they have acquired (Duchscher, 2008:448). The community service nurses need clarity of professional nursing roles to ease them into the transition period. Failure to clarify the professional nurse’s role community service nurses will not provide safe patient practice.

Therefore, the unit manager must assign experienced registered nurses to community service nurses to help them to adjust to the new professional nursing role. The responsibilities of professional nurses must guide community service nurses until they can function on their own and feel confident when nursing patients. The community service nurses’ job description should be clearly written. Duchscher (2008:448) recommends a support network of peers and colleagues to promote on-going professional development.

O’Shea and Kelly (2007:1535) suggest that while new graduate nurses experience problems with role change, they perceive more potential problems than they actually experience in practice. New graduate nurses experience stress, frightening situations, and being in absolute hell because they experience lack of support, guidance, and mentoring in the nursing practice environment. Stress is the state of severe physiological tension (Melgosa, 2011:8). Chang and Hancock (2002:156) define role stress as a consequence of the disparity between a person’s perception of the features of a certain role and the reality of what actually performing that role entails.

Role stress in new graduates might develop as a result of the pressures of lack of confidence, unrealistic expectations by clinical staff, role conflict, and ambiguity (Kelly in Lavoie-Tremblay et al., 2008:291). New graduates’ stressors include not feeling confident or competent, making mistakes because of increased workload, encountering
new situations, and experiencing inconsistent expectations from registered nurses (Oermann & Gavin in Lavoie-Tremblay et al., 2008:291).

Transition from new graduate nurse to registered nurse is challenging and stressful because of the lack of support for new graduate nurses (Higgins et al. in Horsburgh & Ross, 2013:1130). Therefore, procedure manuals must be available to guide the community service nurses.

Mooney (2007:75) indicates that the problems associated with the transition of new graduate nurses have been acknowledged as being traumatic. Most of the participants highlighted the fact that there was no teaching and guidance. Participants explained that lack of experience resulted in them pricking patients more than five times when putting up a drip. The pricking of the patients more than once was due to the participants’ lack of experience, resulting in the loss of confidence and exposing patients to unnecessary pain and infection. The patients will lose faith in the community service nurses and will refuse further treatment from them. When a person experiences fear they cannot relax, they don’t concentrate on what they are doing, and it is easy to make mistakes in these circumstances. Therefore, the experienced registered nurses should carry out the procedure first and then ask the community service nurse to practice until they are competent enough to carry out the procedure on their own.

O’Shea and Kelly (2007:1535) believe that new graduate nurses approach their initial introduction to practice with exhilaration and eagerness, but they experience fear, anxiety, apprehension, and intimidation when the reality of professional practice sets in. The community service nurses’ anxiety was increased due to lack of organisational skills and the accountability associated with their new roles. According to Duchscher in Nematollahi and Isaac (2011:297) new graduate nurses experience steep learning curves throughout their first year of professional practice and often experience feelings of fear, anxiety, and self-doubt as they embark on their career.

The participants stated that being a community service nurse was like entering the real world. Mooney (2005:1612) describes the progression from student to new graduate
nurse as a “reality shock”. Duchscher (2008:449) defines the real world as transition shock and as the experience of moving from the known role of being a student to the unknown role of being a professional nurse. The real world of health care is characterised by repeated intimidation, aggression, or harassment by experienced registered nurses, supervisors, and nursing management (Dyess & Sherman, 2009:405). This behaviour leads to personal and professional harm, which will affect the relationship between experienced registered nurses and community service nurses, resulting in a lack of assistance for new graduate nurses and exacerbating their transition. When new graduate nurses change careers they will leave the nursing profession with staff shortages that will affect patient care. Registered nurses should allow the new graduate nurses to raise their concerns so that all misunderstandings can be corrected.

The lack of professional confidence that new graduates often feel is occasioned by experienced registered nurses ignoring them during practice. There was a general consensus that new graduate nurses need their confidence to be boosted by their colleagues during the initial stages after qualification, and new graduate nurses generally experienced a lack of preparedness and lack of confidence in the new role (Suresh, Matthews & Coyne, 2012:774).

These professional role demands and practice conditions place heavy demands on all nurses, but particularly on new graduate nurses since they must develop competence and become integrated into the professional nurse role during a time of great stress (Kramer et al. 2012:567). Putting community service nurses in charge of the units, and rotating them to high acuity observation wards should be avoided during the initial stages of professional role transition because they may create an unsafe environment for patients and staff (Duchscher, 2008:448). Therefore, consistent support from the experienced registered nurses and management can be facilitated during the new graduate nurses’ transition period by allocating experienced registered nurses to work with the newly graduated nurses. Dyes and Sherman (2009:407) recommended that as part of the orientation, new graduate nurses should receive some training in interpersonal relationship and communication skills, which includes problem-solving
skills and discipline. Blanzola et al. in Missen et al. (2014:2428) recommends education initiatives such as a standardised in-service programme to be included in orientation, and regular interviews of community service nurses by the Gauteng DoH to explore their experiences.

Lack of teaching, supervision, and guidance of new graduate nurses may lead to patients or relatives suing the health institution or Gauteng DoH because of malpractice due to the community service nurses’ lack of experience. Therefore, the community service nurses need guidance and support from experienced registered nurses until they can practice independently.

From the patients and family’s perspective, lack of experience is not an excuse for malpractice. Improvement in support and guidance is required to facilitate the transition of new graduate nurses. Without this support and guidance, patient safety will be compromised and the poorly supported new graduate nurses may be lost to other professions. Therefore, the experienced registered nurses must take full responsibility to teach, guide, and support community service nurses during this transition phase so that they can be retained in the government sectors and fulfil the intended purpose of community service nurses post completion of their training course.

4.2.2 Lack of management support

Participants mentioned that the lack of management support leads to a poor working environment for the community service nurses. They mentioned that they worked under difficult conditions that contributed to their intention to resign after completion of their one-year community service practice. The community service nurses experienced the following and these have been listed as sub-categories, namely lack of resources, lack of conflict management, and poor communication. Management is a critical factor in the development and support of new graduate nurses. According to Hubber (2014:5) and Muller (2009:94), management is a process whereby human, material, financial, physical, and information resources are employed in order to achieve the organisation’s
goals and objectives by applying the fundamental management activities of planning, organising, directing, and control.

Planning helps to formulate the nursing unit’s vision and the philosophy that will direct nursing (Muller, 2009:102). Every ward needs to have a vision that will direct its daily activities, improve patient care, and prevent frustration during execution of daily practice. Nurses who are frustrated in the work environment leave the organisation and move to institutions that give them job satisfaction. Planning of all activities in the ward should include the contribution of community service nurses so that they can feel part of the team. In this study, the managers failed to provide orientation of the ward’s vision and mission statement to direct community service nurses which would have enabled them to provide quality nursing care. Every ward is supposed to have their own vision and mission statement and if they are not available, they must formulate them and all staff, including community service nurses, should abide and apply them when executing their daily practice.

Organising refers to the orderly structuring of functions and responsibilities in order to ensure the smooth running of activities (Muller, 2009:103). Functions and responsibilities must be equally distributed to prevent overwork and exhaustion that leads to poor productivity. One of the community service nurses stated that she was the only professional nurse in the ward with 60 patients, which made it difficult to provide quality nursing care. In this study, the unit managers failed to give registered nurses the responsibility of guiding community service nurses during their daily functions so that they knew what was expected of them.

In terms of promoting quality nursing care, control includes cost-effectiveness and efficiency in the unit, including the control responsibilities related to human resource management in the nursing unit. Control is also the empowerment of subordinates (Muller, 2009:104). In this study, the community service nurses not guided on how to manage patients in their allocated area, and therefore not empowered. Failure to empower community service nurses leads to poor patient care. Therefore, orientation or in-service training should be provided before community service nurses are assigned to specific areas so that they can provide quality nursing care.
4.2.2.1 Lack of resources

The participants stated that staff shortages had an impact on their daily practice because patients did not receive scheduled treatment, which delays patient healing. They felt that they were assigned to the wards to cover staff shortages. Community service nurses felt that their presence did not solve problems because they too would resign after they have completed their one year community service practice. Staff shortages were on-going, other nurses also intended to leave the profession, and the Gauteng DoH were not reaching their objective of retaining staff because of poor working environments. Lack of resources includes both human and material resources.

A transition period is critical for new graduate nurses because it is the period during which they should be socialised in the nursing profession by experienced registered nurses. Shortage of experienced registered nurses leads to poor socialisation of community service nurses because they are overworked, leading to poor quality nursing care. The Canadian Institute for Health Information in Laschinger (2012:475) raised concerns about patients’ safety as a result of inadequate staffing. Lack of staffing contributes to overworking the remaining staff, especially new graduate nurses, which leads to exhaustion, burnout, and poor nursing care. Maslch in Laschinger (2012:474) define burnout as a psychological syndrome of exhaustion and inefficiency, which is experienced in response to chronic job strain.

New graduate nurses are precious human resources since the profession continues to experience a workforce shortage (Laschinger, 2012:472). Griffin and Scot in Laschinger (2012:472) were concerned that many new graduate nurses may leave the nursing profession as a result of inadequate working conditions. The findings in this study showed that community service nurses were not supported by experienced registered nurses. Oosthuizen (2005:117) found that nurses change their work environment due to dissatisfaction with their job situation. Experienced nurses are leaving patients’ bedsides due to resignation and retirement. Work environment dissatisfaction contributes to staff shortages if staff are not replaced (Berezuiik, 2010:n.p.). The shortage of nurses may result in heavy workloads and exhaustion, which will contribute
to poor patient care and impact on the new graduate nurses’ development. When new graduate nurses feel that they are not well socialised by registered nurses, they will leave the hospital after serving their one-year community service practice, and this is going to cause a continuous cycle of staff shortages.

Staff shortages affect quality patient care because new graduate nurses require supervision. The above findings are supported by Saintsing, Gibson, and Penington (2011:355) who state that nurses who are not adequately prepared or socialised will be more likely to make significant mistakes when not supervised. Therefore, hospital management must retain the experienced registered nurses so that they can socialise new graduate nurses into their new roles. The environment should be conducive to retaining new graduate nurses after community service practice. Re-appointment of retired registered nurses should be implemented to socialise and to role model quality care to new graduate nurses in the nursing profession. However, a special programme should be developed to re-train the retired nurses so that they can be relevant to the new development of nursing practice.

