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UNIVERSITY OF KWAZULU-NATAL

**HOSPITAL WORKPLACE EXPERIENCES OF REGISTERED NURSES THAT
HAVE CONTRIBUTED TO THEIR RESIGNATION IN THE
DURBAN METROPOLITAN AREA**

LISA KING

2005

HOSPITAL WORKPLACE EXPERIENCES OF REGISTERED NURSES THAT
HAVE CONTRIBUTED TO THEIR RESIGNATION IN THE
DURBAN METROPOLITAN AREA

A RESEARCH PROPOSAL SUBMITTED TO THE:

FACULTY OF HEALTH SCIENCES

SCHOOL OF NURSING

UNIVERSITY OF KWAZULU-NATAL

AS A PARTIAL REQUIREMENT FOR THE DEGREE:

MASTERS IN NURSING (RESEARCH)

BY:

LISA KING

SUPERVISOR:

PROF. P. MCINERNEY

DECLARATION

I hereby state that apart from items referenced and cited in the body of this research dissertation, that the content contained herein is my own, unaided work. This dissertation has been submitted to the School of Nursing (Health Sciences Faculty) at the University of Kwazulu-Natal, Durban – in partial fulfillment of the requirements for the degree: Masters in Nursing (Research).

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

Lisa King

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

Supervisor: Prof. P. McInerney

31 August 2005

ACKNOWLEDGMENTS

I hereby wish to acknowledge and thank:

- The Department of Health for their interest in this research and for permitting me to undertake the study.
- The Management and Staff of the participating health institutions for permitting me to undertake the study.
- My Supervisor, Prof. P. McInerney for all her guidance and support.

ABSTRACT

Title: Hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban Metropolitan Area.

Aim: The purpose of this research was to explore and describe the hospital workplace experiences that had contributed to the resignations of Registered Nurses in the Durban Metropolitan Area.

Methodology: The broad perspective governing this research is qualitative in nature. The researcher employed a phenomenological approach specifically because the researcher was interested in identifying, describing and understanding the subjective experiences of individual nurses at the two Private and two Provincial health care institutions selected to participate in the study - in respect of their decision (s) to resign from their employment, and /or to leave the nursing profession. Two semi-structured interviews were conducted with each participant by the researcher. The researcher applied the principle of theoretical saturation and a total of fifteen participants and thirty interviews were done. Experiential themes and sub-themes in the data were identified by a process of meaning condensation, and the data were managed by means of a qualitative software package – NVIVO (QSR – NUD*IST).

Findings: The resignations of registered nurses in the Durban Metropolitan Area were found to be linked to their respective hospital workplace experiences. These experiences related to their physical working conditions and environment and included the following: unsupportive management structures, autocratic and dehumanizing management styles, negative stereotypy of nurses and the nursing profession, lack of autonomy in the workplace, professional jealousies and fractures within the profession, sub-optimal

physical working conditions and shortage of staff, equipment and lack of appropriate surgical supplies, concerns regarding occupational safety e.g. the increasing exposure of health care personnel to HIV and AIDS; lack of opportunities for promotion or continuing one's professional education, the experience of workplace violence – predominantly in the form of verbal and psychological abuse, inaccurate systems of performance assessment (Joint Performance Management, Reports, Personal Profile systems) – compounded by favouritism and racism; and inadequate remuneration.

Conclusion: In terms of the findings of this study, the participants' lived experiences in terms of their respective hospital workplace experiences indicated that neither the maintenance factors nor the motivator factors were optimally represented, experienced or enjoyed in their respective workplaces. In terms of Herzberg's Motivator-Maintenance theory, the registered nurses who participated in this study may be described as being 'not satisfied' and 'dissatisfied' with their hospital workplace experiences, physical conditions and environment. A number of recommendations pertaining to strategies for the retention of registered nurses were made for the consideration of both Provincial and Private health care authorities, hospital management structures and the nursing profession respectively. Recommendations for further nursing research were also made.

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CHAPTER ONE

1. INTRODUCTION

The nursing profession in South Africa is currently experiencing an ongoing shortage of nursing personnel. Official recognition of this shortage was forthcoming on the 18 August 2003 by the Minister of Health, Dr. Manto Shabalala- Msimang, who announced via a press release that 31 000 public sector nursing posts across South Africa were vacant (Geyer, 2004a). This situation is further compounded by reports and evidence from both private and public sector institutions of substantial losses of nursing personnel due to either internal migration, (movement of health care personnel across sectors or out of the health care professions), or to external migration (movement of health care professionals to international destinations) (Geyer, 2004a). While the situation of shortage of nursing personnel is not unique to South Africa - many countries are currently experiencing a shortage of nursing personnel - Buchan, Parkin and Sochalski, (2003) argue that developed countries attempt to solve skill shortages by recruiting from developing countries, and that this practice is a key component in the international migration pattern.

This is augmented by findings published by the World Health Organisation (WHO) and the World Health Assembly (WHA) who note that ‘...existing shortages of health personnel in Africa are exacerbated by the recruitment drives by agencies in developed countries for health workers from developing countries...’ (WHA, 2004).

The above situation has been investigated by the International Council of Nurses (ICN), and while the ICN recognises the right of individual nurses to migrate, the Council acknowledges that the international migration of nursing personnel may have an adverse effect on the quality of health care available in countries experiencing a shortage of nursing personnel (ICN, 2001). The ICN (2001) position in respect of the global shortage and migration of nurses is as follows:

‘...(the) ICN condemns the practice of recruiting nurses to countries where authorities have failed to implement sound human resource planning and to seriously address problems which cause nurses to leave the profession and discourage them from returning to nursing;

ICN denounces unethical recruitment practices that exploit nurses or mislead them into accepting job responsibilities and working conditions that are incompatible with their qualifications, skills and experience; (and)

ICN and its member national nurses’ associations call for a regulated recruitment process based on ethical principles that guide informed decision-making and reinforce sound employment policies on the part of governments, employers and nurses, thus supporting fair and cost-effective recruitment and retention practices...’ (ICN, 2001).

South Africa is evidenced as being one of a number of ‘source countries’ from which nursing personnel are actively recruited (Buchan, Parker and Sochalski, 2003), and thus this research study is specifically located within the South African context.

South African Nursing Council Statistics

While the South African Nursing Council notes that there has been, ‘... an overall increase in the total number of nurses on the registers from 173 703 to 177 721 over the

period 1998 to 2003 ...' (South African Nursing Council (SANC), 2004a), these figures represent a modest growth rate of 2.3 %, and are a cause for concern because the South African population has increased from approximately 42.1 million to 46. 43 million over the same period – a growth rate of 10.2 %. This means that for a population of 46. 43 million people there are a total of 177 721 nurses (Registered Nurses, Enrolled Nurses and Enrolled Nursing Assistants), on the registers and rolls. Currently the population per qualified nurse (all categories) nationwide is 261:1 (SANC, 2004a). In respect of Registered nurses the ratio nationwide is 480:1, for Enrolled Nurses the ratio is 1383:1 and for Enrolled Nursing Assistants the ratio is 979:1.

In respect of Registered Nurses in the province of KwaZulu-Natal, the population to Registered Nurse ratio is 532:1 (SANC, 2004a). These population ratios are set to rise substantially given the 10.2 % population growth rate, and this is anticipated to further exacerbate the current crisis of shortage of nursing personnel.

Further analysis of the statistics pertaining to the Registered Nurse category of nursing personnel evidences a 'good growth' in this category of approximately 6.3 %. However this is attributed to the upgrading of Enrolled Nurse and Enrolled Nursing Assistant qualifications by means of bridging programmes to the Registered Nurse category (SANC, 2004a). In contrast the growth evidenced in the Enrolled and Enrolled Nursing Assistant categories of nursing personnel do not evidence as good a growth rate as in the Registered Nurse category. This is attributed to the fact that these categories are constantly being added to while simultaneously losing numbers to bridging programmes

that result in further training and registration in alternate categories (SANC, 2004a).

Hence the 6.3 % growth in the Registered Nurse category is offset by the lesser growth evidenced in the Enrolled Nurse and Enrolled Nursing Assistant categories to result in the overall growth rate of 2.3 % for the nursing profession.

Nurse training programmes

The combined total of nursing students, pupil nurses and pupil nursing auxiliaries who were in training as at the 31 December 2003 was 23 661 (SANC, 2004a). These figures do not reflect drop out and /or failure rates, and thus do not indicate the proportion or percentage of trainees who complete their training and graduate. Given that the duration of training is different for the three categories of nurse i.e. four years for student nurses training to become Registered Nurses, two years for pupil nurses training to become Enrolled Nurses, and one year for pupil nursing auxiliaries training to become Enrolled Nursing Auxiliaries / Assistants, it may be argued that these figures do not contribute meaningfully to an overall analysis of the numbers of qualified individuals actually entering the profession each year.

Based on extrapolations derived from SANC statistics as at the 31 December 2003, and assuming a zero failure rate, approximately 9995 nurses were due to have graduated at the end of 2003 (SANC, 2004a). An analysis of those graduating revealed that approximately 1435 graduates were Registered Nurses, 3622 graduates were Enrolled Nurses and 4938 graduates were Enrolled Nursing Assistants. If one factors in the current

vacant posts in the public sector (31 000), less those offered to the new graduates (9995), it is clear that 21 005 vacant posts will remain in the public sector alone. It is thus evident that the shortage of nursing personnel across South Africa is set to continue.

HIV and AIDS

The Human Science Research Council report on the impact of HIV/AIDS on the health sector notes that approximately 29 % of all health worker deaths are attributed to HIV and AIDS, and that 16 % of health workers will be lost to the workforce by the year 2007 due to AIDS (Geyer, 2004a). Of the 177 721 qualified nurses currently on the SANC registers and rolls, a loss of 16 % translates into 28 435 individuals lost to the nursing workforce by the year 2007. Clearly the number of graduates entering the profession will not be sufficient to replace those lost, nor will the loss of accumulated years of training, post basic training and clinical experience associated with experienced practitioners be readily replaced.

These facts and figures - combined with the effects of internal and external migration of nursing personnel, suggest a loss of nurses to the nursing profession and health sectors across South Africa, and additionally provide the background against which this research study is set.

1.1 PROBLEM STATEMENT

The current shortage of nursing personnel directly impacts on the quality and amount of nursing care available to patients in the health care system, and places a burden on the remaining nursing workforce (Geyer, 2004a). In addition to the shortage of nursing personnel - which has led to recruitment difficulties, the turnover of nursing personnel due to either internal or external migration has resulted in employing bodies facing increased costs through having to continuously provide orientation and supervision to new staff members.

While the South African Nursing Council's statistics are able to give National and Provincial figures in respect of the number of nurses (all categories) per patient, figures that acknowledge the shortage and turnover of nursing personnel in hospitals in the Durban Metropolitan Area are not readily available. In addition no qualitative studies reflecting on nurses' perspectives on the shortage and turnover of personnel were evident in the literature reviewed. Previous studies on the shortage and turnover of nursing personnel, as reviewed in the literature, were predominantly quantitative in nature and the results obtained were by means of questionnaire surveys which did not permit in depth explorations of phenomena at hand.

What was not known were the reason (s) behind the resignations of Registered Nurses in the Durban Metropolitan Area.

1.2 PURPOSE OF THE STUDY

The purpose of this research was to explore and describe the hospital workplace experiences that contributed to the resignations of Registered Nurses working in the Durban Metropolitan Area.

1.3 RESEARCH OBJECTIVES

- 1.3.1 To explore why Registered Nurses in the Durban Metropolitan area are resigning from their posts.
- 1.3.2 To explore the workplace experiences that have contributed to the decision making by these Registered Nurses to resign from their posts.

1.4 RESEARCH QUESTIONS

- 1.4.1 What are the experiences of Registered Nurses in the Durban Metropolitan Area in respect of their nursing work experience?
- 1.4.2 What are the experiences of Registered Nurses in the Durban Metropolitan Area in respect of their working conditions and environment?
- 1.4.3 What experiences are associated with the decision making by Registered Nurses to resign from their employment?
- 1.4.4 Why are Registered Nurses in the Durban Metropolitan Area resigning from their posts?
- 1.4.5 How could the retention of Registered Nurses be improved?

1.5 THE SIGNIFICANCE OF THE STUDY

The primary contribution of this study relates to the creating of localized and/ or regional awareness at middle and senior hospital management level of the workplace experiences of Registered Nurses – workplace experiences that have contributed towards their resignations. Awases, Gbary, Nyoni, and Chatora (2004), have argued that in order for countries to be able to develop interventions that serve to mitigate their losses in respect of their ‘human health care resources’ they need to have ‘... a clear regional picture about the movement of health workers...’ (Awases et al, 2004, p. 62). The researcher posits that having a clear regional and localized picture about the hospital workplace experiences of registered nurses (nursing personnel) further facilitates the development of interventions to retain the services of nursing personnel.

Given that no qualitative research exploring the workplace experiences of nurses in South Africa and the Durban Metropolitan Area was evidenced in the literature reviewed for this study, this study was regarded as being pioneering of this form of inquiry into this area of nursing personnel resources management. If the retention of registered nurses (nursing personnel) is improved, then the quality and quantity of nursing care available to the patient population will be improved. Employing bodies will also benefit – if the workplace experiences of nursing personnel that have contributed to their resignations are identified, made known and solutions to redress problem areas are found, then the costs associated with constant recruitment drives, orientation, supervision and mentoring may be reduced.

1.7 OPERATIONAL DEFINITIONS

Registered nurse: a nurse who has graduated with a recognized degree or diploma in nursing, and who is registered with the South African Nursing Council as a Registered Nurse.

Resignation: for the purposes of this study resignation means that the participant has formally resigned from his or her post and intends leaving at the end of the month, and/or has resigned.

Workplace: for the purposes of this study, the term 'workplace' refers to the hospital setting - both public and private. The focus on the hospital environment was chosen because hospitals are the largest employers of nursing personnel.

Work experience: in this study 'work experience' refers to both the non-material experience of nursing (the act of nursing itself /clinical practice and interaction with one's patients), and to the material aspects of being an employee within an organisation. Specifically the experience of the nurse in respect of the organisational climate, his or her physical working conditions, supervisory and professional support received, and basic conditions of service e.g. salary, and benefits.

CONCLUSION

In this chapter the ongoing shortage and migration of nursing personnel in South Africa was reviewed against: the global trend of developed countries recruiting health care workers from developing countries, South African Nursing Council statistics regarding the total number of nurses on the registers and in training, and the potential and personal impact of HIV and AIDS on the health care worker population in South Africa by the year 2007. While a shortage of nursing personnel directly impacts on the quality and amount of nursing care available to patients and further places a burden on the remaining nursing workforce, it was noted that localized and / or regional figures and qualitative data that acknowledged the shortage and turnover of nursing personnel in the Durban Metropolitan Area were not readily available.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 INTRODUCTION

This review was conducted by hand (books and journals), and via internet and database searches. The primary search engine utilized was 'Google' (advanced search) at <http://www.google.com> and examples of keywords used are: nursing shortage, staff retention, staff turnover, job satisfaction, professional burnout, psychological stress, salaries, image, ageing RN (registered nurse) workforce, and nursing migration. The primary databases that were used were FIRSTSEARCH and MEDLINE. To date the literature reviewed has evidenced that much research has been done internationally on nursing shortages and turnover of nursing personnel. Little has been done nationally and that which is recent (within the last 10 years), has focused on the retention of nursing personnel in rural areas. This review broadly discusses the shortage and turnover of nursing personnel in respect of: the cyclical nature of 'shortages', cost containment measures, and contributing factors. Burnout, nursing migration and the introduction of a new category of health care worker (medical assistants) has additionally been discussed.

2.2 THE CYCLICAL NATURE OF SHORTAGES

Huber (2000) reiterates that the nursing profession has seen cycles of shortage and surplus that have reoccurred increasingly since World War 2. Huber (2000) further argues that in the times where there has been a shortage of nursing personnel there has been a resultant focus on nurse recruitment and retention, and conversely, when there has been a surplus of nursing personnel or an economic downturn this has resulted in management substituting registered nurses (RNs) with assistant categories of health care workers while systematically ignoring the recruitment and retention of RNs. Huber (2000) thus notes that nurses' sense of trust and loyalty in these situations evaporate and that they subsequently perceive their work environment as being hostile in respect of their personal welfare and professional goals. At present the effects of a diminished RN workforce are being felt globally (Janiszewski Goodin, 2003).

2.3 COST CONTAINMENT MEASURES AND THEIR SEQUELAE

The rise of managed health care schemes, private health care organizations, the accreditation of health care institutions, and escalating health care costs have resulted in hospital management having to justify expenditure related to keeping nursing personnel in their positions (Tobin, Yoder Wise and Hull, 1979). Over the years this has given rise to the attitude that 'doctors generate profits while nurses generate costs' in many health care institutions, and this has become even more evident in the wake of managed health care and accreditation initiatives both internationally and nationally (Huber, 2000).

Huber's (2000) findings are paralleled by Brewer and Kovner's (2001) study in respect of nursing shortages in the State of New York in the United States of America. Brewer and Kovner (2001) note that it is predominantly nursing personnel who bear the brunt of cost cutting exercises by employing bodies. Employing bodies seek to maximize their profits and minimize their costs in terms of their total wage bill and benefits payable to staff - because nurse wages comprise the greater portion of a hospital's wage bill, nurses (specifically registered nurses), are the group of health professionals predominantly targeted in respect of cost cutting measures (Brewer and Kovner, 2001). Changes associated with cost cutting measures essentially focus on changing the labour mix in respect of the types of nursing personnel employed (Brewer and Kovner, 2001).

Brewer and Kovner (2001) postulate that:

'...Employers theoretically balance the various types of labour they employ according to the marginal productivity of each. When the cost ... of the type of worker changes, the balance the employer will maintain among the type of worker changes. Economic theory postulates that as the cost per unit of registered nurse time goes down (up) the demand for registered nurses will increase (decrease), and the demand for other types of workers who do similar work will decrease (increase)...' (Brewer and Kovner, 2001, p. 21).

As Registered Nurses are being replaced by assistant categories of nurse and health care workers who are lesser qualified and therefore lesser salaried, this contributes to a negative perception of nursing as a viable career for registered nurses, and contributes

towards many nurses leaving the profession and /or migrating to seek better employment opportunities. In addition the perception by nurses that hospital management structures are more concerned with finance than with patient care – as evidenced through the common practice of ‘freezing posts’, (not filling vacant posts), and expecting the remaining personnel to shoulder the ever increasing workload, further contributes to low morale in the nursing profession (Callaghan, 2003).

Callaghan (2003) further links a climate of uncertainty and change associated with restructuring in the health care services – as related to cost containment measures, to the decreased morale evidenced in the nursing profession - which in turn impacts directly on personnel recruitment and retention efforts.

Brewer and Kovner (2001) note that the demand for registered nurses does fluctuate in a dynamic and competitive market and that this is ‘normal’. In addition Brewer and Kovner (2001) differentiate between the ‘demand’ for registered nurses and the ‘need’ for registered nurses, and argue that while the terms are used interchangeably they have quite different meanings. While ‘demand’ is an economic term referring to the amount of service (registered nurse hours) that an employer (the consumer) would be willing to purchase at a set price, ‘need’ is regarded as a ‘subjective’ judgement about the ideal amount of service (registered nurse hours) that should be utilized irrespective of price (Brewer and Kovner, 2001). While management structures go to great lengths to calculate their ‘demand’ for registered nurse hours, and ergo full time equivalent staff (based on the average daily census and patient acuity ratings), much of what nurses actually do is

not quantifiable, and is not factored into these calculations (Brewer and Kovner, 2001). It may thus be argued that employer perceptions of the 'demand' for Registered Nurses as based on 'registered nurse hours' of care required falls short of the actual 'need' for Registered Nurses, and thus a situation of 'false economy' in terms of staffing ratios is being perpetuated.

2.4 CONTRIBUTING FACTORS

Janiszewski Goodin (2003) identified four major contributing factors to the nursing shortage in the United States of America (USA) – these being the ageing registered nurse (RN) workforce, declining enrolment, the changing work climate and the poor image of nursing. These contributing factors were identified by means of an 'integrative literature review of published literature', and the solutions presented by Janiszewski Goodin to redress the shortage of nursing personnel were derived from an analysis of the contributing factors.

These solutions focused on four main areas: supportive legislation, improving the image of nursing, and exploring recruitment and retainment efforts. While Janiszewski Goodin's paper provides 'a comprehensive review of the current RN workforce situation in the USA', and heightens an awareness of 'new' factors contributing to the shortage of nursing personnel, it is postulated that the causes of the current shortage of nursing personnel - as experienced in the USA - differs from the causes of nursing shortages in the past. Shortages of nursing personnel in the past were attributed to increasing

population growth (after World War 2), to dissatisfaction with working conditions, and to a lack of professional autonomy. While these factors have been readily identified and addressed in the USA, it might be argued that in addition to the above 'new' factors, the precipitating factors of the South African nursing shortage are still quagmired in dissatisfactory working conditions, lack of professional autonomy and population growth factors.

Booyens' (1985), study in 1983 (Opmerkings oor 'n Ondersoek na die Tekort aan Verpleegpersoneel in Transvaalse Provinsiale Hospitale), evidenced that the primary factors associated with the shortage of nursing personnel in Transvaal Provincial Hospitals – in respect of nursing personnel leaving the profession and /or their current employment, related to the following sources of dissatisfaction: irregular hours of duty and poorly organized shifts, insufficient differentiation in salaries in respect of varied responsibilities undertaken by nursing personnel – as too the quantity and quality of the nursing service delivered, a belief that nurses were underpaid (Booyens' study evidenced that two thirds of her respondents indicated that they were unhappy with their salaries), poor support from nursing service managers (a chief complaint being that nurses felt that they were not given enough recognition for their efforts), insufficient opportunities for promotion and insufficient opportunities for participation in decision making.

Additional sources of dissatisfaction identified by Booyens (1985) related to dissatisfaction with the calibre and abilities of junior student nurses, not enough autonomy and an undervaluing of professional judgement, and insufficient opportunities

for further education and advancement in the clinical situation. Interestingly ‘job satisfaction’ was not found to be a factor contributing to the turnover/ shortage of nursing personnel. Booyens (1985) notes that overall, nurses enjoyed a high degree of job satisfaction - in respect of their performance of their daily nursing tasks, and that it was apparent that ‘job dissatisfaction’ was not a factor contributing to driving nursing personnel out of the profession or a situation of employment. Colavecchio (1982) as cited in Booyens (1985) argues that while nurses complain about the work environment and their working conditions - it is not ‘the patient’ or ‘nursing’ that drives nurses out of the profession. This finding was reinforced by Callaghan (2003) who found that none of the participants in her study, ‘...complained of stress related to spending so much time with people who are sick or dying, ... (and that) other aspects of the job made them unhappy...’ (Callaghan, 2003, p. 88). These ‘other aspects’ were found to relate to low pay, lack of support for continuing education, limited opportunities for promotion, lack of resources and job insecurity – all of which contributed to low morale and a high turnover of nursing personnel (Callaghan, 2003).

Recently Jackson, Clare and Mannix (2002) argued that workplace violence was a major factor affecting the recruitment and retention of nursing staff and that violence against nurses was a significant problem in the workplace. International studies across the United States, Sweden, and Australia further evidenced that, ‘... high levels of workplace violence and harassment are a problem for nurses internationally...’ (Jackson et al, 2002, p. 13). Workplace violence was described as encompassing incidents of physical aggression, harassment, sexual harassment, bullying, intimidation, assault, and includes

rudeness, verbal abuse, humiliation and denial of opportunities (Jackson et al, 2002).

While a proportion of workplace violence was attributed to patients, relatives and friends of patients, a significant source of workplace violence was found to be that perpetrated by medical staff and by nurses to other nurses (Jackson et al, 2002). Taylor (1999), as cited in Jackson et al (2002), notes that bullying is a particular form of workplace harassment that is a recognised occupational stressor for nurses. Jackson et al (2002) notes that line managers are evidenced as repeatedly being prone to bullying subordinate staff – as evidenced through, ‘...excessive verbal abuse and criticism, intimidation, threats, ridicule (in front of spectators), making excessive and impossible demands, withholding information, inequitable rostering practices, rumour mongering, blocking opportunities for promotion or training, removing responsibility, and misuse of power to incite others to marginalise or exclude the victim...’ (Paterson as cited in Jackson, (2002), p. 15). In addition to collegial acts of violence and aggression, it is further argued that violence in nursing does not occur in isolation – that organisations have a central role in the perpetuation of workplace violence (Jackson et al, 2002). Workplace environments are further argued to perpetuate existing cultures of oppression by not having clear policies dealing with incidents of workplace violence, and through their managerial budgeting and staffing decisions that contribute towards conditions that increase their nursing personnel’s exposure to workplace violence – e.g. situations where hospitals are short staffed and personnel work with increased workloads (Jackson et al, 2002).