According to Erasmus and Blaauw (2009:1), the shortage of nursing staff is a concern in many countries. The new graduate nurses are dissatisfied with working conditions such as heavy workloads, the unsatisfactory state of hospitals, a lack of basic resources, and unrealistic demands from management. At a nursing summit on the 4th April 2011, the current Minister of Health, Dr. Motsoaledi, emphasised that South Africa is facing a critical shortage of doctors and nurses. The DoH’s objective was to attract new graduate nurses and to retain them, hence community service practice was introduced to all health professionals.

The new graduates might feel exploited by management and react by absenting themselves from work. Absenteeism of new graduate nurses further aggravates the staff shortages, resulting in poor nursing care. Absenteeism of community service nurses delays their registration with the SANC. Therefore, management must use urgency/temporary nurses to cover the staff shortages. Caregivers and support staff must be used to curb the nursing staff shortage by performing non-nursing
responsibilities such as the washing, feeding, and turning of patients, and giving experienced registered nurses the opportunity to induct community service nurses and to concentrate on nursing duties that require highly skilled personnel (Daffron & Hart, 2001:208).

The participants stated that they did not expect to be in the wards to be overcrowded with patients, since during their training they were taught the ideal nurse patient ratio. Five staff members, namely a sister, an enrolled nurse, and three auxiliary nurses were usually in the night shift staff complement. Saintsing et al. (2011:357) states that new graduate nurses are assigned more patients than they were used to in their clinical training. The number of patients assigned to new graduate nurses may have an effect on new graduate nurses because of the extra workload. Aiken in Stam, Laschinger, Ragan, and Wong (2015:192) found that nurses working in hospitals with a patient to nurse ratio of 1:8 are more likely to experience job dissatisfaction, and further proposed that it is unsafe to nurse many patients because adverse events could occur without being noticed. Inadequate staffing causes exhaustion and emotional imbalance in new graduate nurses. Lavoie-Tremblay et al. (2008:291) found that new graduate nurses experience symptoms of burnout and mental exhaustion.

Yeh and Yu (2009:3450) explained that nursing staff shortage is a global problem. Due to staff shortages, nurses who remain in the hospital have to care for more patients, which put more strain on them. Nurses continue to leave the hospital, thereby exacerbating the staff shortages (Hassmiller & Cozine, 2006:269). New graduate nurses will not have support from experienced registered nurses to mentor them during their community service practice. Berliner and Ginzberg in Yeh and Yu (2009: 3450) stated that the nursing staff shortage is caused by the failure to attract and keep new nurses.

Berliner and Ginzberg in Yeh and Yu (2009:3450) stated that the aging nursing workforce has direct consequences on staffing. Most of the nurses are retiring or are near retirement, others are absent from work due to illness like HIV/AIDS, and the young generations are attracted to other industries that provide more opportunities and job satisfaction. Cullinan in Mudaly and Nkosi (2015:628) stated that hospitals in
KwaZulu Natal are significantly strained because of the HIV/AIDS epidemic, having to care for very sick people who need specialised treatment and care. This epidemic causes overcrowding of patients in understaffed wards.

Stam et al. (2015:192) stated that new graduate nurses left their first position within a year after graduating, due to inadequate staffing. Therefore, the hospital management should develop a strategy to prevent staff shortages in the hospital by employing more nurses and retaining them. The hospital must make use of agency nurses and allow permanent nurses to work controlled overtime to ease staff shortages. Hassmiller and Cozine (2006:269) stated that many hospitals are hiring temporary nurses to address staff shortages, but the use of agency staff has raised a concern about the consistency and quality of care provided by these temporary staff. The agency nurses do not practicing daily, and if they practice daily, they move from one hospital to another, which affects their competency. They place extra workload on the registered nurses because they need to be taught and orientated instead of being able to concentrate on guiding new graduate nurses. The registered nurses will not have enough time to induct community service nurses because more energy will be channelled to agency staff. The use of agency nurses impacts on the hospital’s budget because they can expose the hospital to patient litigation and time wasted due to lack of competency.

Participants stated that the lack of material resources was a major problem that impacted daily practice. During an emergency were expected to run around sourcing equipment. Sometimes there would be only one piece of equipment for use in a full ward and this delays patient treatment, and the health of patients is compromised. Lack of material resources inhibits the new graduate nurses clinical learning (Suresh et al., 2012:775). Material resources refer to the general supplies and equipment in the nursing unit to ensure quality patient care (Suresh et al. 2012:775). Quality nursing care can only be rendered if there is sufficient equipment to meet the needs of the patients and improve the nurses’ productivity (Booyens, 2008:161). Therefore, the unit manager should ensure that all the necessary material resources are available and functioning well. It is the unit manager’s responsibility to order equipment according to the maximum number of patients, and the equipment must be kept under lock and key to
safeguard against loss and misuse (Booyens, 2008:161). The unit manager must provide in-service education to all staff in the ward teaching them how to use the equipment and to report any equipment that is broken or not in good working condition (Booyens, 2008:166). All broken equipment must be sent for repairs so that there should be no shortage of equipment. If equipment is not serviced or repaired, patient care will be affected.

Participants stated that there were insufficient beds for the patients, and that patients were moved to other wards without any policy in place for transferring of patients without a doctor’s approval. Other patients had to bring their own food, pyjamas, pillows, and blankets. Patients have the right to be nursed in a clean environment (Patients’ Rights Charter in Muller, 2009:15). It was difficult for community service nurses to maintain the patient cleanliness if patients use their own pyjamas and linen. Other patients were from distant areas and their families were unable to visit them and supply clean bedding and pyjamas. Soiled bed linen and pyjamas expose patients to infections and lowers their self esteem. Therefore, the unit manager must motivate for fresh linen supplies so that patients can use hospital pyjamas and linen that can be taken to the laundry when it is soiled.

There should be a policy that allows the wards to admit patients according to the number of available beds in the wards. There should be a ward to which overflow patients can be admitted to avoid having to move patients from one ward to another. Patients have the right to be nursed in a safe environment (Patients’ Rights Charter in Muller, 2009:15). Lack of safety exposes the community service nurses to an unsafe environment. If patients fall, the community service nurses have to write incident reports and this could demoralise them. The researcher believes that there should be a policy on how to move patients, which will protect patients and new graduates nurses. Patient admission must be carried out according to the availability of beds in the ward, and if the ward is full, the patients should be referred to other hospitals.
4.2.2.2 Lack of conflict management

Participants stated that they were unhappy and overworked due to late-coming and absenteeism, which was not addressed by the managers. When the unit manager was confronted, she stated that she was aware of the dissatisfaction but did nothing about it, resulting in conflict between the unhappy staff who are always on duty and on time and those who are deliberately not on duty because the unit manager tolerates their absence. Conflict is a situation where there is a conflict of interest between two persons or group (Muller, 2009:185). A hospital environment is exposed to many types of conflict that are compounded by the ever limited staffing supply, decrease in the availability of resources, and continuous changes (Zakari, Al Khamis & Hamadi, 2010:298). Conflicts are highly diverse and may occur from miscommunication and from group competition for resources (Zakari, et al. 2010:298). Conflict is inevitable were people work together. Frequent conflict is detrimental to the quality of a nurse’s working life. Conflict among nurses has the potential to have a negative impact on the retention of qualified nurses, new graduate nurses, and patients’ outcomes (Almost, Doran, Hall & Laschinger, 2010:982).

Zakari et al. (2010:298) stated that conflict between nurses generates negative feelings. The community service nurses believed that the unit manager showed favouritism and disrespect. Fox in Lee et al. (2012:790) found that the quality of interaction between staff members was unhealthy and went against the successful integration of new graduate nurses into the workplace.

The above conflict was due to the unit manager and community service nurses’ lack of communication. The unit manager is supposed to inform other staff members, including community service nurses, even if she does not explain the details of the problem. Failure to inform staff of arranged matters causes conflict, because the rest of the staff will consider it to be a case of favouritism, which may lead to the ward being unmanageable. The other staff might arrive late or absent themselves as a sign of their dissatisfaction. Poor nurse–to-nurse relationships may have significant consequences, such as poor work performance (Moore, Leahy, Sublet & Lanig, 2013:173). According to
the Labour Relations Act (Act no. 66 of 1995), every employee must work 40 hours per week. Therefore, the unit managers must communicate with the rest of the staff about any decisions they make, to prevent dissatisfaction that could lead to conflict, and explain how an absent individual is going to make up their unworked hours. When the employee has problems, arrangements must be made in such a way that every employee works for 40 hours. The employee may be given the opportunity to start work late but to leave late in order to make up the missed hours, or they may sign a leave form for the hours and days they didn’t work.

The participants stated that some of the matrons were unable to solve their off-duty problems when the unit managers changed shifts without informing them. Hamblin, Essnmarcher, Upfal, Russel, Luborsky, Ager, and Arnetz (2015:2459) concur with the findings stating that senior staff may bully newly graduated nurses. Bullying is the term used to describe disruptive personal behaviour; it involves a power gradient and causes on-going conflict (Moore et al., 2013:173). Evidence from literature shows that new graduate nurses are the most vulnerable to co-worker conflict. This happens because they usually avoid conflict by performing responsibilities allocated by the unit manager, which leaves them unsatisfied and stressed. Many nurses work in unhealthy environments where disruptive nurse-to-nurse relationships have become the norm. Unit managers are supposed to create environments that are free from conflict. Healthy environments will foster trust, respect for others, skilled communication, collaboration, and open, positive, face-to-face interaction (Moore et al., 2013:172).

Conflict affects new graduate nurses’ concentration, which may affect their performance. New graduate nurses who are targeted may have difficulty in being smoothly integrated into the profession due to continuous unresolved conflicts (Moore et al. 2013:173). The unit manager must treat all subordinates fairly and with respect to promote high morale in the ward. When subordinates are not treated fairly, they become demotivated, thus increasing staff turnover and poor nursing care. Therefore, the unit manager must discuss duty changes with the person involved and give reasons for the change. New graduate nurses are social human beings, and they plan their own lives according to their off-duty times. When off-duty times are changed without consultation,
it will cause an individual to absent herself, which will leave the remaining staff overworked.