The findings of the above study in respect of the effects of workplace violence on nursing personnel evidences that in addition to having to deal with poor working relationships

with colleagues, nursing personnel suffer the effects of post traumatic stress – anxiety, insomnia, and impaired concentration – all of which impact on their work performance and on patient care (Jackson et al, 2002). Additional research has evidenced that the above findings correlate with increased incidences of absenteeism, sick leave, drug and alcohol abuse, burnout and high staff turnover rates (Jackson et al, 2002).

In the South African context, Kgosimore (2004) notes that workplace violence has become a daily occupational hazard, and that the Democratic Nursing Organisation of South Africa (DENOSA), has evidenced that there has been an increased number of complaints from nurses who have suffered abuse in the workplace.

2.4.1 PUSH AND PULL FACTORS

Buchan, Parker and Sochalski (2003) note that there is continued debate about the effects of migration of nurses - particularly from developing countries. The main ‘push’ factors identified by Buchan et al (i.e. those factors that precipitate external migration), parallel those evidenced in the discussion on ‘contributing factors’ e.g. low pay and poor employment conditions in source countries. ‘Pull’ factors are defined as those factors that facilitate the migration of nursing personnel, e.g. active recruitment drives and attractive benefit packages as offered by developed countries, and better career prospects (Buchan et al, 2003).

Buchan et al (2003) further argue that the degree of ‘push’ and ‘pull’ is related to the level of pay, career prospects, working conditions and environment that exist in the

source country and in the destination country. Where there is a significant discrepancy between these, then the 'pull' of the destination country will be felt (Buchan et al, 2003). Buchan et al (2003) further note that there are other factors which act as 'push' factors in some countries e.g. the effects of HIV and AIDS on already overburdened health care systems and health care workers, and concerns about 'personal safety' and security in areas of conflict. Additional 'pull' factors relating to travel opportunities and humanitarian aid work were also identified as being relevant for individual nurses (Buchan et al, 2003).

2.5 BURNOUT

Lewis (1988) states that burnout contributes significantly to staff turnover and that burnout may be attributed to a combination of factors inherent in the work situation - such as staff shortages, time shortages and excessive work loads. Additional factors that contributed towards burnout were identified as relating to organisational relationships – relationships that revealed a paucity of social support from management structures, an absence of constructive feedback from colleagues, and unrealistic and unclear expectations from management (Lewis, 1988). Geyer (2004a) argues that this absence of 'caring for the carer', in addition to being a large factor for the low morale evidenced in nursing, is one of the biggest contributing factors to compassionate fatigue and burnout among nurses.

In addition, stifled professional growth in terms of lack of opportunities for promotion and continuing education, were also cited as contributing to burnout (Lewis, 1988).

Lewis (1988) further argues that there is a need for employers to acknowledge that the causes of burnout are embedded in the work environment, and that employers need to formulate strategies to identify burnout and combat it.

Geyer (2004a) notes that the predominant trend internationally – in respect of alleviating excessive workloads, avoiding compassionate fatigue and preventing burnout, has been to implement legislation advocating minimum adequate staffing ratios per unit. Most international ratios stipulate that a ratio of one registered nurse to four patients is required per unit - in addition to other categories of nursing staff or health care worker, and furthermore reiterates that registered nurses and other categories of nursing staff / health care worker are not interchangeable (Geyer, 2004a).

Lewis (1988) further notes that if management structures are to be proactive in preventing burnout among their nursing personnel, they need to recognise that nursing personnel require not only the satisfaction of their working 'needs', but an all round 'quality of living' in their workplace environment. This is augmented by Callaghan (2003) who argues that job satisfaction is related to the freedom to make decisions and having 'job control' in terms of being able to exercise professional latitude.

2.6 MEDICAL ASSISTANT PROGRAMME

Recent events (29/30 March 2004) have seen the Minister of Health launch the ‘medical assistants programme’ (Geyer, 2004b). This programme is not a post basic programme, and is based on the medical curriculum – essentially it encompasses three years of general training followed by a one year internship and registration with the Health Professions Council of South Africa. While the new category of health worker is not intended to replace any other category of health care worker, it is clear from a preliminary analysis of the proposed scope of practice of the medical assistant (MA), that there is much overlap between the scope of practice of the MA and that of registered nurses. DENOSA was not consulted in the process of creating a new category of health worker, and there is much discussion regarding issues of rank and pay (Geyer, 2004b). At present it would seem that the MA would rank lower than a doctor but higher than a registered nurse, thus potentially seeding the ground for role conflict, ambiguity and undermining the authority of the registered nurse and midwife (Geyer, 2004b).

Geyer (2004b) argues that the creating of additional categories of health care worker to ‘add’ to the health team will not necessarily lead to the better delivery of health care services, or alleviate the workload on nursing personnel. Geyer (2004b) notes that in addition to the shortage of nursing personnel, current health infrastructures and resources need to be upgraded in order to provide an efficient and effective health care service. Given that newly qualified MA’s will require direct supervision and mentoring – and that while this will not be an ‘official’ part of the ‘job description’ of nursing personnel,

experience has shown that it is usually nursing personnel who support and provide the initial and extensive supervision required by junior medical personnel. In an already compromised health care service this places additional stress on the role and responsibility of the registered nurse and additionally adds to the workload.

Working conditions and having the opportunity and /or latitude to exercise one's professional judgement are important factors in maintaining the motivation of personnel (Geyer, 2004b). The creation of the MA category of health care worker may well negate the professional scope of practice of the registered nurse thus contributing to job dissatisfaction, and precipitate a further exodus of practitioners from the nursing profession.

2.7 NURSE MIGRATION

The migration of nurses has been defined as follows: internal migration – meaning movement by nursing personnel across sectors i.e. from public hospitals to private hospitals, external migration – meaning movement of nursing personnel to international destinations, and /or as 'out of the profession into other fields' (Geyer, 2004a).

Irrespective of the type of migration i.e. whether or not nurses are migrating internally or externally, the consequences for employing bodies and for the health care system as a whole are severe. The loss of skilled nurses reduces and limits the delivery of a health care service (Geyer, 2004a). Given the volume of the patient population, limited resources in terms of the reduced numbers of nurses further impacts on the quality of

nursing care that can be given because increased workloads borne by the remaining nurses mean that there is less time for individualized patient care.

Geyer (2004a) additionally argues that new graduates who lack expertise and clinical experience are less likely to receive the support and supervision that they need, and that increasingly non-registered nurses are expected by management structures to practice outside of their scope of practice in order to 'deal with' the increased workload.

Currently the Democratic Nursing Association of South Africa and the South African Nursing Council have not furnished details of how many nurses are working abroad (Naidu, 2004). The Secretary-General of the Public Servants Association, Anton Lourens as cited by Naidu (2004) states that people (e.g. nurses), are emigrating because they are '...fed up with the system, not only poor salaries...' (Naidu, 2004, p.1). Geyer (2004a) argues that nurses are '...often the victims of an inadequate system where adverse incidents are quickly apportioned to the nurse irrespective of how the system ... [in respect of a lack of resources, poor infrastructure, no supervision, inadequate training, and increased workloads] ... has contributed to the mistake...' (Geyer, 2004a, p. 35).

Kingma (2001) notes that the migration of nurses is precipitated by the search for better pay, better learning opportunities and professional development, personal safety and a better quality of life. While nurses from developed countries tend to migrate for better career opportunities, matters pertaining to pay and continuing education were the

foremost reasons for migration given by nurses from developing countries e.g. South Africa (Kingma, 2001).

2.8. ORGANISATIONAL CLIMATE AND PERSONNEL MOTIVATION

In the literature reviewed specific human resource management strategies in respect of nursing personnel were not evident. General human resource and organisational management theories do bear relevance to the hospital situation because these inform the management styles of senior personnel (their attitudes towards the organisation's personnel), and also their practices and policies which in turn impact on the overall organisational climate. Herzberg's Two-Factor Theory of Motivation was evidenced as being particularly relevant to the work situation.

Herzberg's theory is a motivational theory that is empirically grounded. It was developed through a research process that asked people to describe aspects of their work environment that affected their motivation and job satisfaction and specifically addressed issues in the workplace (Owens, 1998).

Herzberg's theory of motivation takes the concept of personnel motivation beyond a traditional hierarchy of needs (e.g. Maslow's hierarchy of Needs), and identifies two independent categories of variables that affect the behaviour of personnel in an organisation with regard to work motivation. These categories are related to separate 'clusters of conditions', and are labeled as being either 'Motivators' (also referred to as

‘satisfiers’) – which consist of those experiences that motivate personnel towards delivering superior performance in the work place, and which lead to job satisfaction, or ‘Hygienes’ (also referred to as ‘Maintenance factors’ and/ or ‘dissatisfiers’) – which consist of those conditions that essentially serve only to prevent job dissatisfaction and apathy (Owens, 1998). (See Figure 1).

		<u>MOTIVATORS</u> (Satisfiers)	
		PRESENT	NOT PRESENT
<u>MAINTENANCE FACTORS</u> (Dissatisfiers)	PRESENT	SATISFIED Personnel	NOT SATISFIED Personnel
	NOT PRESENT	NOT DISSATISFIED Personnel	DISSATISFIED Personnel

Figure 1.

Model of Herzberg’s Motivator – Maintenance theory adapted from Owens, 1998.

Herzberg argues that the traditionally held view that the opposite of ‘job satisfaction’ is ‘job dissatisfaction’, is flawed (Owens, 1998). Herzberg posits that the opposite of

'satisfaction' is 'no satisfaction', and that the opposite of 'dissatisfied' is 'not dissatisfied' - and therefore removing a source of 'dissatisfaction', e.g. poor salary, working conditions, attitudes and policies, does not lead to motivation or job satisfaction for the employee.

Herzberg does emphasize that despite not being able to motivate people to achieve job satisfaction through these 'maintenance factors', they must be present before the motivational factors can be effective.

The conditions (motivational factors) that give rise to motivation are: achievement, recognition, the challenge of the work itself, responsibility, advancement and promotion, and personal and professional growth (Owens, 1998). Thus motivation as evidenced through job satisfaction is attributed to innate human characteristics and intrinsic factors, while job dissatisfaction is linked to the characteristics of the organisation, and to the organisational climate (Owens, 1998). (See Figure 2).

Thus in respect of staff retention and keeping staff turnover figures to a minimum, it is important that nurse managers and hospital management recognize that in terms of Herzberg's model, dissatisfied personnel are less likely to maintain long term employment with their employing body, and ergo to remain in the nursing profession.