The new graduate nurses have followed the correct channels of communication by reporting to the matron. According to the Labour Relations Act (Act no. 66 of 1995), a staff member must report to the immediate supervisor, and they do not get a response from the immediate supervisor, they should escalate the matter to the next level supervisor. The matron did not attend to new graduate nurses’ grievances accordingly. Strong nursing leadership is required to assist in the unit’s conflict management process, and to act in a professional manner when dealing with conflict situations (Zakari et al., 2010:298). As the professional code of ethics guides nursing practice, a good working environment guides and encourages nurses to work in a professional manner to reduce conflict. Good interpersonal relationships are the key to quality of work life.

Therefore, the hospital managers and unit managers must promote an environment that is conflict free. Moore et al. (2013: 173) suggest that the managers must implement zero-tolerance policies and a code of conduct must be applicable to all employees. The managers must apply conflict management processes when conflict is identified. The matron is supposed to follow the principles of conflict management when solving problems to prevent continuous conflict and to discourage it. Participants stated that conflict management is vital in nursing. Conflict management refers to the styles used by either or both parties to cope with a conflict (Leever, Hulst, Berendsen, Boendermaker, Roodenberg & Pols, 2010:613). According to Muller (2009:187), the following principles should be applied in a conflict management situation, namely identify the conflict, confrontation, solution, and assessment.

**Identify the conflict**

The conflict must be identified and both parties must admit that there is a problem. The nature and extent of the conflict should be analysed. In this study there was a misunderstanding between the unit manager and the new graduate nurse because the community service nurse was not satisfied about the change to her off-duty without
having been informed. The community service informed the unit manager about her dissatisfaction and she was ignored by the unit manager, which was against resolution of the conflict.

Confrontation
Confrontation is an intentional effort to assist the interested parties in their investigations of the causes and consequences of the conflict. The purpose of the confrontation is to search for the truth. The assistant director has to identify why the unit manager changed the off-duty times without informing the community service nurse. Both parties should be allowed to tell their sides of the story without sides being taken and all possible solutions should be listed.

Solution
The best suitable solution is selected, and the two parties have to agree to implement the solution. The plan of action is drawn up and the unit manager and the community service nurse must commit themselves to its implementation. The plan should promote harmony in the ward. The written agreement should be kept in the ward for future reference.

Assessment
The Assistant Director should do a continuous assessment to check the degree of peace and harmony. If peace has not been adequately achieved, the parties should be confronted again.

4.2.2.3 Poor communication

The participants stated that the Gauteng DoH failed to inform them about their placement and they did not ask the participants for their preference of a specific area before assigning them. They received assignment letters from the college stating the hospital and the department to which they had been assigned. They were not given the opportunity to change the hospital or department after their assignment. Communication is the interactive behaviour between people and it involves the transmission of a
message from one or more people (Muller, 2009:202). Communication is important and makes the community service nurses feel part of the decisions regarding the hospital allocation is integral to the process of growth. The findings were supported by Leever et al. (2010:613) who stated that communication requires that parties who perceive different aspects, communicate with each other. New graduate nurses reported frequent experiences of poor communication with other nurses.

The Gauteng DoH is responsible for assigning community service nurses to the clinical area. They were supposed to allow the community service nurses to choose their first and second preferences so that they could be assigned to where they would be productive. To assign them for the purpose of curbing nursing staff shortages was not a good idea, because people work better where they feel comfortable. When community service nurses are not satisfied with the assigned areas they are not productive and they are more likely to leave the hospital or ward after completing their one-year community service practice due to anger.

Therefore, the Gauteng DoH should improve their communication with the community service nurses so that they can retain them at the government hospitals. They can design the document in such a way that the community service nurses can choose the hospital and the department before final assignment is decided upon. The community service nurses must be allowed to change if they wish to do so, because if they work where they do not feel comfortable, there is the possibility of losing them.

Participants stated that favouritism existed in the ward because the unit manager gave information to auxiliary nurses due to trust and their long experience working in the ward. In every ward there is an organogram that shows the line of communication. An organogram is a graphic and written illustration of the job/post of individuals, which shows the line of authority (Muller, 2009:120). According to the organogram, the line of authority is from the unit manager to the registered nurses, community service nurses, enrolled nurses, and enrolled nursing auxiliary. The unit manager is supposed to disseminate information using the organogram. It is important to transmit messages in the right way and at the right time (Muller, 2009:206). Messages that are not well
transmitted in the ward cause friction and mistrust in unit managers, and promote poor morale, which will affect productivity.

Therefore, the unit manager must follow the line of communication in the ward. To give the information to the enrolled nursing auxiliary shows disrespect towards registered nurses and community service nurses, and it shows that authority is wielded over the most junior person because of their inexperience. The unit managers need to promote effective communication in the ward to improve the well-being and retention of new graduate nurses in the nursing profession (Suresh et al. 2012:776). The unit manager should be familiar with the internal and external communication methods so that messages will be transmitted in the most effective and efficient manner (Muller, 2009:206). Dyes and Sherman (2009:409) recommend the following strategies for effective and efficient communication in the ward:

- holding of regular meetings in the ward to create an environment that is conducive to communication by encouraging active participation during meetings;
- encouraging all members, especially community service nurses, to voice their concern to prevent conflict in the ward; and implementing an open door policy where the subordinates are encouraged to discuss urgent, burning issues instead of waiting for scheduled meetings.

Muller (2009:207) recommended the following strategies for effective and efficient communication in the ward:

**Patient Reports**

Patient reports should be handed over during shift changes so that everybody in the ward understands the patient’s condition in totality, which will promote patient care. The unit manager should educate everybody in the ward, especially the community service nurses, on how to give and receive good patient reports. Community service nurses must be encouraged to give patient reports under the supervision of the unit manager or registered nurses. Good report writing should be encouraged and reports must be written daily and whenever there is a need to promote good communication between nurses.
Management information system
A management information system is a means of communication using technology. The unit manager can promote communication by using technology such as telephones, emails, bundle messages, or whatsapp groups, especially with community service nurses since they are conversant with these methods that can reach everybody wherever they are, and it will deter favouritism. Members should be encouraged to read their emails always to prevent missing important messages.

Communication book
Subordinates should be encouraged to read the communication book daily and regularly. They must also write important information in the communication book to keep staff updated.

Bulletin board
The bulletin board is a communication strategy that is located in a prominent place and is accessible to everybody. The unit manager must keep all circulars and notices on the bulletin board after reading them. Community service nurses must be educated and encouraged to check and read circulars and notices, especially after returning from off-duty or leave. The staff should be educated as to how long messages can stay on the bulletin board before they should be filed.

The participants complained that the unit manager shouted at them. They felt that they were criticised for the mistakes they made but when they did well nobody appreciated their efforts. Lee et al. (2012:792) concur with the findings by stating that new graduate nurses were openly and publicly criticised and this behaviour was considered as the norm. Lee et al. (2012:795) state that senior managers do not question themselves about their ill-treatment of new graduate nurses because they perceive the behaviour as acceptable.

The new graduate nurses' satisfaction with the team is characterised by respectful interaction with other health care professionals (Pfaff, Baxter, Jack & Ploeg, 2014:1147). The unit manager should reprimand staff with respect and should do so in
private. The unit manager must praise staff for a job well done, to encourage them to work well. New graduate nurses need support from the experienced registered nurses, unit managers, and assistant directors during their transition period. The ill-treatment of new graduate nurses results in them being afraid to ask question when there is a need to do so, which will affect effective integration into the workplace and create dysfunctional relationships. Pfaff et al. (2014:1146) state that the amount of respect and communication senior nurses shows to new graduate nurses can promote or break communication and trust. Building trust is not easy, and the nursing profession can lose the community service nurses who are the future backbone of the nursing profession.

Therefore, unit managers must promote harmony in the unit by respecting all nursing staff in the unit, especially community service nurses. Harmony refers to creating unity and a pleasant atmosphere in a group. Harmony is accomplished by teamwork, positive morale, and members’ motivation (Muller, 2009:173).

Good management is the key to attracting and retaining new graduate nurses. Lack of management support may demoralise new graduate nurses perceptions of a nursing career, which may contribute to their desire to leave the profession after completion of their one-year community service practice. The nursing managers should create an environment that is conducive to nursing practice and promotes the effective transition of community service nurses from novice to expert. The environment should have adequate human and material resources, promote good interpersonal relationships, and be free from conflict.

### 4.2.3 Negative Attitudes of Staff Members

The participants stated that experienced nursing staff’s negative attitudes contributed to the poor quality of nursing care. According to Louw and Edwards (2011:176), attitude is described as irreverent behaviour. Participants were unable to question experienced registered nurses when they experienced nursing challenges. They described such attitudes as a reality shock because they were not expecting these attitudes. The sub-categories of attitude were identified as disrespect, name-calling, and intolerance.
4.2.3.1 Disrespect, name calling and intolerance

- **Disrespect**

The participants stated that they were disrespected by all categories, namely managers, experienced registered nurses, enrolled nurses, enrolled auxiliary nurses, and radiographers, because they were community service nurses. Disrespect is when one person undermines another in the working environment. Duncan, Maclntosh, and Taylor (2008:238) described disrespect as the horizontal hostility that occurs in academic and clinical settings. Horizontal hostility includes criticism, verbal abuse, and apathy towards fellow nurses in the workplace (Duncan et al. 2008:238). Longo et al. in Dyess and Sherman (2009:407) defined disrespect as the horizontal violence and aggression demonstrated by colleagues, and it includes emotional, physical, and verbal threats, and criticism. Victims of bullying may suffer from stress-related health problems such as nausea, headaches, insomnia, anxiety, and depression (Townsend, 2011:14). Participants in Dyess and Sherman’s study (2009:407) stated that they too experienced unkind nurses in their practice settings.

Community service nurses need to be respected like any other human being; if they are not respected they will not respect others and there will be no teamwork. When there is no teamwork, the patient will not receive quality patient care, and the community service nurses will be stressed. Disrespect will result in dysfunctional relationships in the ward (Lee et al. 2012:790). Longo and Sherman (2007:41) explain that it is a nurse’s right to work in a violence-free environment.

Therefore, the nursing managers should encourage respect between employees and nobody should be allowed to disrespect others but treat each other with dignity and respect. According to the Constitution of Republic of South African (Act 108 of 1996 chapter 2) everybody has the right to dignity. In wards where members respect each other, members have strong relationships and work as a team, which influences quality nursing care and encourages community service nurses to stay in the profession or at the health care facility. During induction, the community service nurses should be informed on how to deal with disrespect in the ward. Specific information about
horizontal violence should be shared with new graduate nurses (Dyess & Sherman, 2009:407). The community service nurses should be informed about the Labour Relations Act (Act no. 66 of 1995, as amended), and should be encouraged to read it as it will help them to identify unacceptable behaviour and to report such behaviour.