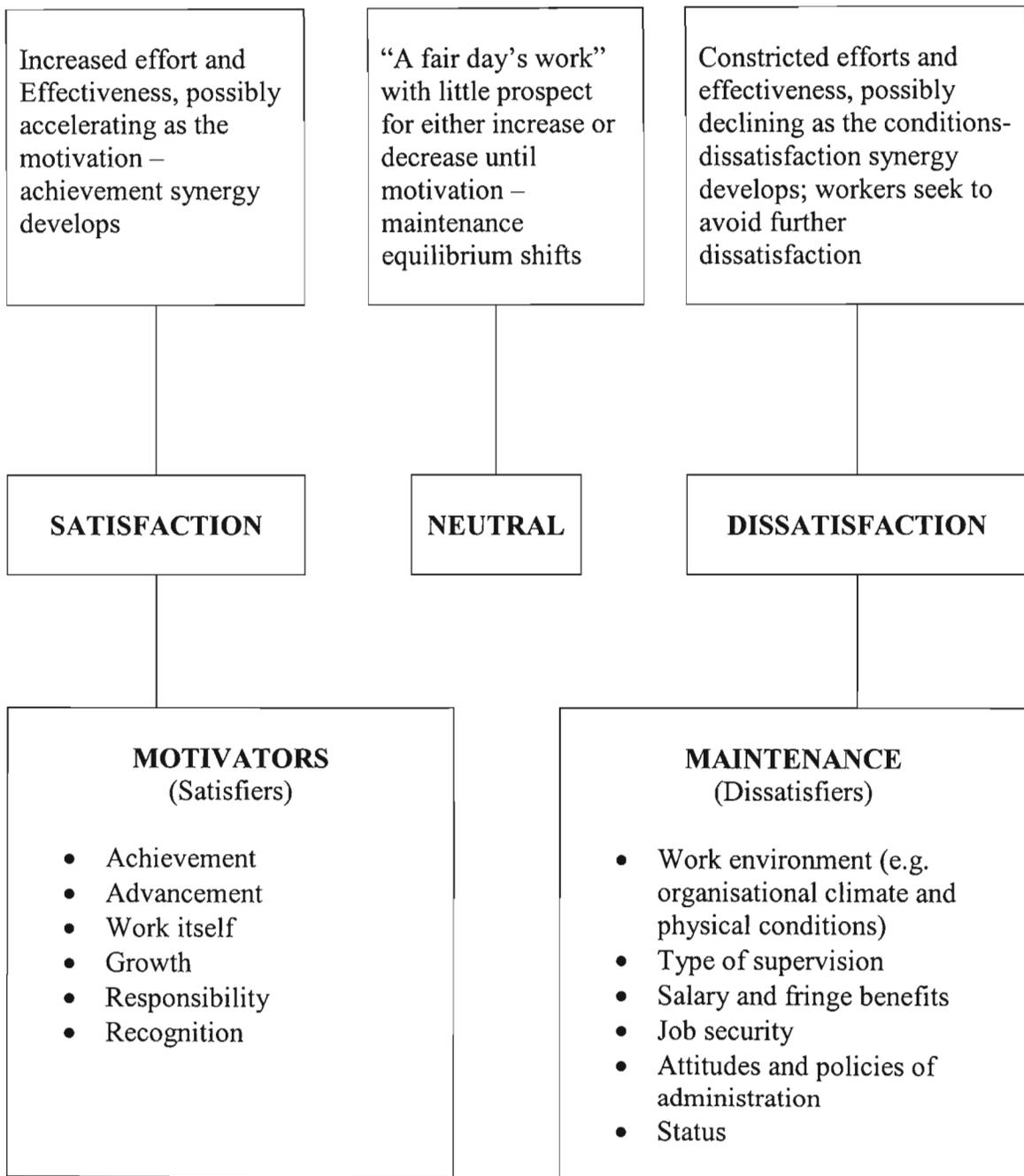


Figure 2.

Model of Herzberg’s Motivator–Maintenance theory taken from Owens (1998, p.149).

2.8.1 STRATEGIES TO PREVENT THE BRAIN DRAIN OF NURSING

PERSONNEL

The International Council of Nurses (ICN) has developed and disseminated policy guidelines for the 'ethical recruitment of nurses' in an attempt to regulate the international recruitment process, and stem the 'brain drain' (ICN, 2001). There are thirteen key principles that under gird the ICN policy on the international recruitment of nurses – these pertain to: effective human resources planning by both source and destination countries, credible nursing regulation, access to full employment information in respect of nurses already in a country that is recruiting nurses from abroad, freedom of movement and discrimination, the establishment of good faith contracting, equal pay for work of equal value, access to grievance procedures, a safe work environment, effective orientation/mentoring and supervision, employment trial periods, freedom of association and the regulation of recruitment (ICN, 2001).

Various policy responses have been initiated and/ or considered by different countries in their endeavours to contain the loss of nursing personnel due to external migration (Buchan et al, 2003). Buchan et al (2003) posit that there are three main options for governments and agencies wanting to change the brain drain dynamic in respect of the shortage and migration of nursing personnel in their countries.

Option one was for the governments concerned to support improvements in pay, and working conditions for nurses and also to improve the prestige of nursing in their country

– the rationale being that this would encourage nurses to remain in their home country if the quality of their work life was significantly improved. Essentially option one is intended to reduce the outflow of nursing personnel by means of addressing the ‘push’ factors that have precipitated the shortage and migration e.g. addressing issues of poor pay, poor working conditions, high workloads and responding to concerns in respect of security, continuing education and career prospects. Option two referred to bilateral ‘country to country’ agreements to manage and regulate the flow of nurses, while option three referred to the instituting of an arrangement whereby compensation would flow from the country recruiting nurses from abroad, back to the source country (ICN, 2003).

Buchan et al (2003) additionally note however that monetary and regulatory barriers do nothing to address the factors and experiences that precipitate migration, and that these barriers disregard the inalienable right of the individual to free mobility.

The World Health Organisation (WHO) via the World Health Assembly (WHA) argues that interventions to mitigate migration and to stem the brain drain of nursing personnel have failed (WHA, 2004). This is attributed to the fact that socio-economic conditions for nurses in their home countries have not been significantly improved, and to the fact that government approaches to the problem have been only ‘piecemeal’ (WHA, 2004).

The World Health Organisation recommends that each country should ‘...devise its own strategy for dealing with the brain drain...’ (WHA, 2004). Interventions recommended include the reviewing of salaries for the ‘caring professions’ (i.e. the nursing profession),

and the implementing of incentive systems. The WHO further recommends that existing policies and strategies in respect of the retention of health care workers be reviewed.

Further recommendations by the WHO and the WHA in respect of ‘source’ countries experiencing the brain drain of nursing personnel, are included verbatim below.

‘...Source countries should:

Establish and maintain appropriate information systems on human resources, including a database on migration in order to provide evidence for policy, planning and day-to-day decision-making and to monitor the effect of any intervention programme implemented;

Consider using resources accrued from debt relief and development-assistance programmes to augment salaries and incentives for health workers; and

Strive to create an enabling sociopolitical environment for provision of health services, improving equipment and drugs supply, and expanding continuing education for health workers, so as to contribute to the retention of health workers...’
(WHA, 2004).

The WHO further recommends that the ‘Commonwealth Code of Practice for International Recruitment of Health Workers’ – as promulgated by the ICN, should be adopted, implemented and adhered to by all countries (WHA, 2004). It is thus envisaged that this code of practice in respect of the ‘ethical recruitment’ of nurses will regulate the migration of nurses, and in time address the situation of shortage of nursing personnel.

CONCLUSION

Many of the factors associated with the shortage and turnover of nursing personnel globally appear to be universal in nature (WHO, 2003). It is interesting to note that the literature focuses almost exclusively on 'maintenance' factors i.e. those factors that relate directly to the work environment (e.g. organisational climate and physical conditions), salary and fringe benefits, job security, attitudes and policies of administration, supervision and status. 'Motivator' factors such as professional achievement and advancement, the nature of the work itself, professional growth, responsibility and recognition were not significantly documented or reflected in the literature reviewed.

CHAPTER THREE

3. METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research design that was employed by the researcher, the population and sample of nursing personnel that were used in the study, and the procedures that were followed to obtain the sample. Data collection processes and the mode of data analysis are discussed, as are ethical considerations, strengths and limitations of the study.

3.2 RESEARCH STRATEGY AND APPROACH

The broad paradigm of this research is that of the qualitative research field. Wilson (1985) argues that the qualitative research process entails the ‘non-numerical organisation and interpretation of data’ – such that the researcher’s discovery of patterns, themes, categories and qualities in field notes, interview transcripts, documents and case studies is facilitated. The qualitative approach thus not only permitted the researcher to explore each individual participant’s hospital workplace experience, but additionally facilitated a descriptive discussion of the findings of the study.

The researcher employed a phenomenological approach specifically because the researcher was interested in identifying, describing and understanding the subjective experience of individual nurses in the nursing profession in respect of their decision (s) to resign from their employment, and /or to leave the nursing profession. Crotty (1996) additionally argues that the phenomenological method uncovers the meaning of human experience in its situated context, and thus the phenomenological approach enabled the researcher to interpret the meaning of each of the study's participants' experiences in relation to their individual contexts. It was the 'lived hospital workplace experiences' of Registered Nurses who had resigned from their posts that the researcher intended to make intelligible. These 'lived experiences' were analyzed and the experiences that had contributed to the individual's decision to resign from her or his employment and/ or to leave the nursing profession were identified and described.

3.3 POPULATION

The population for this study: all Registered Nurses in the Durban Metropolitan Area who were employed in either Private or Provincial/ Public hospitals, and who were in their resignation month and / or who had resigned.

3.4 SAMPLE AND SAMPLING PROCEDURE

This research was carried out at four hospitals in the Durban Metropolitan Area. Two Provincial and two Private hospitals were purposively selected as research settings. The rationale for choosing both Provincial and Private hospitals were as follows:

- Both types of health care institutions provide the majority of employment opportunities for Registered Nurses
- Both types of health care institutions are currently experiencing the effects of nurse migration
- Utilizing both types of health care institutions enabled the researcher to present a more comprehensive view with regard to the phenomenon being studied.

The specific hospitals that participated in the study were approached by the researcher for the following reasons: their size (as the largest employers of nursing personnel in the Durban Metropolitan Area), their prominence in the community, and because as institutions that are 'training' hospitals (in that they each conduct nurse education and training programmes), they are primarily affected by internal, external and 'out' migration of nursing personnel.

3.4.1 SELECTION OF PARTICIPANTS

The sampling method employed by the researcher in this study was that of purposive sampling (a non-probability method of sampling), since it involved the deliberate choice participants (Polit and Hungler, 1997). The participants in this study had to meet the inclusion criteria for the study. The inclusion criteria for the study were as follows – the participants:

- Had to be registered nurses
- Must have been qualified for at least one year
- Must have been employed by their employing body for at least 6 months, and
- Must have tendered their resignation / be in their resignation month, or have resigned from their post

Permission was obtained from both the Department of Health and the relevant authorities at each institution. Thereafter a list of Registered Nurses in their resignation month was obtained from a designated liaison person (Chief Nursing Service Manager, deputy Nursing Service Manager, and/ or Human Resources personnel member) at each participating hospital. Personnel were then contacted by the researcher who then explained the purpose of the research to each participant. Where the participant was not 'on duty', a letter (in a sealed envelope) containing the contact details of the researcher, and an explanation of the purpose of the research was left for the participant with the unit manager or shift leader. Participants were asked to contact the researcher if they felt that they would like to participate in the study. The voluntary nature of participation in the

study was emphasised, and participants were advised that if they decided to participate in the study that they could withdraw at any time.

A theoretical sampling strategy was additionally used in the sample selection process - i.e. the researcher continued recruiting participants and sampling until data saturation was achieved. Data saturation was considered to have been achieved when no new information was forthcoming from subsequent interviews at each institution, at which point sampling at the institution was drawn to a close. Theoretical saturation was achieved both within each institution and between institutions.

3.5 DATA COLLECTION PROCESS

Two semi-structured interviews were conducted with each participant by the researcher. The first interview was conducted face to face while the second interview was conducted per telephone due to logistical constraints. A semi-structured interview format was selected because it accommodated the specific questions and issues that the researcher needed to have addressed, and simultaneously allowed the researcher a degree of flexibility in terms of 'the order' in which topics were considered. In accordance with Denscombe's (1998) findings, the semi-structured format permitted the interviewees to speak more widely on issues raised either by the researcher or themselves. Denscombe (1998) argues that the semi-structured interview format '...permits... interviewees to use their own words and develop their own thoughts...' (Denscombe, 1998, p. 113), and thus the interview format used in this study was suited to the investigating of personal

accounts of experiences and feelings and complements the phenomenological approach utilized in this study.

The first interview was based on open-ended questions that were designed to elicit the individuals' reasons for terminating their employment, their attitudes towards their employing body, their perception of their work experience at the institution, and what they would consider to be adequate 'motivator' and 'maintenance' factors in their work environment (see Appendix One). The second interview was a verifying interview in which the researcher presented the summarized material from the first interview to the participant - in order to obtain confirmation of the material. Clarification in respect of the researcher's interpretation of the material was obtained, and participants were afforded the opportunity to add new information to the interview (see Appendix Three).

With the exception of one participant who consented to take part in the study but who refused permission for the interview to be recorded, each face to face interview was recorded. Permission for the tape recording of interviews was obtained from each participant and written consent for this recording was obtained. Written consent pertaining to the individual's participation in the study itself was obtained from each participant prior to the interview commencing.

The interviews were conducted at times that were convenient to both the participant and their respective hospital. The venues for the interviews were mutually agreed upon by the researcher and the participant. Interviews were conducted in a range of venues e.g. in an

empty office or treatment room within the hospital as well as in the nurses' home and in a private venue. The privacy of each interaction was ensured and interruptions were kept to a minimum. At each interview a pseudonym was chosen by each participant in order to ensure that his or her identity in the study remained confidential.

Field notes were compiled during the interview (see Appendix Three). The field notes provided the researcher with information regarding the verbal and non-verbal communication patterns of the participant and on the quality of the rapport established with the participant. The field notes additionally included basic demographic information regarding the age and gender of the participants, and information such as the time, place and duration of the interview.

3.6 DATA ANALYSIS

Kvale (1996) reiterates that the purpose of the qualitative research interview relates to the '...description and interpretation of themes in the subject's lived world...' (Kvale, 1996, p.187), and thus that the analysis of qualitative data evidences a continuum between description and interpretation. Kvale (1996) additionally notes that there are three parts to qualitative data analysis:- first the structuring of the 'large and complex body of interview material', then clarification of the material by eliminating superfluous material e.g. repetitions, and digressions and anything that is deemed non-essential, and finally the analysis 'proper'.

In structuring the data collected in this research, the researcher transcribed each of the interviews from the recordings made in respect of each interview. Each transcription (hard copy) was then checked against the relevant recording. Where the researcher had not been permitted to record the interview, an account of the interview and of the material obtained was written up immediately after the interview. A qualitative data management package (NVIVO / QSR – NUD*IST) was used to organize the transcriptions and facilitated the subsequent coding of the material. Any digressions and repetitions evidenced in each transcript were eliminated.

When conducting the analysis ‘proper’, the researcher developed the meanings in each participant’s interviews through the description and interpretation of these while considering the participant’s own understanding. The specific approach utilized in the analysis ‘proper’ –as described above and in respect of the data collected was that of ‘meaning condensation’ (Kvale, 1996). This process entailed summarizing that which was expressed by the participants into briefer statements so that the main sense of what was said became evident in a few words. Having reduced the data, the researcher then identified the main theme (s) that were evidenced in each of the participant’s statements, and coded them appropriately. Natural meaning units that were found to be common were grouped together. The meanings of these ‘natural meaning units’ (statements) and themes were then analyzed in terms of the ‘specific purposes of the study’. In this study the purpose of the study was to identify and describe the hospital workplace experiences that had contributed to the resignation of registered nursing personnel in the Durban Metropolitan Area.

Kvale (1996) notes that the method of ‘meaning condensation’ is an empirically phenomenological method - thus in terms of this research, the utilization of this method of data analysis complements the overall phenomenological research strategy.

3.7 ETHICAL CONSIDERATIONS

Written permission was obtained from the University of KwaZulu – Natal’s School of Nursing Research Ethics Committee (see Appendix Four), and ethical clearance was obtained prior to approaching the Department of Health (see Appendix Five), and the respective institutions selected to take part in the study (see Appendix Seven). Thereafter written permission was obtained from the Department of Health in Pietermaritzburg (see Appendix Six) and from the relevant Hospital and Chief Nursing Service Managers at the State and Private hospitals selected to take part in the research study. (See Appendices Eight through Eleven). Gaining permission to conduct the study was a vital step in ensuring access to each institution, and further enabled the researcher to access information regarding those who had terminated their employment at the respective institutions. All of the participants in this study were informed that permission to conduct the study had been received from the relevant authorities in their covering letters (see Appendix Twelve). This was necessary in order to show that:

- the rules and regulations with regard to each organisation had been complied with
 - with regard to the conducting of research on their premises.

- that management had given permission for the participant's details (names and current units that they were working on only) to be released to the researcher, and
- those staff who wanted to participate in the study were permitted to do so if they so wished.

Communication with participants was as follows:

- Via the Nursing Service Managers (or designated liaison person) in each hospital who were asked to identify staff members who were in their resignation month
- Via the covering letter that was given to each participant.

The participant covering letter explained the nature of the research study and emphasized that participation in the study was voluntary. Participants were advised that they could withdraw at any time from the study, and that their privacy and right to confidentiality would not be breached in any way. Confidentiality was maintained by: ensuring that the names, identity, employee and contact numbers of the participants were not recorded on any of the transcripts, follow up interviews or field notes, by using pseudonyms on these documents (pseudonyms were additionally used in respect of the participating health care institutions), and by keeping names, pseudonyms and contact details in a safe and locked place away from the transcripts.

Although participation in this study denoted the informed consent of the staff member concerned, written permission to record the interviews and written consent pertaining to

their taking part in the study was obtained from each participant. A consent form was attached to each covering letter and this was completed and signed prior to the commencement of each interview (see Appendix Twelve). During the research process the tapes were kept in a safe, locked place. The researcher's contact details, and credentials were recorded in the covering letter, and thus this gave all of the participants the opportunity to contact the researcher if they wished.

3.7.1 TRUSTWORTHINESS OF THE RESEARCH

The four criteria by means of which the trustworthiness of this study was established were those advocated by Guba as cited by Krefting (1991). The criteria are: truth value, applicability, consistency and neutrality. In qualitative research these assessment criteria are respectively defined as credibility, transferability, dependability and confirmability (Krefting, 1991).

Credibility

Establishing the credibility of this research was approached in several ways. First the researcher 'bracketed' and documented any personally held presuppositions and biases about the phenomenon at hand - so that 'researcher effects' did not skew or bias the interpretations of data analyzed (see Appendix Two).

While the identities of each of the participants and their participating organizations were not documented in the study and were referred to throughout by means of pseudonyms,

the researcher was able to further establish the credibility of the study by ensuring that the participants were accurately described by means of appropriate demographic information.

Prolonged engagement with each participant in the form of an initial interview followed by a clarifying interview further enhanced the credibility of the study. The clarifying interview enabled the themes and categories identified by the researcher (from the meaning condensation and analysis of the previous interview) to be presented to the participant for verification and clarification. The researcher engaged with each participant in an earnest, unobtrusive manner and this enabled the researcher to establish a rapport and build trust with each participant. This in turn served to encourage a more spontaneous response from each participant (Holloway and Wheeler, 1996).

Simultaneous observation of each participant throughout the interview – as documented in the field notes, further contributed to the credibility of the study in that the researcher was able to ascertain whether or not the participant's verbal and non-verbal communications were congruent.

Credibility was further enhanced by the researcher presenting the data, data analysis and conclusions for 'peer debriefing'. 'Peer debriefing' involved the presenting of the data (recordings, transcriptions and field notes), data analysis and conclusions to a more experienced researcher (research supervisor) who had experience in research, and in the research method used in the study, for evaluation. The strategy of 'peer debriefing'

ensured that rigour had been applied in the research process, data collection, analysis and in respect of the conclusions drawn in the study (Holloway and Wheeler, 1996).

Transferability

By providing a thick (dense) description in respect of the demographics of the individuals who have participated in the study, and also in respect of each of their work place experiences and contexts, the researcher has facilitated the reader's being able to assess the transferability of the findings of this study to their own contexts (Krefting, 1991).

Dependability

The dependability of this research study was closely linked to its credibility (Holloway and Wheeler, 1996). The dependability of this study was established by means of external checks and by a process of audit - by means of which the data analysis and conclusions drawn were authenticated by the researcher's supervisor. Member checking was additionally employed whereby the researcher was able to present the summarized data from each interview back to the respective participants for validation and clarification. In accordance with Brink (1993), this enabled the researcher to obtain feedback about the accuracy of the content of the interview.

Confirmability

Confirmability means that, '...the data are linked to their sources for the reader to establish that the conclusions and interpretations arise directly from them...' (Holloway and Wheeler, 1996, p. 168).

In this study the researcher used the participant's own words and expressions to summarize, illustrate or clarify any points made. Steps taken by the researcher in the data analysis process involved the establishing of identifying codes for each interview e.g. the transcript of participant **RN X** was coded TX. Where quotes were taken from this transcript to substantiate a point, these have been referred to by means of these code letters and are additionally followed by the page number and segment reference e.g. **TX/1/1** – means: the transcript of **RN X**, page one, segment one, and **TX/F/1/1** – means: the transcript of **RN X**, follow up interview, page one, segment one. In this way the researcher was able to create a substantive audit trail which facilitated any cross referencing and which served to link the data directly to its source (see Appendix Three).

Analyzed data (condensed meanings which resulted in the themes and categories being identified), conclusions drawn, and any information regarding the research process e.g. proposal and expectations, design strategies and methodology, were additionally subjected to audit and external checking.

Confirmability was also enhanced by means of triangulation. Brink (1993) defines triangulation as ‘...the use of two or more data sources, methods, investigators, theoretical perspectives and approaches to [the] analysis of ... a single phenomenon...’ (Brink, 1993, p. 37). Essentially triangulation increases the validity of a study by increasing the field of study. In this study triangulation was achieved by collecting data from two types of health care institution (Provincial hospitals and Private hospitals), and by sampling at four different health care institutions (i.e. at two Provincial hospitals and

two Private hospitals). In addition to this data were collected from multiple participants at each hospital until data saturation was achieved. (Sampling was conducted according to the principle of theoretical saturation). Thus the collecting of data in this manner enabled the researcher to present a more complete picture of the hospital workplace experiences of Registered Nurses in the Durban Metropolitan Area.

3.8 STRENGTHS AND LIMITATIONS OF THE STUDY

The limitations associated with this study are associated with the small scale of the study and to the researcher having used a purposive sample technique in the selecting of participants to take part in the study. These factors mean that the researcher was less able to generalize the findings of the study to other contexts outside of the study and that the sample used was not necessarily representative of the population being investigated. Time constraints however necessitated the scale and sampling method utilized in this research.

An additional limitation was the presence of the researcher and the need to record the interviews since not all of the participants were at ease with having the interview recorded. In accordance with the writing of Babbie and Mouton (1991), it was noted that some of the study's participants' responses were less than spontaneous. Babbie and Mouton (1991) have argued that the interview situation is 'unknown' to most participants and that it is not uncommon for participants to experience the interview as a test, or a 'spying operation'. These fears may have had an effect on the responses of the

participants and therefore it was necessary to establish a rapport with the participants and to assure them of the researcher's independence from their institution, the neutrality of the researcher and to reinforce the fact that all material obtained was confidential, and that this confidentiality would be maintained by the researcher.

The strength of this study pertains to the phenomenological nature of the study, and that the participants' own words have been used by the researcher to describe their hospital workplace experiences.

3.9. CONCLUSION

This chapter has detailed the qualitative approach and purposive research methodology of the study. Concordance between the phenomenological research design and methodology – as pertaining to the data collection and data analysis (meaning condensation) has been demonstrated. The ethical considerations, trustworthiness, limitations and strength of the study have additionally been discussed.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter describes the participants who took part in the study and discusses the study's field notes and findings. Having reduced the data, the researcher - via a process of meaning condensation, was able to identify experiential themes from the natural meaning units that were evidenced in each of the participant's statements (Kvale, 1996). (Natural meaning units that were found to be common were grouped together, and coded appropriately). The meanings of these 'natural meaning units' (statements) and the subsequent experiential themes were then analyzed, described and interpreted in terms of the specific purposes of the study.

4.2 A description of the participants, the settings and interview processes, and synthesis of field notes

4.2.1 The participants

A total of fifteen participants were interviewed – thirteen female and two male registered nurses. Thirty interviews were conducted – two per participant (an initial interview followed by a 'follow up' and clarification interview). The follow up interviews were

predominantly conducted telephonically due to logistical constraints e.g. time and the fact that most of the participants had left their respective health care facilities at the time of follow up. The sample was representative of all race groups in almost equal proportions. Most of the participants were in the 30 to 40 year age bracket with the youngest participant being 23 years old and the oldest being 52 years old. The participants' area of speciality varied from those who were working in non-specialised units e.g. male surgical and medical wards, to those who worked in specialised units e.g. intensive care, renal unit and trauma/ casualty.

The qualifications of the participants ranged from those who had qualified as registered nurses by means of the bridging course (six participants), to those who had qualified by means of the three year diploma in general nursing (three participants), to those who held the four year diploma in nursing (general, community and psychiatric) and midwifery (six participants). One participant (previously a bridging course qualified registered nurse) held a BCur degree in nursing education and nursing administration, and had achieved post basic qualifications in midwifery, community and psychiatric nursing.