The participants stated that the matrons shouted at them in front of their patients. The participants thought that the patients would lose faith and confidence in them because patients can identify matrons by their different uniforms. These findings were supported by Lee et al. (2012:792) who stated that senior nurses were openly and publicly criticise the new graduate nurses. This type of criticism is considered as workplace violence, as abusive, and is unwarranted behaviour (Lee et al. 2012:795). Laschinger (2012:475) describes this type of behaviour as bullying. Workplace bullying is a situation where someone is subjected to social isolation or exclusion, their work effort is devalued, they are threatened, and bad comments are aimed at tormenting or frustrating them (Laschinger, 2012:475). Participants stated that the unit manager isolated the community service nurses from the rest of the team. The participants further stated that when somebody shouted at them they took it to mean that they were stupid, and this type of behaviour lowers self esteem and confidence. Muller (2009:184) states that managers should be sensitive to the subordinates because subordinates expect to be treated with dignity by managers. The manager should identify the community service nurses' needs and treat them with consideration. If the unit manager identifies a weakness or inappropriate behaviour from the community service nurses, the unit manager should call them, and if necessary, send them to attend an appropriate workshop.

Being ridiculed by the unit manager in front of patients and juniors demonstrates lack of respect. The formation of cliques that excludes new graduate nurses causes discontent among community service nurses (Kelly et al. in Laschinger 2012:474). According to Boychuck and Duchser in Laschinger (2012:474), the new graduate nurses experience negative workgroup interaction, which results in high levels of incivility and burnout. Workplace incivility is defined as a deviant behaviour with ambiguous intent to harm the
new graduate nurse, and is in violation of workplace norms for mutual respect (Laschinger, 2012:474)

The community service nurses are human beings and they need to be respected by the managers. Disrespect creates an environment that is not safe for the patients because of poor teamwork that results from disrespect. Community service nurses may ignore the ill-treatment or be aggressive towards their seniors, resulting in chaos in the ward. When community service nurses don’t listen to their seniors or argue with them in front of patients, chaos may ensue. This behaviour will cause tension and it will affect nursing care because the community service nurses may absent themselves from work and even consider leaving the hospital at the end of the contract period as they don’t believe that their contribution to the ward is valued. Quine in Laschinger (2012:475) found that nurses who experienced bullying had lower job satisfaction, lower self esteem, lacked confidence, had higher turnover intentions, experienced increased clinical levels of anxiety and depression, and took more sick days. New graduate nurses tolerated ill treatment, but later in the transition process, they use passive aggression (Lee et al. 2012:795). Passive aggression is a non-verbal aggression that manifests in negative behaviour. The individual will bottle up their feelings, grow quiet, and give angry looks to other (Ham, 2011:n.p.). Therefore, the community service nurses must be encouraged to report disrespect or bullying as soon as possible. Townsend (2011:15) recommends the following strategy to prevent bullying in the work environment.

Creating a healthy work environment

The unit manager should encourage respect for every staff member, including new graduate nurses. New graduate nurses should be welcomed and made to feel part of the ward or organisation. The unit manager should use a conflict management strategy when confronting the perpetrator. Unit managers should act as role models to demonstrate professional behaviour. Professional behaviour includes respect for fellow colleagues. Unit managers should not shout at subordinates or reprimand them in front of others, and they should not divulge any personal information to fellow colleagues.
Zero tolerance policy on ill treatment of staff

The unit manager has a direct responsibility to set standards of zero-tolerance. New graduate nurses must be informed about the zero-tolerance policy during orientation and should be encouraged to make use of the policy. Flateau-Lux and Gravels' (2014:228) strategies to ensure zero-tolerance policy are as follows:

- developing a ward-based code of conduct to eliminate horizontal violence;
- empowering new graduate nurses to report nurses who perpetrate violence without fear of retaliation;
- discussing any bullying incidents during staff meetings;
- providing new graduate nurses with conflict management skills; and
- reinforcing and enforcing processes to address and eliminate incidence of horizontal violence.

The participants stated that they developed a strategy of not delegating tasks to the enrolled nurses but rather carrying out the duties themselves because the enrolled nurses do not accept the delegations, which leads to exhaustion and stress. In support, Dyess and Sherman’s study (2009:407) participants stated that they experienced a situation where unlicensed staff did not respond to a request and the participants chose to ignore them and do the task themselves.

Delegation refers to the supervisor’s division of duties, tasks, and responsibilities (Muller, 2009:125). The purpose of delegation is to render quality patient care (Ruff, 2011:7). Enrolled nurses should understand that delegation is not done according to the enrolled nurses experience but according to the principles and processes of delegation, which require assessment of work, subordinate’s competencies/abilities, and their professional accountabilities (Muller, 2009:125).

Assessment of work

The supervisor has to analyse the nature, type, and amount of work and the scope of practice. The community service nurses cannot delegate the responsibilities of professional nurses to the enrolled nurses because their scope of practice only allows them to do limited work. Delegation does not end when delegating, but the person who
delegates the duties must take full responsibility for the performance of that duty, therefore according to the scope of practice, the enrolled nurses must function under a qualified professional nurse.

**Assessment of subordinates**

Assessment of subordinate requires the supervisor to know whether or not the subordinates have the required competencies/abilities to perform the task safely and adequately. Due to the subordinates’ limited scope of practice, there are duties and responsibilities that cannot be delegated to them. Community service nurses may not have experience but they are senior to the enrolled nurses. Therefore, the enrolled nurses must learn to respect the delegated work conferred to them by community service nurses.

**Delegation of duties, tasks, and responsibilities**

Professional accountability can only be delegated to professional nurses. The delegator should exercise the necessary supervision and control, which are the professional nurses responsibilities. The delegator must utilise the principles of leadership according to the type of subordinates they are dealing with. Therefore the enrolled nurses must accept the fact that the community service nurses are practicing as professional nurses and they have to supervise them.

Therefore, the unit managers must support the community service nurses by ensuring that all delegated staff functions according to their scope of practice. The necessary disciplinary steps must be followed against those who do not work according to the delegation, because that type of behaviour is insubordination. Insubordination is defined as an unwillingness to submit to authority, either through an open refusal disobeying orders, failure to carry out orders, or an attempt to undermine managerial authority (Labour Relations Act, Act no. 66 of 1995, as amended). The unit manager has the responsibility to discipline personnel who fail to conform to the organisation’s code of conduct (Muller, 2009:323).
**Name calling**

The participants felt unhappy and disappointed because they were called by different names. They were called ‘community serve nurse’, ‘the one who has just qualified’, ‘slow learners’, ‘just arrived’ and ‘Simakaleng’ meaning ‘always wandering and lost’, ‘mafikizolo’ meaning you have just arrived yesterday, ‘sethotho’ meaning ‘you are stupid’, and ‘spanner’ meaning ‘you replace where there is a shortage’. Community service nurses felt that being called names was a sign of disrespect and non-acceptance by the ward staff.

The participants stated that they were called ‘slow leaner’ or ‘dumb’ because they did not learn fast enough. They decided not to question their superiors if they did not understand but rather sought information from their peers. New graduate nurses do not want to appear stupid amongst their peers and fellow colleagues (Teoh, Pua & Chan, 2012:145). The term ‘slow leaner’ undermines the intelligence of community service nurses. They maybe new in their roles and may be unfamiliar with new procedures, diagnosis, equipment, standards, and the environment but they are qualified nurses who merely need time to settle into their new roles.

The community service nurses can settle well into their new roles with the help of senior nurses. The manner in which the new graduate nurses are addressed causes them stress (Suresh et al. 2012:774). Stress is caused by intimidation, and lack of respect from permanent staff that have been in the ward for a long period. Name-calling causes community service nurses to experience low self esteem and poor morale, leading to absenteeism or the possibility of resigning after their one-year community service contract expires. The community service nurses feel powerless when they are called names. Lee et al. (2012:792) state that new graduate nurses are faced with difficulties and do not know how to ask for help or how to ask senior nurses questions. The above behaviour is seen as abusive and unwarranted (Lee et al. 2012:795).

Community service nurses need senior professional nurses to clarify some of the challenges they identified during their transition period. Failure to ask questions from senior nurses will hinder community service nurses’ progress and they will not gain confidence. The nursing profession has a high rate of staff shortages, and therefore
community service nurses need to be supported during their transition periods since they are valuable future nurses who are going to be the backbone of the nursing profession.

Therefore, community service nurses must be called by their legal names. The experienced registered nurses should be patient with the community service nurses, and allow them to ask as many questions as possible because this transition period adjustment is a challenge for them (Lee et al. 2012:795). The participants believe that the name ‘community service nurse’ should not be used because they are taken for granted. The community service nurses believe that they are bullied because they are ‘community service nurses.

- Intolerance
Participants stated that the registered nurses were impatient, agitated, and irritable. Dyess and Sherman (2009:408) state that new graduate nurses have many questions when they enter practice and seek advice from registered nurses. The registered nurses were described as resources for information, but others were unwilling to respond to the new graduate nurses questions (Chandler, 2012:106). The new graduate nurses reported that they received incorrect answers from registered nurses (Dyess & Sherman, 2009:408). The new graduate nurses felt stupid when they asked questions that were unanswered (Chandler, 2012:106).

The registered nurses have to keep their knowledge up to date so that they are able to give new graduate nurses correct information. Incorrect information will endanger the patients’ lives because the new graduate nurses may continue using that incorrect information. To ensure patient safety, registered nurses need to update their knowledge, because the new graduate nurses are expected to ask for advice or assistance at any time when the need arises (Ballem & McIntosh, 2014:381). Therefore, the registered nurses should continuously develop themselves to keep abreast with current knowledge. There should be continuous, structured in-service training for all nurses to avoid intolerance due to insecurity and to provide safe patient care. Ballem & Mcintosh (2014:384) recommend the following strategies:
• knowledge prevents intolerance and builds patience;
• registered nurses should be knowledgeable and encourage new graduate nurses to ask questions; and
• managers should pair mentors with new graduate nurses to ensure that transmission of knowledge remains consistent throughout.