The most common post-basic qualification achieved by the three year diploma qualified registered nurses was midwifery, and one three year diploma qualified registered nurse had achieved a post-basic qualification in intensive care nursing. Of the four year diploma in nursing (general, community and psychiatric) and midwifery qualified participants, two had achieved a post-basic qualification in intensive care nursing. Post-basic qualifications in respect of the trauma course (held by one bridging course qualified

participant), and in occupational health nursing (held by a three year diploma qualified registered nurse with midwifery), were noted. In terms of the nursing hierarchy, the participants represented the levels of professional nurse, senior professional nurse and chief professional nurse. Two participants were unit managers.

As registered nurses, the combined years of experience of the participants was one hundred and forty four years – the earliest qualification as a registered nurse was in 1972, and the most recent were the bridging course qualified registered nurses in 2004. It is thus evident that the profession is losing highly experienced and well qualified individuals.

The majority of the participants' gross earnings were between six and seven thousand rand per month - with the exception of the three oldest participants (with an average of twenty six years experience between them) who were earning between eleven and twelve thousand rand per month, and one of the unit managers (eleven years of experience) who was earning in excess of twelve thousand rand per month. The second unit manager was earning between seven and eight thousand rand per month and had nine years of nursing experience.

All of the participants had tendered their resignations and were thus in their resignation month at the time of interview and all had been employed at their respective health care institutions in excess of six months. Some of the participants had been at their institution for a considerable length of time and had done their basic training at the institution. One of the participants had been with the institution for fifteen years.

4.2.2 The settings and interview processes

The majority of the initial interviews took place within the hospital setting – usually in an empty treatment room, staff tea lounge or area elsewhere within the hospital. Three interviews (RN M, RN W and RN X) were conducted away from the hospital - one in an empty lounge in the nurses' home, and the other two were conducted in private venues as per each participant's choice.

A concerted effort was made to ensure that interruptions were kept to a minimum, and where possible the researcher placed a notice on the door to the venue advising that a 'meeting' was in progress. Despite these efforts, a number of interruptions presented with certain interviews – usually medical staff looking for something. Where interruptions occurred, the interview was halted and the tape recorder was turned off until the situation had been resolved. Prior to each interview commencing the voluntary nature of participating in the study, and matters pertaining to confidentiality were emphasized. Pseudonyms (letters of the alphabet) – as a means to facilitate anonymity, were chosen by the participants.

Informed consent with regard to taking part in the study, and for the tape recording of the interview was obtained from each participant prior to the commencement of the interview. Only one participant refused permission for the interview to be recorded. This participant consented to be interviewed and permitted the researcher to write down key

words and phrases throughout the interview. The majority of the participants were punctual in observing the times agreed to for the interviews.

4.2.3 Field notes

Field notes were compiled during and immediately after the interview. The field notes provided the researcher with information regarding the verbal and non-verbal communication patterns of the participant, and on the quality of the rapport established with the participant. The field notes additionally included basic demographic information regarding the age and gender of the participants, and information such as the time, place and duration of the interview (see above).

A synthesis of the field notes with regard to the verbal and non-verbal communications of the participants evidenced that the majority of the participants were uncomfortable discussing matters pertaining to hospital management and their attitudes towards nursing staff, remuneration and certain collegial relationships in the workplace. This discomfort was conveyed through a noticeable reduction and/ or avoidance of eye contact, by means of a change in body posture (arms folded across the chest), fidgeting with jewellery (ear rings, rings), adjusting items of clothing and fidgeting with ears / rubbing the nose and neck. With certain participants, discomfort was also conveyed by means of giggling, inappropriate laughter / jokes and silences when awkward situations were discussed and in the case of one participant by means of clicking a ballpoint pen mechanism throughout the interview.

While a number of participants were emotive in their responses, a large degree of discomfort was expressed by one participant who openly cried when discussing her situation. Possible resistance and discomfort at being interviewed was additionally conveyed by one participant who arrived late for a scheduled appointment claiming to have forgotten that a meeting was scheduled and who voluntarily admitted to having ignored the researcher's attempts at contacting her telephonically. One participant openly expressed a degree of hostility and aggression towards the researcher – despite having agreed to participate in the study. This was conveyed through a negative and hostile attitude and verbalization. This participant not only refused to have the interview recorded and refused to be interviewed in a private venue, but spent much of the interview scanning the environment and looking around to see if anybody was listening in on the interview. Where participant discomfort was evident, the researcher asked the participant if he or she would like to halt the interview, withdraw or re schedule the interview. None of the participants opted to withdraw or to re schedule their interview.

Despite the discomfort and tension conveyed by the non-verbal communications of certain participants with regard to specific matters, the majority of the participants were enthusiastic about taking part in the study and wanted to have their opinions and voices heard. RN **W** stated that she had decided to take part because she had reached the end of her tether and that 'it was time that the truth about nurses and their situations came out'. Most expressed an appreciation that somebody was taking an interest in the nurses and their situation, but added that they doubted that anything could be done about it since they [the government and their respective hospital management structures] already 'know

these things', and choose to do nothing about it. The researcher attempted to create a good rapport with the participants by utilizing a basic listening sequence (attending and listening behaviours) that included maintaining appropriate eye contact, summarizing, paraphrasing, and the mirroring of verbal and non verbal patterns.

4.3 Difficulties experienced in conducting the research

Despite obtaining ethical clearance and permission from the Department of Health to conduct this study, significant difficulty in obtaining permission to conduct the study in the Provincial hospitals was experienced by the researcher. On average it took four months for these institutions to process the request, and each submitted additional criteria that had to be met prior to granting the researcher access to their facility. Due to logistical constraints, it was decided by the researcher that it would be easier to interview the participants at their relevant institutions – often this meant that participants would be interviewed while they were either 'on duty', or during their tea or lunch times. This was problematic in respect of those participants who worked on closed units e.g. ICU and trauma/ casualty because they were not able to relax fully and were constantly watching the time to ensure that they were not late in getting back to the unit. Three participants agreed to be interviewed on their 'day off' – either at the institution or at a venue of their choice – this was found to be more conducive to the interview process. A further problem encountered by the researcher was that many of the participants – although eager to participate, initially regarded the study and the researcher with a degree of apprehension – as if the study was part of a 'spying operation'. The researcher found that she had to

spend time allaying participants' fears, and had to repeatedly emphasize the fact that she was not aligned to any of the institutions or their management structures, that participation was voluntary and that all material was confidential. Once this had been established the participants were more at ease with being interviewed and with discussing their working conditions, reasons for resigning and other relevant matters.

4.4. Discussion of the findings

The researcher personally transcribed each of the taped interviews and then checked the transcriptions against the recordings. This process facilitated the researcher becoming immersed in the text and in the narratives of each participant. The volume of data were managed using NVIVO (QSR NUD*IST). Having reduced the data, the researcher - via a process of meaning condensation, was able to identify the experiential themes from the natural meaning units that were evidenced in each of the participant's statements. Natural meaning units that were found to be common were grouped together, and were then coded appropriately. The meanings of these natural meaning units (statements) and the subsequent experiential themes were then analyzed in terms of the 'specific purposes of the study'. In this discussion, the experiential themes are further subdivided into sub-categories. The sub-categories have been derived from the coded natural meaning units (see Table 4.1).

Table 4.1: Experiential themes and sub-themes

Experiential theme	Sub-theme
Working conditions and experience	<ul style="list-style-type: none">• Physical environment• Workplace violence• Occupational safety• Staffing practices• Hours of duty• Labour practices• Racism• Performance appraisals
Salary, remuneration and other structures	<ul style="list-style-type: none">• Transparency• Capped salary progression• ‘Scare Skills’ allowances
Interpersonal relationships in the workplace	<ul style="list-style-type: none">• Relationships with nursing and hospital management• Relationships with medical professionals• Relationships with nursing colleagues• Relationships with patients

Nursing and the nursing profession	<ul style="list-style-type: none"> • Contemporary nurse training • Morale • Burnout
Resignation – recourse to enact personal and positive change	<ul style="list-style-type: none"> • Trigger incidents • Continuing education and staff development • Promotion opportunities • Autonomy

4.4.1 Experiential theme: Working conditions and experience

In this study ‘work experience’ and ergo working conditions were operationalised as referring to both the non-material experience of nursing (the act of nursing itself /clinical practice and interaction with one’s patients), and to the material aspects of being an employee within an organisation. Specifically the experience of the nurse in respect of the organisational climate, his or her physical working conditions, supervisory and professional support received, and basic conditions of service e.g. salary, and benefits.

4.4.1.1 Sub-theme: Physical environment

The researcher noted that substantial differences in physical working conditions for nursing personnel exist in the health care institutions of the Durban Metropolitan Area (DMA). The disparity is particularly evident between Provincial and Private hospital groups, although neither Provincial nor Private health care institutions could be described as furnishing optimal working conditions for their nursing personnel. While the participants were for the most part stoical about these conditions it was noted that these conditions were a contributing factor in perpetuating stressful working conditions, and dissatisfaction.

In Provincial hospitals, facilities catering for the physical needs of nursing staff were sub-optimal – as illustrated by the following comments:

On nursing staff ablution facilities (toilets):

‘... it is clean ... but not that much ... you can use it – you can say that it is not cleaned daily – but it is clean [enough]...’ TD/8/81.

On staff meals and the provision of tea, coffee, sugar and milk for those nursing personnel on duty:

‘... Food? (laughs). Let’s start with food ... there is **nothing** – because you have to carry everything – sugar, tea, milk ...everything ... you only get water here ...’ TG/13/177.

The provision of meals, tea, coffee, sugar and milk for staff that are on duty was uniformly not available in the Provincial hospitals. Although these hospitals had

‘subsidized staff canteens’ that the nursing staff could patronize during their lunch break, it was felt that prices were too expensive:

‘... [At] ... other hospitals ... I have seen ... I have seen those canteen staff are having discounts ... but here we don’t have a discount. When you are coming from outside ... that meal there, it is R10 ... if you are a staff it is R10 – there is no discount but other hospitals are being discounted... [i.e. staff receive subsidized meals]...’ TD/8/87.

While the quality of the meals on offer was not raised by the participants in the Provincial hospitals, some of the participants from the Private hospitals noted that the quality of the meals on offer at the subsidized staff canteens was poor. This is encapsulated in the following comment by RN X:

‘... the meals ... **are horrible**. Horrendous. Um ... I think that more than 50 % of the nursing staff don’t eat/ have lunch at the hospital – they bring their own meals ... it is subsidized – we pay one rand for a coupon ... I don’t know how much a meal costs because we just pay one rand and the hospital pays the balance but ... I think that if they sold a plate of food for eight rand, and it was presentable and worth it - nobody would hesitate to buy a good plate of food for lunch, you know - but because it is one rand- I think they make it like half ... it is really like one rand’s worth [of food]..!’ TX/11/113-115.

On the safety of personal belongings e.g. handbags:

While some of the units did have lockers for the staff to store their belongings in, the consideration for the safety of the personal belongings of nursing personnel was not

uniform. On certain units there were insufficient lockers available for all the staff on duty and this situation was compounded by staff that had left the unit and who had not vacated the lockers and/or returned the keys.

‘... we do have place for ... for those things ... but it is not being reviewed. Because now sometimes for example ... we are having lockers here to put our things – if those people [other nursing staff] ... have gone to other places, there is no one who is looking after those people and says ‘...no take out your things, give us back your keys because we want to use the thing. Other people who are new in the place end up putting their bags everywhere in the duty room, in the cupboards where there is no need of putting those bags there...’ TD/8/75.

‘...you scratch around for places to put your handbag ... there is no ... like lockers you know [for] permanent staff members. There are various cupboards in the place ... [where] ... people just stash their handbags and that...’ TW/21/176.

On the provision of a clean, comfortable, quiet and private space away from the unit in which to take designated breaks:

‘...we have no tea lounge, no private area where we can go away for a tea break ... there aren’t even any chairs ... even on the unit – the matron she is saying that you don’t come to work to sit – so we can’t have any chairs... even in the duty room...’ TF/2/20.

‘... There is a staff lounge but it is in a filthy condition most of the time - I never go in there or very seldom...’ TW/21/ 176.

On the provision of equipment and surgical supplies

A recurring theme at the Provincial hospitals pertained to the lack of basic equipment that was needed by the nursing personnel in order to deliver safe and efficient nursing care.

The shortage of basic equipment e.g. baumanometers (blood pressure monitoring devices), glucometers (blood glucose monitoring devices) and Ivacs (intravenous therapy regulation and monitoring devices), was attributed to budget constraints. As evidenced by the following comment from RN D:

‘... it is about the budget - because now ... the charge nurses they are afraid of ‘over doing’ things because they said that they are being accused ... [of] ... misusing their budgets of the wards’ ...’ **TD/19/225**.

As a result of these budget constraints, each unit was only permitted to have one of an item – e.g. one baumanometer. RN D’s unit is a male surgical unit with an average daily bed occupancy of 35 patients. Each of these patients must have their blood pressure monitored at six hourly intervals – this excludes those patients who have come back from theatre throughout the day and who must have their blood pressure monitored at more frequent intervals. If one takes five minutes per patient to obtain a blood pressure reading, and there are 35 patients, it takes 175 minutes (almost three hours) to do a single blood pressure observation round on the unit. The equipment is used continuously and with constant use needs to be sent away for repairs and or servicing. A further dissatisfaction in this regard is that not only does the equipment take a long time to be returned, but that there are no equipment reserves to fall back on when the unit’s sole baumanometer is sent

away. Nursing personnel must then borrow equipment from other wards to carry out their duties – this situation is well illustrated by the following comments:

‘... you have to go to the other wards to ask for a GM machine [glucometer], to ask for a ‘Dinamap’ [baumanometer]... all those things – because now ... ours is gone for repairs. You must go from ground floor to the last floor up asking for ‘Dinamap’ ... and items...’ **TD/20/227.**

‘... these things because you are using it daily, it is easy to be damaged – it needs to be repaired, it has to be serviced ... so when it is gone – you have nothing ...’ **TD/20/235.**

‘... with equipment, we do have problems like – you know this hospital is very old, even with the structures you can tell, the equipment is not enough because they will tell you that you can’t order this because of this insufficient funds, waiting for year end blah, blah, blah – you also hear those stories ... so you find that most of the time we are using very old equipment, because if you want to order something, there is red tape ... it takes long – you don’t get something that you want [need]...’ **TG/12/158.**

In respect of surgical supplies (e.g. bandages, needles, syringes, wound dressings and stitch cutters), a reoccurring theme in the Provincial hospitals was that shortages with regard to these items was precipitated by problems in the surgical stores department with clerks not placing orders timeously. Problems with surgical stores were further compounded by the tendency of the surgical stores personnel to order the cheapest product available to them however the nursing personnel believe that this is an example of ‘false economy’ since the quality of these cheap products is poor, and patient care is compromised. This point is well illustrated by **RN G** who states:

‘... the ‘A-pak’ – the one we use for oxygen, you can see that it is something which is very cheap ... because when you try to put it up it just breaks, or it will leak ... [and] you will have to use strapping and all to make it work ...’ **TG/12/170**.

The gravity of the situation is further evident in the following excerpt from **RN D**:

‘... we were are running short of things for certain months – for example like eh ... ‘Be Sures’ [incontinence pads] ... linen protectors...and the nappies ...those things we need it in the hospital ... we need it urgently – but now ... since ... February / March we don’t have the nappies and the ‘Be Sures’ - those linen protectors ... even with the stitch cutters – BP blades ... ai we have suffered a lot. Just stitch cutters ... how can we remove the sutures with the previous ... stitch cutter? It is impossible ... as it is we are ... using even the blades to remove the sutures ... last week we are having rusted blades [from having to soak the blades in Hibitane solution prior to reusing them] – because now we are using it even tomorrow and then tomorrow – because now it was not there ... the disposable [stitch cutters and] there were no blades that were disposable...’ **TD/ 21/245-247**.

In contrast to their colleagues in the Provincial hospitals, the physical needs of nursing personnel in the private hospitals appear to be better catered for. While no free meals are provided for nursing personnel on duty, staff do have access to subsidized canteens, and tea, coffee, milk and sugar are provided for in designated shift breaks. Clean ablution facilities, facilities for the safe keeping of personal items while on duty, and designated quiet areas for lunch breaks/ teas are in evidence.

As identified in the literature and with reference to Herzberg’s theory of motivation, there are a number of variables that affect the behaviour of personnel in an organisation – these variables may be divided into two independent categories: the ‘Motivators’

(essentially ‘satisfier variables’ that motivate personnel towards delivering a superior performance in the workplace and which lead to job satisfaction), and the ‘Hygienes’ (essentially ‘maintenance’ variables which serve to prevent job dissatisfaction). While Herzberg argues that removing sources of dissatisfaction in the workplace does not lead to motivation or job satisfaction for an employee (in terms of the theory removing sources of dissatisfaction does not result in ‘satisfied’ employees, but results in employees who are ‘not dissatisfied’), he notes that the ‘Hygienes’ must be present – i.e. the maintenance factors, must be present before the ‘Motivator’ variables can be effective. In effect, the basic working conditions of one’s employees, the meeting of their physical needs in their workplace environment and ensuring that they have the necessary equipment and supplies with which they are enabled to carry out their duties is paramount.

4.4.1.2 Sub-theme: Workplace violence

The majority of participants indicated that they had experienced violence in the workplace. The episodes of workplace violence ranged from verbal abuse, malicious gossiping and intimidation to actual physical assault on the RN’s person, e.g. as with RN W who was assaulted by a nursing colleague who was upset at not being given the charge position that she had been given on a particular shift:

‘...I was in charge of the night shift um ... before I went to do midwifery ... [this] is where this person had me by the scruff of the neck – because she was a B. Soc Science student ... that had midwifery and I didn’t – and she wanted to know from **me** why

Sr G---I wasn't putting her in charge on night duty. And she dragged me around because '...it is not fair...' TW/17/151.

RN W did not report the incident and stated:

'... I just kept quiet – it happened on a Saturday afternoon, and I just kept out of her way - because I was going off to do midwifery and that. And we didn't work together subsequently...' TW/18/153.

This incident of **RN W's** was not the only physical assault that she had experienced on duty. Subsequent physical assaults had been perpetrated by patients:

'...I have been hit – thought that my sternum was broken once ... I got clocked (assaulted) quite a shot that time, and ja ... I have been hit a couple of times...' TW/10/81&83.

RN C also indicated that she had experienced a physical assault on her person from a patient, she had been struck on the jaw and had sustained bruising – while the incident had been documented and reported, nothing came of it and no charges were laid against the patient. **RN C** was of the opinion that the assault had been deliberate and that the patient had been in control of his faculties at the time of the assault.

It was noted that the male registered nurses' (**RNs M and Y**) experiences of workplace violence differed from that of their female colleagues. While workplace violence in respect of concerns about physical safety was 'not an issue' for the male registered nurses, their experience of verbal abuse from the patients and public was also less. This

was attributed to the fact that often patients and their relatives thought that they were doctors and not nursing staff and were accordingly more respectful.

When confronted by verbal abuse by medical personnel and from colleagues – usually senior colleagues, most of the participants reported that they felt unhappy with the outcomes of the situation but that they felt unable to do anything about it because if they reported it to management either nothing would be done about it or they would be branded ‘trouble makers’. In the private hospitals the participants were of the opinion that nothing was done about these incidents because of management’s attitude that the doctors were the customers and the nurses were just employees who must get on with the job and go the ‘extra mile’ – this is evident through the following comments by **RNs X and K** respectively:

‘...[there was] one incident where um a doctor was very, very rude to one of the sisters ...ok ... but um as usual, management sides with the doctors – because they are somehow more important than the nursing staff (nervous laughter). Ja ... I think you have got to put up a lot with the doctors in the private sector, much more than you have to in the provincial hospitals ... the doctors are ... they are rude to you ... the manner in which they talk to you ...’ **TX/5/58-60**.

‘... I was new in the position [and] I went and introduced myself, basically um just wanted to know what his preferences were ... just thought it was polite. Well I got in to introduce myself to him and he went off the rails! **Went off!** [Shouting] “...So what makes you think that you are qualified to take the position and who do you think you are, and there should have ... there were other applications uh ... that were put through for this post – they were much more experienced than you were ... how come you got the

post...?”. He wasn’t called in as such – he went to management, and management and him sort of had a chat... I don’t really know the outcome...’ **TK/7/54 & 68**.

The most frequent sources of verbal abuse and assault experienced by the participants were from patients and their relatives at both public and private institutions:

‘... it depends on which department you are working, like ... I worked in trauma unit for 4 years – there was a lot of verbal abuse from the public – **a lot** from the public, and from the patients...’ **TG/11/152**. [Provincial hospital].

‘... you do get um patients that are – just totally you know abusive and unco-operative and things like that, and they are either psychiatric or they are drunk or something like that – you got to deal with them. Um and you have got to try and restrain them or some how ... or you know to help themselves, ...so that they don’t hurt themselves and then you end up getting in the middle and they start / and they lash out at you and they might smack you or something like that. Um ... ja ... that happens - but you just get so used to it that you don’t actually worry about yourself, you are more worried about your patient hurting themselves and what ever... um that you just do anything that you can to protect them, and then you just end up getting ‘donnered’ [assaulted] in the process...’ **TH/7/37**. [Private hospital].

The next most common source of abuse for the participants was the verbal abuse and rudeness at the hands of medical practitioners in the private hospitals, and from senior nursing colleagues respectively:

‘... uh ... the doctors (says with a tone of resignation), the doctors are always screaming and shouting and ... especially in theatre, uh but I won’t say [that they are] physically violent (laughs nervously)... there is certain doctors that ... (starts to tap table) make you feel like you don’t know anything, and **they’re** the ‘doctor’; its affects you psychologically because he actually belittles you. He doesn’t um call you aside and say ‘listen this or that or that – please can I have this and that, and that for the next time’ – it’s in front of the patients and you look like you don’t, you don’t actually know what you are doing...’ TZ/5/61, 65&75.

Jackson et al (2002) describe workplace violence as encompassing incidents of physical aggression, harassment, sexual harassment, bullying, intimidation, assault. The definition also includes rudeness, verbal abuse, humiliation and denial of opportunities. Jackson et al (2002) further note that organisations have a central role in the perpetuation of workplace violence in that they perpetuate existing cultures of oppression by not having clear policies for dealing with incidents of workplace violence and through decisions that contribute towards increasing their personnel’s exposure to workplace violence. Most of the participants who had experienced incidences of intimidation, bullying, and verbal abuse either regarded it as part of the job, tried to ignore it in the hope that things would just get better or didn’t know how to go about remediating the situation without having to resort to resigning from their post.

4.4.1.3 Sub-theme: Occupational safety

A number of participants voiced concerns about their occupational safety in the workplace. These concerns were related to a perception by the participants that they were increasingly being exposed to pathogens e.g. MRSA (multiple resistant Staphylococcus Aureus), Tb (pulmonary tuberculosis) and to HIV (human immunodeficiency virus).

While departmental policies were in place to deal with clients that presented with these ailments and others, the increased number of clients being treated at facilities that were not designed to cope with the volume of patients now presenting with these conditions was seen as problematic. This is evidenced through the following comments:

‘... Working environment is ok but there is a lot more bugs (pathogenic organisms, bacteria) and that out there ... exposing you...’ **TC/11/140**. [Private hospital].

‘... nursing patients has changed a lot as well since we started nursing ... but when I first started nursing there wasn’t ... all this AIDS (clears throat) and TB and things like that as well, so you weren’t at such a risk of getting infected with anything, um ... whereas now we deal with it in high numbers everyday. Um ... and especially being a mother and things like that you have got to think of your health as well, I mean I have had a needle stick injury, I think probably 60% of the hospital probably has had needle stick injuries by now (clears throat), and it’s reality - uh you know ... We are nursing patients with active TB, and all sorts of diseases and things like that ... and you do run a risk – but obviously you do take precautions and things like that, but there is always that ... that risk ...’ **TH/4/22**. [Private hospital].

4.4.1.4 Sub-theme: Staffing practices

All of the participants in the study voiced their concerns over the staffing practices in their institutions – staffing practices referring to the manner in which qualified nursing personnel were allocated to units. In addition to having to work short staffed and with newly qualified staff that lack vital experience and who therefore require supervision and mentoring, significant dissatisfaction was voiced over ‘rotation policies’ in practice at one of the Provincial hospitals. In terms of this policy, all nursing staff members are

required to rotate through the different specialty areas and units – this impacts negatively on the high care and intensive care / trauma units who rely on the ‘trained’ staff in order to function safely, efficiently and effectively. The frustration at this situation is well illustrated in the following comment by **RN Y**:

‘... So now it is frustrating when you have taught someone something, then when you - once you have taught someone something then you rely on that person. So you say “...ok even if I am busy [with a patient], she will, she knows that ... she will do it ...”. Then the next month you find that she is going to another department now and a new person who doesn’t know anything will come to the department. You have to start afresh now teaching ...’ **TM/9/81**.