Having a mentor reduces the frustration that new graduate nurses feel and it facilitates learning the organisation’s policies and procedures (Dyess & Sherman, 2009:409).

The participants stated that the doctors shouted at them during resuscitation. They further stated that the shouting confused them because they did not understand what the doctors needed. Billings and Halstead (2009:95) state that the highest incidence of workplace violence occurs during emergency. Environment challenges are characterised by high stress, which requires excellent communication. The stress is aggravated by the need to save lives. Billings and Halstead (2009:95) state that disruptive behaviour during resuscitation undermines the quest to save a patient’s life. During emergency there should be calm and respectful communication so that everybody can understand and follow instructions from the leader of the resuscitation. Best patient care practice is facilitated by teamwork and acceptable attitudes by all team members.

4.3 SUMMARY

The unit managers should promote an environment that is conducive to the transition of community service nurses. There should be a mutual respect between all stakeholders, including the community service nurses. All staff members must be called by their real names. There should be zero-tolerance to name calling. The environment must encourage community service nurses to question for clarity, and correct answers should be provided. Intolerance, disrespect, poor communication, and name-calling result from insecurity that is due to a lack of knowledge. Therefore, building confidence through up-skilling of professional nurses and community nurses is the answer to these challenges.
CHAPTER FIVE
STRATEGIES, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION

5.1 INTRODUCTION

This chapter focuses on the experiences of new nursing graduates regarding community service practice in Johannesburg. Strategies are described following extensive conceptualisation of the findings within the relevant literature, and the researcher’s interpretation of the findings led to the conclusions. Conclusions form the basis of the described strategies. The limitations, recommendations, and conclusion of the study are described in this chapter.

The presented strategies answer the second research question:

- What should be done to improve the community service practice of new graduate nurses in a Johannesburg hospital?

The supporting strategies in table 5.1 are in accordance with the categories and sub-categories indicated in table 3.1 in Chapter Three.

5.2 STRATEGIES TO IMPROVE COMMUNITY SERVICE PRACTICE IN JOHANNESBURG

A strategy refers to the formulation of an organisation’s goals and objectives and the action plans to achieve those objectives over a specific period of time, in order to allocate resources that will create a competitive advantage over a similar organisation. A strategy is a plan of action that prescribes resource allocation and other activities for dealing with the environment and helping the organisation to attain its goals (Muller, Bezuidenhout & Jooste, 2011:569).
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<tr>
<th>CATEGORY</th>
<th>SUB-CATEGORIES</th>
<th>OBJECTIVES</th>
<th>SUPPORTING STRATEGY OR ACTION</th>
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</table>
| 5.1.1 Lack of teaching, guidance, and support | 5.1.1.1 Lack of teaching, supervision, and support | To create an environment that is conducive to teach, supervise, and support the community service nurses | • Participatory management should be encouraged to have a planned teaching programme in the ward (Leggat, Balding & Schiftan, 2015:1582)  
• Community service nurses should be sent to workshops and in-service training programmes to upgrade their knowledge and skills (Leggat et al., 2015:1582)  
• The unit manager should teach and involve community service nurses during ward rounds so that they can learn different types of diagnosis and their management (Leggat et al., 2015:1582)  
• The unit manager should allocate some of the responsibilities to community service nurses under the supervision of an experienced registered nurse (Leggat et al., 2015:1582)  
• The unit manager should provide a mentor to clarify any of the community service nurse concerns (Sherman & Bishop, 2007:75) |
• The unit manager should allow the community service nurses to attend leaders’ meetings, and they should give feedback in the ward (Sherman & Bishop, 2007:25)

• The unit manager should give community service nurses assignments to collect data, to analyse the work, and to create a plan of action related to their findings (Hillman & Foster, 2010:54)

• On-going support to strengthen competency and reduce high turnover should be provided (Dyess & Sherman, 2009:405)

• Simulations should be provided for the development of opportunities for decision-making skills through the use of critical thinking, technical skills, and self confidence (Ackerman in Hillman & Foster, 2010:54)

• Community service nurses should be encouraged to use reflective narrative reflective journals, individual interviews, and the use of preceptors and coaching, which will emphasise the development of clinical skills, critical thinking, and skills development (Fonreris & Paden-McAlpine, 2007:412)
• The institution should provide a one-year support programme for skills development (Dyess & Sherman, 2009:405)

• There should be a formal mentorship programme for community service nurses that should be evaluated annually for its effectiveness (Maben et al., 2006:475; Ballem & MacIntosh, 2015:384; Sherman & Bishop, 2007:25; Horsburg & Ross, 2013:1131; Leggat et al., 2015:1578)

• The unit manager should discuss the uncivil behaviour or performance of both registered professional nurses and the community service nurses, and correct the behaviour that could derail a nursing career (Sherman & Bishop, 2007:25)

• The unit manager should identify the community service nurses’ talents and develop them at an early stage (Sherman & Bishop, 2007:25)

• After the completion of community service practice, the Gauteng DoH should conduct an experiential survey with community service nurses to determine their work satisfaction and determine areas of improvement
| 5.1.1.2 Fear / uncertainty resulting from lack of experience | To alleviate anxiety and build confidence in community service nurses | • Community service nurses should not be allocated the responsibility of managing a ward without supervision (Duchscher, 2008:448).
• The Gauteng DoH should implement peer support networks and encourage colleagues to promote free conversation regarding their experiences (Horsburg & Ross, 2013:1131)
• Community service nurses should receive training in interpersonal relationships and communication skills to increase their confidence (Dyess & Sherman, 2009:407)

| 5.1.2 Lack of management support | 5.1.2.1 Lack of resources | To ensure provision of adequate human and material resources to promote good quality nursing care | • To curb the shortage of nursing staff the hospital should use caregivers and support staff to perform non-nursing tasks, giving experienced registered nurses the opportunity to induct community service nurses (Draffron & Hart, 2001:208, Hassmiller &

(Nematollahi & Isaac, 2011:198)
• The hospital management should design and provide specific programmes to assist community service nurses in highly specialised areas like the ICU (Dyess & Sherman, 2009:408)
| 5.1.2.2 Lack of conflict management | To improve and maintain good interpersonal relationships | • A healthy environment should be provided to foster trust, respect for others, skilled communication, collaboration, and open face-to-face interaction (Moore et al., 2013:172)  
• The ward needs strong nursing leadership to assist in the conflict management process (Zakari et al., 2010:298)  
• There should be a zero-tolerance policy on code of conduct transgressions for all employees (Moore et al., 2013:173) |
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<td>5.1.2.3 Poor communication</td>
<td>To promote good communication in the ward</td>
<td>• The unit manager should promote effective and appropriate communication in the ward to improve the</td>
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well-being and retention of community service nurses in the nursing profession (Suresh et al., 2012:776)

- It is important that top management transmit messages in the most effective and efficient way in the ward (Muller, 2009:206)
- Regular ward meetings should be held to create an environment of free conversation and thoughts and feelings can be shared (Dyess & Sherman, 2009:448)
- An open-door policy in the ward should be implemented where subordinates are encouraged to discuss urgent issues freely (Dyess & Sherman, 2009:409)
- Proper handing over of the patient reports during shift changes should be encouraged so that everybody understands the patient’s condition in totality, to promote continuity of patient care (Dyess & Sherman, 2009:409)
- The unit manager should promote communication by using a management information system where whatsapp and bulk messages are used to reach all employees (Dyess & Sherman, 2009:409)
| 5.1.3 Negative attitudes of staff members | Disrespect | To promote mutual respect in the unit | - The unit manager should have a communication book in the ward and encourage subordinates to read it daily and to regularly update themselves on the ward happenings (Dyess & Sherman, 2009:409)  
- All circulars and notices should be kept on the bulletin board to facilitate communication (Dyess & Sherman, 2009:409)  
- The unit manager should promote harmony in the ward by respecting all staff, including community service nurses (Muller, 2009:173)  
- The unit manager should address specific information about horizontal violence with the community service nurses (Dyess & Sherman, 2009:407)  
- The unit manager should create a healthy working environment to encourage respect for every staff member, including community service nurses (Townsend, 2012:15)  
- Ill-treatment of staff should not be tolerated (Townsend, 2012:15, Flateau & Gravels, 2014:228)  
- The unit manager should discipline the personnel who fail to conform to the organisational code of conduct |
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<tr>
<td>Name-calling</td>
<td>To encourage correct use of names</td>
<td>The experienced registered nurses should be patient with community service nurses and allow them to ask as many questions as possible (Lee et al., 2012:795).</td>
<td>There should be zero tolerance of name-calling (Townsend, 2012:15, Flateau &amp; Gravels, 2014:228)</td>
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<tr>
<td>Intolerance</td>
<td>To promote tolerance towards each other</td>
<td>Lack of knowledge creates insecurity and intolerance. Registered nurses should be knowledgeable and encourage community service nurses to ask questions (Dyess &amp; Sherman, 2009:409).</td>
<td>The unit manager should pair mentors with community service nurses and ensure that transmission of knowledge remains consistent throughout (Dyess &amp; Sherman, 2009:409). The unit manager should discourage disruptive behaviour during procedures such as resuscitation (Billings &amp; Halstead, 2009: 95).</td>
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5.3 LIMITATIONS

The study was conducted in one public hospital, which limits the generalisation of the findings.

5.4 RECOMMENDATIONS

The recommendations are based on the findings of the study in terms of nursing practice, nursing education, and nursing research.

5.4.1 Nursing practice

The described strategies should be implemented in order to improve the practice of community service nurses in Johannesburg hospital. The Gauteng DoH should conduct a perceptual survey to explore the experiences of community service nurses on the completion of their contracts.

5.4.2 Nursing education

Professional nurses should have in-service education on the implementation of the described strategies. Mentorship, coaching, guidance, and support should be the order of the day to retain community service nurses.

5.4.3 Nursing research

A replication of this study should be done in other public hospitals in order to generalise the findings. A hypothesis could be generated from the study and tested for its feasibility through research.

5.5 CONCLUSION

This chapter focused on the description of strategies, limitations, general recommendations, and conclusion. It would be interesting to explore the experiences of professional nurses working with community service nurses to get a broader picture of their problems.
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ANNEXURE A

FACULTY OF HEALTH SCIENCES

HIGHER DEGREES COMMITTEE

HDC 55/02-2011
29 August 2011

TITLE OF RESEARCH PROPOSAL: Experiences of new nurse graduates regarding community service practice in Johannesburg

DEPARTMENT OR PROGRAMME: MCUR: Nursing

RESEARCHER: MKANSI, MIH STUDENT NO. 920314914

SUPERVISOR: Prof MM Chabedi

CO-SUPERVISOR: Ms J Malesela

The Faculty Higher Degree Committee has scrutinised your research proposal and confirm that it complies with the approved research standards of University of Johannesburg.

The attached recommendations were made by the committee which will improve the quality of your proposal.

Please make these changes and corrections to the satisfaction of the supervisor(s) and submit a corrected copy of the proposal to the Faculty Research Administrator.

The HDC would like to extend their good wishes to you in your endeavour of your research project.

Yours sincerely,

Prof. Heidi Abrahams

Chair: Faculty of Health Sciences HDC
ANNEXURE B

FACULTY OF HEALTH SCIENCES
ACADEMIC ETHICS COMMITTEE

AEC56/01-2011
29 August 2011

TITLE OF RESEARCH PROPOSAL: Experiences of new nurse graduates regarding community service practice in Johannesburg

DEPARTMENT OR PROGRAMME: M.CUR: Nursing

RESEARCHER: MKANSI, MH STUDENT NO. 220314914
SUPERVISOR: Prof MM Chabedi
CO-SUPERVISOR: Ms J Malesela

The Faculty Academic Ethics Committee has scrutinised your research proposal and confirm that it complies with the approved ethical standards of the University of Johannesburg.

The AEC would like to extend their good wishes to you in your endeavour of your research project.

Yours sincerely

[Signature]
Prof M Poggenpoel
Chair: Faculty of Health Sciences: AEC
MEDICAL ADVISORY COMMITTEE
CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL
PERMISSION TO CONDUCT RESEARCH
Date: 10 July 2012

TITLE OF PROJECT: The experience of new graduates in nursing regarding community service practice in Johannesburg clinical facilities

UNIVERSITY: Johannesburg

Principal Investigator: Ms M Mkansi

Department: Nursing Education

Supervisor (if relevant): Prof M Chabell and Ms Malesela

Permission Head Department (where research conducted):

Date of start of proposed study: As soon as permission is granted

Date of completion of data collection: Two months after starting

The Medical Advisory Committee recommends that the said research be conducted at Chris Hani Baragwanath Hospital. The CEO/management of Chris Hani Baragwanath Hospital is accordingly informed and the study is subject to:

- Permission having been granted by the Committee for Ethics Committee of the University of Johannesburg;
- the Hospital will not incur extra costs as a result of the research being conducted on its patients within the hospital;
- the MAC will be informed of any serious adverse events as soon as they occur;
- permission is granted for the duration of the Ethics Committee approval.

Recommended
(On behalf of the MAC)
Date: 10 July 2012

Approved/Not Approved
Hospital Management
Date: 13/07/12

Reviewed by
19/07/2012
ANNEXURE D

Health and Social Development
Department: Health and Social Development
GAUTENG PROVINCE

Vision of the Department

“To be the first provider of quality health and social services to the people in Gauteng”

POLICY, PLANNING AND RESEARCH (PPR)
Enquiries: Dr B Ikalaeng
Tel: +2711 335 3500
Fax: +2711 335 3675 Email: Bridget.Ikalaeng@gauteng.gov.za

<table>
<thead>
<tr>
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<tr>
<td>Contact number</td>
<td>Tel: 011 983 3047</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:Mahlodi.Mkansi@gauteng.gov.za">Mahlodi.Mkansi@gauteng.gov.za</a></td>
</tr>
<tr>
<td>Researcher /Principal investigator (PI)</td>
<td>Mkaladi Mahlodi Helen</td>
</tr>
<tr>
<td>Supervisor</td>
<td>Prof M Chabali</td>
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<tr>
<td>Institution</td>
<td>University of Johannesburg</td>
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<tr>
<td>Research title</td>
<td>The experience of new graduates in nursing regarding community service practice in Johannesburg clinical facilities.</td>
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</table>

This approval is granted only for a research proposal submitted to GDHSD by Mkaladi Mahlodi Helen entitled “The experience of new graduates in nursing regarding community service practice in Johannesburg clinical facilities.”
Approval is hereby granted by the Gauteng Department of Health and Social Development for the above mentioned research study proposal for a study to be conducted within GDHSD domain. Approval is limited to compliance with the following terms and conditions:

1. All principles and South African regulations pertaining to ethics of research are observed and adhered to by all involved in the research project. Ethics approval is only acceptable if it has been provided by a South African research ethics committee which is accredited by the National Health Research Ethics Council (NHREC) of South Africa; this is regardless of whether ethics approval has been granted elsewhere.

Of key importance for all researchers is that they abide by all research ethics principles and practice relating to human subjects as contained in the Declaration of Helsinki (1964, amended in 1983) and the constitution of the Republic of South Africa in its entirety. Declaration of Helsinki upholds the following principles when conducting research, respect for:

- Human dignity;
- Autonomy;
- Informed consent;
- Vulnerable persons;
- Confidentiality;
- Lack of harm;
- Maximum benefit;
- and justice

2. The GDHSD is indemnified from any form of liability arising from or as a consequence of the process or outcomes of any research approved by HOD and conducted within the GDHSD domain;

3. Researchers commit to providing the GDHSD with periodic progress and a final report; short term projects are expected to submit progress reports on a more frequent basis and all reports must be submitted to the Director: Policy, Planning and Research of the GDHSD;

4. The Principal Investigator shall promptly inform the above mentioned office of changes of contact details or physical address of the researching individual, organisation or team;

5. The Principal Investigator shall inform the above office and make arrangements to discuss their findings with GDHSD prior to dissemination;

6. The Principal Investigator shall promptly inform the above mentioned office of any adverse situation which may be a health hazard to any of the participants;

7. The Principal Investigator shall request in writing authorization by the HOD via PPR for any intended changes of any form to the original and approved research proposal;

8. If for any reason the research is discontinued, the Principal Investigator must inform the above mentioned office of the reasons for such discontinuation;

9. A formal research report upon completion should be submitted to the Director: Policy, Planning and Research of the GDHSD with recommendations and implications for GDHSD, the Directorate will make this report available for the HOD.

This approval is granted only for a research proposal submitted to GDHSD by Mkiansi Mahloeti Helen entitled “The experience of new graduates in nursing regarding community service practice in Johannesburg clinical facilities.”
AGREEMENT BETWEEN THE GAUTENG DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT (GDHSD) AND THE

RESEARCHER

Mrs. C Nkosi
Acting Director; Policy Planning and Research

Date: 2011/12/13

Signature: [Signature]

Name and surname of Principal Researcher

Research/Academic Institution

Date:

Signature: [Signature]

This approval is granted only for a research proposal submitted to GDHSD by Mkansi Mahlodi Helen entitled "The experience of new graduates in nursing regarding community service practice in Johannesburg clinical facilities."
Dear Prospective Participant

CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

I wish to invite you to participate in a research project entitled: “The experience of new graduates in nursing regarding community service practice in Johannesburg”, as part of the requirement for the acquisition of a Masters degree in Professional Nursing Science: Nursing Education. This study will be conducted under the supervision and guidance of Prof. M.M Chabeli and Mrs. J. Malesela of the Department of Nursing at the University of Johannesburg.

The purpose and objective of the research project is to explore and describe the lived experience of new graduate nurses regarding community service practice. Data will be collected from graduates' nurses who have completed their one year community service in 2010 who were purposefully selected through individual face-to-face semi-structured interviews. Two questions will be posed: what are your experiences regarding community service practice in Johannesburg? What should be done in order to improve community service practice in nursing? Probing will be done to get the in-depth information regarding the phenomenon. Each interview will last approximately 45 to 60 minutes. I request permission to audiotape the interviews in order to increase the accuracy and credibility of data collected and to assist with verbatim transcription of the information. These audiotapes will be kept in safe place under lock and key and will be destroyed two years after completion of the study. Permission will be obtained from the University of Johannesburg, the Faculty of Health Science Higher degree and Ethics Committee, the Department of Health, the participants and the management of the participating hospital before commencing with the data collection.

Arrangement will be made with you once permission has been granted as to the date, time and venue where the individual interview will be conducted within a private comfortable venue away from disturbances.

Your participation in this study will be voluntary and you have the right to withdraw at any stage of the research should you wish to do so. Your name will not be divulged during the interview process related to this study. The interviewer will keep your name anonymous and refer to participants using code. The name of your institution will not be divulged. The information related to the interviews will not be accessible to anyone except the supervisor, the co-supervisor, the interviewer and the independent co-coder who will be purposefully selected because of the expertise in qualitative research.

The results of the study may be published in a professional journal or presented at professional conferences. The researcher does not envisage any risks from the study. The benefit of this study is that strategies to improve the community service practice around
Johannesburg will be described. The research results will be available to you on request. Your signing of the consent below will be indication of agreeing to participate voluntarily in the study.

Please feel free to ask question about the study and about being a participant in this study from the following contact details.

Fax: (011) 794 8210
E-mail: m.mkansi@yahoo.com
Postal address: Box 2113
            Randparkridge
            2156

Thanking you in advance,

..................................................................
MKANSI M.H. (MCUR STUDENT)

..................................................................
Prof. M.M.CHABEDLI (SUPERVISOR)

..................................................................
MERS.J.MALESELA (CO-SUPERVISOR)

CONSENT FORM FOR PARTICIPATION

I ....................................................., understand the purpose of the study. I also understand that my rights as a participant will be respected. I voluntarily consent to participate in the study without fear of intimidation. I understand that I can withdraw from participation at any stage of the study.

Participant’s Name:...............................Signature:....................Date:........................

CONSENT FORM FOR PERMISSION TO USE TAPE RECORDER

I ....................................................., understand the purpose of the study. I also understand that my rights as a participant will be respected. I voluntarily consent to participate in the study without fear of intimidation. I understand that I can withdraw from participation at any stage of the study.

Participant's Name:...............................Signature:....................Date:........................
ANNEXURE F

ISABELLA MORRIS
Editor
M.A. Writing – University of the Witwatersrand

1E Westlake Drive, Lakeside, 1609
081-0468501

15 December 2015

TO WHOM IT MAY CONCERN

University of Johannesburg

Dear Sir/Madam,

CERTIFICATE OF EDITING – MH Mkansi

I hereby confirm that Mahlodi Helen Mkansi’s dissertation entitled “EXPERIENCES OF NEW NURSING GRADUATES REGARDING COMMUNITY SERVICE PRACTICE IN JOHANNESBURG” for the University of Johannesburg was edited by me in November 2015.

I have not had sight of the final document reflecting acceptance or rejection of suggested edits.

Sincerely

Isabella Morris
Professional Editors’ Guild Associate Editor
Box 2113  
Randparkridge  
2156  
17/06/2014

Dear Doctor Mahape

Kindly analyse the enclosed data from the transcribed (11) audiotaped individual interviews using Tesch’s protocol (in Creswell, 1994: 154-155) of open coding:
1. Read through all the transcriptions carefully to get a sense of the whole. Ideas will be written down as they come to mind.
2. One short interesting interview will be selected and thoughts will be written on the margins.
3. A list of all topics will be made and similar topics will be clustered together and these topics will be formed into columns that will be arranged as major topics, unique topics and left overs.
4. Topics will be abbreviated as codes, and codes will be written next to appropriate segments of text.
5. Find the most descriptive wording for topics and turn them into categories. The total list of categories will be reduced by grouping the topics that relate to each other. Lines between categories will be drawn to show interrelationships.
6. A final decision will be made on the abbreviation for each category and these codes will be alphabetized.
7. The data material belonging to each category will be assembled in one place and a preliminary analysis will be performed.
8. The existing data will be recorded.

N.B. A copy of Chapter One of the study has been attached.

Thanking you in anticipation,
Mahledi Helen Mkanshi
MCur (Nursing Education) student

Dr. Mahape

08-07-2014
ANNEXURE H

Participant 03

Interviewer: How is it like to be a community service nurse in Johannesburg clinical area?

Participant: Ok! Let’s start by when they were placing you, they don’t tell you where you was going to be placed. I was just surprised; they gave me a letter that you are going to be placed at such and such hospital or wherever. But they didn’t tell me which department. When it came to placing, you find out that you didn’t like the department. They didn’t give me/us an opportunity to change or anything but I didn’t like that department. I wished to change because I didn’t enjoy myself in that department but I have to work.

Interviewer: Tell me more about enjoying yourself?

Participant: Maybe one will love to work in labour ward, and one will love to work with kids at paediatric, if maybe you are placed in paediatric ward you will be enjoying your work but you are doing what you love, but now you are placed maybe labour ward and you don’t like it. I know you are taught you are qualified to work at that place, but we are humans. You have to be comfortable because this is the place you are going to spend most of your time. You have to be comfortable and you have to love what you are doing, that’s what I mean, you would do quality work if you do what you love. Then if you work anyplace you don’t love, you just go there to work because you want to finish this contract so that you can go out of this place.

Interviewer: From what you are saying you said you want to finish the contract, what makes you wanting to finish the contract?

Participant: You have to finish that contract, at the place you have been placed, and then you will move wherever you want. Otherwise you are forced to stay and work those two years and after that you can move around

Interviewer: Are you telling me that where you were placed you didn’t enjoy yourself?

Participant: Yes, not much but eventually you get used to the job, yes you get used to work there, you get used to the frustration of the work and became part of you. At the back of your mind you know I am going to leave this place because I am not happy

Interviewer: you talked about frustration can you please tell me more about those frustrations?

Participant: Frustration is when you come to work, there was no equipment; you have to run around looking for syringes, needles, medications. Before you work you have to run around that’s most frustrating part of the job, most frustrating part. Other thing is you know where I worked it was specialised unit. You are doing same job, working hard as those people who are earning more than you and you know that you are doing same nursing
care. Maybe if they said there is an allowance at the department I was working at but there was no allowance, maybe I would have stayed. There was no allowance and working your head off.

Interviewer: You said you have worked with people earning more, who are those people?

Participant: Like the seniors, our seniors you know professional nurses, when you have speciality you are paid more. We didn’t expect doing those ventilation machines those escalators and everything but we worked. Experience was fine but we worked, sometimes they just leave a work on you even though you are a junior.

Interviewer: Who was leaving the work with?

Participant: The senior, senior sisters sometimes they didn’t assist us. When your patient complicate or you was nursing 2 patient’s, very sick patients, asking them to help because I was still busy with the other one, they would say is your patient. You have to do it but time would be running out because you had to give 8am medication, and also medication for the other one and there was a list of medication. If someone can assist you, a chief leader giving medication for the other patients it will be better.

Interviewer: Who was that chief leader?

Participant: One of the sister, Oh in that department I worked, there were chief leaders whom, if you didn’t find maybe a syringe, you should ask her that I want a syringe, I want medication so she was the one whom you would ask but most of the time it doesn’t happen like that. When you told her that there was no syringe, she would say” so what must I do if there were no syringes, just call another ward if they have and it becomes your responsibility again but was her responsibility. The shift leaders were not allocated patients they were just allocated to see what was not available, what could they do to assist the other sisters in the ward.

Interviewer: When they were not assisting it seems as if you were frustrated?

Participant: Yes, you become frustrated, because in hospital you follow the doctor’s orders, she was very angry and when the doctor comes and orders were not done they shout at you, while you tried to explain that I was still busy with the patient. They will say No, No what if the patient dies because you didn’t give treatment. So you become frustrated.

Interviewer: Why are you talking about the work load, when you say workload what do you mean?

Participant: Too much work let’s say for instance you are resuscitating this patient because usually you nurse two patients, you was resuscitating this patient, and they were busy finishing with their patients, when you went to your patients you find that nothing has been done. You have to start afresh, giving medication doing this, re-dripping and doing all
of that. No that’s too much for you because you have been resuscitating there, so if people can work as a team maybe this place could be enjoyable.

Interviewer: It seems as if you were not working as a team can you please explain more?

Participant: Like I will make an example of resuscitation again, with resuscitation people will see that you are resuscitating they won’t come and assist you, when there were resuscitation you have to run around. The doctors will call this and this, because of shortages you have to look around from adrenaline, no adrenaline, Calcium gluconate no calcium gluconate. You have to run around, at least if there was someone who you just tell them please adrenaline even if you didn’t tell them. The doctor would say adrenaline and he will run around and I would keep on begging or do something but not running around and the doctor wont shout you.

Interviewer: who was this someone who was supposed to run around?

Participant: The chief leader because most of the time the shift leader was not allocated patients. Other nurses they were assisting if they were not busy with their patient. Where I was allocated, we nursed very critical patient, so you won’t blame the other nurses why they didn’t help while I was resuscitating. But the chief leader must assist because she was allocated to help or assist when there was a need/problem.

Interviewer: Can you tell me more about your experience?

Participant: I didn’t like the place at first but just because I have to serve, I have to adjust in the morning when I wake up, I have to tell myself that I am going there, I have to run around before I work. I have to look for heart machine, heart strips and other things. It was our daily life so we were complaining every day about that place, ohh! Who would ever come and change that place, Even though there were managers, when I left there they were three operational managers but there was no different, we were still running around looking for the equipment. So my experience there was not good, it was not good even when I worked there. On the first week we were sisters, we were junior sisters. We were supposed to be taught the work by senior sister, they let staff nurse to teach us, I know they know the work than us because we were new but that’s not right because at the end the staff nurse would look down on us. We didn’t like it but we did complain about it so they allocated a sister to teach us on how to do things or how to go about in the unit. That’s showed that we were welcomed, we have to adjust.

They allocated us with a staff nurse and auxiliary nurse in the cubicle, you ask the staff nurse she would tell you that leave it I would do it myself. So how I was going to learn because you ask her so that you can learn, ask the auxiliary nurse they do the same thing, that’s why we complained that we won’t know? Some were rude some were willing to teach, but at the end those people would never know that we were sisters, we were their senior. When they try to delegate them they said no, why you don’t do it yourself. In the first place the senior sisters have said the staff nurses would teach you, so you can’t delegate someone who taught you.
Interviewer: When you talk about taught by staff nurse, you look angry what was your feeling at that moment?

Participant: We were feeling like, we felt very small because we were not getting information ones even the staff nurses when they are teaching you, they become angry and rude because you asked too much questions. They got attitude that you was a sister you must know everything, they didn’t consider that you was new in the department and from school. Maybe you worked in the unit three years ago while I was a student. They got that attitude of this person was new in this department and I had to share with her the information so that she can know. They got that thing of (Ma...........)showing you in a negative way, you must feel it before you know it, and it made us angry, but we have overcome it that’s why we complained and the sisters taught us.

Interviewer: When you delegate staff nurses, what was their reaction?

Participant: Others they become angry, others will tell you why you don’t do it yourself, just do it because you know how to do it. You know where I worked especially in the cubicle the sister should do supervision and overall of things, she must check if things were done well and medication was given and many things. You can’t allocate many babies to yourself so that you could other things. When you allocate three patients to the staff nurse and you took two and auxiliary three patients. They would complain because you are a sister you suppose to take more patients but at the end when the drip tissue they call the sister, when there was something they didn’t understand they call the sister. You have to leave whatever you are doing and attend to that problem, so at least if you had few patients and do your work quickly so that you can attend to all other things. So the staff nurses were not cooperative, yes I could put it in that way, most of them where not co-operative. They always complained “OK just help the patient, why didn’t you call someone else” those were the things that were not good about that place.

Interviewer: From what you have said, it seems as if you have two roles, I staff nurses have to teach and sometimes you have to supervise them tell me more?

Participant: We didn’t supervise them immediately when we went there because we didn’t know the job. When they identified that there was light in community service nurses, they said we must supervise enrolled and enrolled nursing auxiliary and check if the work was well done. You have to check bed by bed if medication was given. They used to undermine us, no one is perfect, they have been there longer and we were not comfortable. Even though, I coped, I coped.

Interviewer: Who are those who undermine you?

Participant: The enrolled nurses and the nursing auxiliary were undermining us. As I said they will say look at her what does she know. Even if you make a mistake, they won’t say sister you have made a mistake here, they will show each other look at what she has done here instead of correcting you.
Interviewer: If you talk about when you arrive you didn’t know anything, after how long would you say you knew everything, and who was teaching you?

Participant: It’s not that we didn’t know anything you know that thing to be reminded, you know at paediatric medication has to be calculated, if someone remind you that the formula was like this, everything would come back. The senior sister didn’t want to do their job because they didn’t teach us instead they gave the staff nurses the responsibilities to teach us. Is where the problem started and they were undermining us? You think you are clever now but I am the one who taught you the work and everything it was not good

Interviewer: Tell me more.

Participant: You know if they see that you are good but the other community serve nurses were not as good you. The staff nurse will come and say “Woo! Your Colleague she is too slow I will say “I asked them why they don’t correct her how things were done because you know the work more than her. Just show and I’m sure she will never come and ask you again. The staff nurse were just like that, every staff member, every new member who went to the unit was supposed to feel it, you must just feel it that you was new they will make your head spin. Even when you ask, they say you ask too much instead of just teaching you, so that you can know the work and stop bothering them, they are just like that. So I always say no, why you want to make a person feel that they were new in the department. I know work more than you and just stop going behind their back telling other people their mistakes and what have they done just stop doing it. I am the lucky one because I always catch, or recall things very quickly. If you taught me ones, I will catch it; I don’t think I will bother you again. But if I don’t understand I would come back to you, as people we are not the same. The one’s that didn’t catch quickly there were the victim of the staff nurses, they would say you are too slow, you don’t want to learn, you have been there for six months and you should know everything” and was a learning process. Wherever you go was just a learning process. Things change every day, even medication name, today is Flaggy and tomorrow is Metranazole you will identify such things when you won’t find Flagyl. It was there but it was written in another name. Why don’t they say it’s written in another name and stop shouting and giving you attitude?

Interviewer: What do you mean when you say they were shouting you?

Participant: Like they gave you attitude, to say you are slow learner or you are dump. Why don’t you catch and you end up feeling small? End up not wanting to ask anything and instead asked other community serve nurses because you don’t want to be undermined. You have to take 30 minutes for everything, trying this and this because I wanted to feel comfortable and giving each other support. So it was like that most of the time you don’t ask the senior because they would say “I told you last week, I don’t understand why you don’t know after a year, you should have known by now. It’s not supposed to be like that, things change.

Interviewer: From what I have gathered it seems as you were afraid to ask the senior sisters, tell me more
Participant: After we have complained they saw that they have to teach the community serve nurse they don’t have a choice because we have complained. When they teach you something you have to grab it quickly because if you ask them you become afraid and end up doing wrong things, or you don’t do it at all, because you are afraid to be called a dumb, or a slow learner. If only the attitude of senior sisters can change and they can have equipment’s, maybe life will be easier.

Interviewer: How was your feeling when you didn’t do the work or doing it wrong?

Participant: You don’t feel okay because will have that conscious telling you this thing is wrong, this thing is wrong but at the end you do go to other colleagues, the community service nurses and tell them that I have done this, please come and help me and everything. It will take time for us to find the way; have to do this thing because we are afraid to go to the senior.

Interviewer: Where you comfortable to ask colleagues?

Participant: Yes I was comfortable because others were brighter than others; they were the ones who knew the work quickly so you find the ones who were afraid to go to the senior sisters. You will ask her how to do this and this. They will say Ok is fine lets me go to the sister and will come back with the answer and we will do the work.

Interviewer: Which means you have two types of community service nurses, those who can go to the sister and those who won’t.

Participant: There were those who said “you know what, I’m not here for them, and I’m here to work even if she doesn’t like me or she doesn’t want to teach me. I will go and ask because I am here to work. There were that community serve nurse who has those attitudes and there were the ones who helped the others and we were helping each other. The other ones were afraid of the one who said I`m not here for”.

Interviewer: Do you think is good to ask same colleague and who have same qualification?

Participant: There are people who grasp faster for sure eventually she will know better than me and I don’t think there is anything wrong to ask the colleague because she know something that I don’t?

Interviewer: You have said you have complained, to whom have you complained and what was the outcome?

Participant: We as the community service nurses we had small meetings because we didn’t like what was happening, to be taught by staff nurses because at the end they were undermine us. We have to complain during morning assembly. We didn’t point at one person, we pointed to everyone that there was something which was going on that we are taught by staff nurses we would like at least one sisters or 2 senior nurse. Just to teach us
or assist us with the work so that we know the work properly. That’s where they allocated one senior sister for help us to teach us the work.

Interviewer: At that moment you were complaining, what was their reaction?

Participant: They say they didn’t know we felt like that, they thought that staff nurses have been there more than us and they know the work then they didn’t saw any problem when teaching us, we said there is a problem because they undermine us, and sometimes when you ask them they will say leave it I will do it myself, so how are we going to learn, then they said No, they didn’t know that we felt like that, so they allocate us a sister

Interviewer: When you say they were undermining you in which way they were undermining you?

Participant: They will go behind your back; even if you delegate them they will not accept the delegation. They will say does it yourself? You have to ask one of the auxiliary nurses from other cubicle to do it, they didn’t see you as a senior to them they see you as an equal or below them and you can’t tell them what to do. I have been here more than you, and that was what happened.

Interviewer: From what I have gathered from you, you said the enrolled nurse didn’t respect you, how was your feeling when they didn’t respect you?

Participant: I felt angry, but I didn’t want to cause trouble I kept quiet and we just continue working. But before I left there, there was a meeting because I those things of the staff nurses were escalating, they even disrespect senior sister. They didn’t want to be delegated even by them so there was a meeting that was held to tell the staff nurses what is their responsibility expertise because they didn’t want to do their job. So I thought it was corrected but there were those ones who were resistance because they were used to be disrespectful and undermining others. I gained experience as I was working there because I knew how to use a ventilator; I know how to resuscitate patient, but the attitude! If attitude can change, it will be better, much better.

Interviewer: There is anything you want to tell me about your experience?

Participant: My experience there Mmh! You know what is happening there that I don’t really understand, is a big unit, they are adding more operational managers and we really didn’t think are working because even if I can go there today I won’t find 1ml syringes, If I find 1ml syringe, I won’t find 10ml syringe, if there is a green needle, I won’t find the yellow needle. I remember when they were renovating we have to move to general Intensive Care Unit general department. When we worked there everything was available and we enjoyed working there. You want 2mls syringes you just take, a 10mls you just take. You don’t even ask anyone where I can find this. Where can I find this everything was available in the department? Four are sitting and writing book for what? They didn’t order because they were not aware of what was short in this department. There was a shortage of staff but they were not employing in the department. You work in the cubicle and were 17pts
and we were only three and we have to divide ourselves for those patients. It was overload, it is overload, and you will never do quality care, never quality care being three at 17pts that is abnormal. That's was very abnormal and we became frustrated. I left the place and went to work somewhere where I can be comfortable and equipments were available. I know that each and every place have their own challenges but I want that place that is better than that’s one. You have to adjust because was the place where you stay most of your time, so you just have to adjust. You don’t wake up early in the morning happy to go to work.

Interviewer: It shows you were not happy in that department

Participant: No, not that I was not happy at all but, there where good times because sometimes when you don’t nurse very critical patients you know you are going to finish at time, you will have time to write a report and time for everything, you have time to run around especially if the patient is having only 2 antibiotic, so that was fine with me. The only part I enjoyed was when there was an outing.

Interviewer: From your experience you have identified that other ward run smoothly and they have equipment, what caused that?

Participant: We did ask after we moved back to our ward, what is the problem because when we were at that other ward they were having everything, syringes, haemoglucotest, machines, everything was there. They told us maybe was ordering. I thought it was 2 year when we went to that place when they were renovating our ward, but nothing changed. They said they have to appoint someone who was going manage the stock and do it like other ward. Nothing has changed, instead they were just adding more on their writing and I don’t know what they are writing.

Interviewer: What you have observed is that you are having more operational managers?

Participant: Because when I left there they were having three Operational managers

Interviewer: What do you think about these three operational managers?

Participant: There was no different because there was shortage of equipments and ordering was their responsibility, instead they would be telling us why you are not wearing your uniform? I said I’m not here for a uniform I’m here for the patient. They would be saying infection. You know what they don’t worry about infection when they allocate patients in the cubicle. The cubicles were suppose to accommodate ten patients seventeen patients, now you tell me infection rate is high. What must I do because I do wash my hands? I follow the infection control policies but the infection was still high. Was over crowding but no one identified that, they have identified a problem but it seems as if they are helpless or anything I don’t know?

Like they are doing anything about it, they are not doing anything about it. In other hospitals, when they say they are full they don’t admit any more patients. But there they were admitting everybody. They even opened a new cubicle without staff, no equipment
and overcrowding was there. They are accepting everyone. At the end of the day they will call staff meetings for infections we had to wash our hand and you knew that, it was very tiring and frustrating because you knew you do everything, the next thing a meeting will be called for infection rate that is high. The don’t see that was overcrowding there, most of the cubicle would have sixteen patients, seventeen patients with different organism. New patient would have infection, how did he got the infection and they blame the nurse, it was frustrating because of overcrowding and everything is blamed on a nurses. Doctors don’t do anything wrong, is the nurse. I know, we spend more time with patients the doctors will come with the stethoscope and they don’t even wipe them, they went to another patient and they don’t wipe them. Isn’t that a cross infection, we do raise those issues but they go into vein. So now the experiences I won’t say they were good, but they were good times and bad times.

Interviewer: What do you think it should be done for community serve nurses practice in Johannesburg clinical facilities?

Participant: I won’t say people must be placed in places they like because other wards will be empty, that one is fine so that you can learn. They can allocate wherever but there must be learning, you know the work but the attitude of seniors staff to junior staff was bad, if they can just change the attitude and start to teach the community serve nurses, things will be better. Equipment was the most frustrating thing ever, to have enough equipment in the units. I’m telling you thing will go very well because you don’t have to run around looking for equipment. If those 2 things change, I’m telling you the hospital with be a better place.

Interviewer: Who are these juniors?

Participant: If I go to the place and there is a sister, the community serve nurses are juniors, but they are seniors to staff nurses. The senior sisters should change their attitude and teach us the junior’s sisters and it suppose to be sisters to sisters, staff nurse to staff nurse things can go well, not staff nurse to sister or sister to staff nurse. A sister can teach a staff nurse, or a staff nurse can teach a staff nurse, or staff nurse can teach auxiliary nurse not the other way around. Not an auxiliary teaches the sister because at the end comes that problem of undermining. Like they look down on you, when they see that you know the work, you don’t go and ask them anything so when you are about to delegate, they give you an attitude. No I taught you this things so you can’t tell me anything that’s what am trying to say

Interviewer: Thanks for your participation.