Participants in both Provincial and Private hospitals voiced their frustration at management practices that treated nursing personnel as ‘interchangeable cogs’ within their institutions. Many voiced the opinion that nursing has changed in respect of the knowledge and expertise required from one area to another, e.g. a paediatric nurse is not trained to work in orthopaedics, theatre nurses are not intensive care nurses and midwives are not geriatric nurses. While basic nursing care remains the same, the knowledge and expertise required of the personnel in these areas is specialised. The majority of the participants felt that the ‘shunting’ of nursing staff between units that were short staffed e.g. due to absenteeism, was not a solution to the current shortage of staff, and that the practice was merely that of ‘crisis management’. In itself, the practice was identified by the participants at one of the Provincial hospitals as being key to their problems with chronic absenteeism – because the staff do not want to work in areas that they are not

qualified to work in, they would rather call in sick. Being moved around to various units was a major source of unhappiness, and was additionally felt to compromise client care.

Participants in both Provincial and Private hospitals voiced their concern over flexi-time practices. As part of cost containment measures, both Private hospitals have implemented flexi-time work policies – that is if there are not enough patients on a unit then the staff are required either to go off duty and to work back the time at a later date (usually at the unit's convenience) or to go and work on another unit. Again this was a source of dissatisfaction for these participants since if the other units were covered and their services were not required then they had no choice but to go off duty and owe the department 'hours'. This situation was explained by **RN K** as follows:

'... the staff get very frustrated ... when ... they have to go to all the other place(s) that are unhappy for them [i.e. not their area of specialty or preference]. And then they also get unhappy because after like a week of being quiet [i.e. being sent home] they might owe you like three or four days ... which is like 36 to 48 hours – and although you can carry your time over three months at the end of those three months you have to sign your annual leave ... because ... you going to pay this back. It is a roll over system where after three months you have to have a zero balance ...so if you have worked too many days over [then] we will pay you out for them, but if you are short you have to sign your leave for them...' **TK/12/88**.

The participants at Provincial hospitals were similarly unhappy with the flexi-time systems in operation in their institutions. As stated by **RN Y**:

‘... you are expected to work overtime for ward coverage and uh not ... remunerated for it. You are then told that you can take your time back – but you ... but you take your time back at the ward’s convenience. And I mean that ... that is not fair at all ... because it is **not at my convenience that they expect me to work overtime...**’ TY/28/312.

Some of the participants additionally described staffing practices that significantly impinged on their good will, their private lives and which were generally felt to be inconsiderate of their humanity, e.g. RN M noted that:

‘... sometimes if a person who is booking of sick is working night duty – [and] you are on duty already in the morning, they will ask you to go home and to come back in the evening. If they ... have phoned around for people who are off and they ... all say no they can’t make it ... they will ask you to go and come back in the evening...’ TM/10/91.

While management officially maintain that the staff are under no pressure to acquiesce to these requests, the reality of the situation is that the staff do feel pressurized into ‘making the ‘right’ choice, as explained by RN M:

‘... no there is no problem if you say no ... **but** like ...but if you are off and they phone you - they ask ... you the reason ... they ask the reason why - if you say no you can’t make it, they ask you the reason ... there a book there in the department ...where a person who is phoning for staff ... has to write who he/ she phoned, and what that person said. If that person refused [they need to document] ... why the person refused ... I don’t like that. That it is not right that. It is not their right... it is not for them to know what you are doing during your day off ... I think it is enough if you tell them ‘no, I can’t make it’ ... I think that is enough, you don’t have to give them reason now that uh ... ‘...I am not coming because I am doing this and that...’ – that is personal... that is ...maybe you will

be doing a personal thing- so now we have to disclose that. It is not right...’ **TM/11/97-99.**

An additional frustration with regard to staffing practices in the Private hospitals related to the employment and use of caregivers on the units. Caregivers are non-nursing personnel who are employed to carry out ‘basic nursing care’ e.g. assisting patients to the bath/ giving bed baths, dusting the unit and handing out meals. The problem is that caregivers are factored into the total staffing allocation for the unit and as such make up the numbers of ‘nurses’ on the unit. Their presence on the unit means that trained nursing personnel (registered nurses and enrolled nurses) numbers are reduced, however because the scope of practice for a caregiver is limited, the bulk of the nursing care must still be performed either by a registered nurse or enrolled nurse as appropriate e.g. the suctioning of tracheotomies, dressings, administration of intravenous medications and analgesic preparations. This is illustrated in a comment by **RN S:**

‘... we are left with caregivers that are not allowed to do much of the work anyway – so at the end of the day you are left – you know doing everything ... and we only work with lets say between 7 and 8 staff [one or two sisters, an enrolled nurse and/or an enrolled nursing auxiliary – the rest are caregivers, on a seven to seven shift in a 45 bed unit encompassing a two bed high care facility that occupies one of these staff members full time; some of these staff will go off duty at one o’ clock, some at four o’clock, and others at five leaving a reduced staff complement on duty until seven o’ clock] ... and then you have theatre cases, dressings, trachy care ...’ **TS/4/73.**

The use of session staff to make up short falls in staffing was an additional source of unhappiness for many of the participants since it was felt that while the assistance and

contributions of these nursing personnel was needed, the constant supervision of these personnel and shouldering of responsibility for their decisions by the permanent staff was a source of stress.

While the professionalism of these session staff was recognized – in that on paper they would be accountable for their own acts and omissions in respect of the patient care that was delivered by them, in reality the consequences of the actions and/ or omissions by the session staff were usually borne by the permanent staff members who happened to be on duty – that is they were called to account for the actions of others by unit management and/ or medical personnel. This was compounded by the fact that session staff were not always ‘permanent sessions’, and were therefore constantly needing to be orientated to the unit. This was found to be a significant source of dissatisfaction for all participants and especially for those working in the specialty areas of ICU, cardiac and neurology wards. In an ICU the minimum staff to patient ratio (acuity) is one registered nurse to one patient however nurses in these specialty areas are increasingly finding that this standard is being compromised. This is illustrated by the following comments from **RN X**, an ICU trained nurse, and **RN F**, who had extensive ICU work experience respectively:

‘... We are very, very short staffed. We work with four permanent staff on each shift – we work on an eleven bedded ICU – and we run on session staff, and um at the end of the day you are responsible for your patient and the session/ the outside worker that is working next to you [and their patient] and if anything goes wrong – although they are RNs and um responsible for their own actions and whatever, you are still ... you are accountable for them ... because you are the permanent staff member, and no matter how much you can uh ... try to explain that we are short staffed – or [that] we are busy, [or]

that you can't have your patient and that [of the] session staff [to supervise] ... nobody listens – they do something wrong **you** have to write a statement...I think that really puts pressure on the staff...' **TX/7/76**. (Private hospital).

'... The staff shortage has resulted in a critical situation that has impacted on the staff left behind, increasingly the ICU staff are finding themselves looking after two or more patients irrespective of whether they are ventilated or not. Not the ideal situation...'
TF/2/6. (Provincial hospital).

4.4.1.5 Sub-theme: Hours of duty

Hours of duty in terms of the shifts available to nursing personnel, was found to be a cause of much unhappiness for half of the participants interviewed – from both Provincial and Private institutions. While all the nurses accepted that service delivery in respect of patient care was a 24 hour concern, it was felt that the current shifts available to nursing personnel were not conducive towards the optimum physical and psychological wellbeing of the nurses and their families, and therefore indirectly impacted on the quality of client care. The shift patterns that were considered to be most problematic were those in effect on specialty units, e.g. ICU, high care units and trauma units. This is because the shifts in these departments are 12 hour shifts that usually start at 07h00 and finish at 19h00, and because nursing personnel do not have a choice in determining how they will work their 42 hour week. Given that the majority of nursing personnel are women, and that a large percentage have young families, these working hours – irrespective of how they are patterned, impact negatively on these nurses and their families. For **RN H** the impact of working these long shifts is evident:

‘... The main problem is the hours. I have a young family, I have got three children one aged 6, one is nearly 4 and one is 2 and a half, and ... in this unit you only work ... [clicks tongue] 12 hour shifts, and every second weekend I am working the whole Friday, Saturday, Sunday from 07h00 to 19h00; so that is basically your whole weekend gone, and you don’t get to see your family ... and my... my husband is putting pressure on me because he has got to now sit at home the whole weekend and look after three small kids on his own, and he can’t get anything else done ... it’s difficult ...you know. And it’s difficult getting home at like half past seven / quarter eight in the evening. The kids aren’t bathed, and they are running amok and now you are tired from working all day, you are irritable when you get home, and you have got a headache ... and then the house is a mess and you have got to try and sort everything out ... it’s its hard. Then the kids say “...well why do you take so long? Why are you at work all day?”. And especially on the weekends when they wake up while I am creeping out in the morning to go to work – and they wake up and then they start crying because ‘why are you going to work – it’s a weekend?’. So it’s mainly the working hours on the weekends, and the getting home late in the evenings, so I **need** a normal hour job, where I get home, I pick the kids up from school, I can get home and can do their homework, I can start the supper... I can have a normal life ... I have got children to sort out, and I can’t have a nursing career and a family with kids at the same time - because shift work and family just do not mix. **TH/2/16 & 179.** (Private hospital).

Again this disillusionment with the shift pattern available was evidenced by **RN K**:

‘... I have had a baby, and I don’t really want my baby to be brought up in an environment that I can’t see him or have anything to do with him. And I have made it very clear to management that if they had had a crèche on site, I would have stayed...’ **TK/2/18**; and ... I cannot be a weekend mother! **TK/19/138.** (Private hospital).

A further variable that complicated the above situation in both the Provincial and Private hospitals was that pertaining to the shortage of nursing personnel. The shortage of nurses

and again particularly in the specialty areas, means that often the staff are unable to form set teams that work a specific shift pattern opposite to each other. In order to ensure that the unit is covered staff are allocated haphazard duties and often at short notice. This means that in addition to working long hours which are strenuous in themselves, there are no patterns or predictability with regard to the shifts worked. This impacts negatively on the quality of life for nursing personnel because they cannot plan and organize their personal lives effectively.

In one of the Provincial hospitals the compulsory rotation of staff between day and night duty was particularly problematic for those who were single parents and with limited access to social support from families and friends. This was particularly the case for **RN G**:

‘... I do have a problem if I am working night duty, because I am now a single parent – my husband was killed 5 years ago ... and I am staying with my two children, so I have to be with them most of the time ...so that’s the main problem ...so if I can get something like in a college it will be much better because I won’t do night duty ... it so difficult to ... talk to the management, if you tell them that “... I have got this problem, I can’t do night duty because of this and that...[the children]...”, they will tell that “...but you have a hospital situation – you can’t have a problem which is unresolved ... you have to work night duty...it is a hospital rule...”...’. **TG/7/92&94**. (Provincial hospital).

While day shift hours of duty were not problematic for **RN G**, her family responsibilities, and the needs of her children were negatively affected by compulsory night duty shifts.

For the remaining participants in the study, nursing hours of duty and shifts were not problematic either because their children were now older (at secondary school, university or adults) and no longer required as much attention, or because they did not have children. All of the participants however agreed that working shifts when one was responsible for young children was particularly strenuous.

4.4.1.6 Sub-theme: Labour practices

A number of labour practices perpetrated by both Provincial hospitals and one Private institution were cited by five participants as being at the root of their dissatisfaction with their current work situation.

The practice of not employing registered nurses in their professional capacity i.e. as registered nurses with SANC registration, but as staff nurses (and ergo staff nurses being employed and paid as enrolled nursing auxiliaries), was found to be a significant problem. Not only were the two RNs in this situation being used as RNs on the unit (unofficially) e.g. in terms of the care that they were expected to provide and in terms of the responsibilities that they carried, but they were not being paid as RNs. For **RN D**, the rationale for this situation, as given by the management at the institution, was that she had bridged from staff nurse to registered nurse privately – i.e. at a private nursing college, and therefore because she had not done the course through them, she was not eligible for a RN post at the institution. **RN D** had tried unsuccessfully to be admitted to the bridging course through the institution for over ten years, and had finally elected to

finance her own studies in her own time. This point is illustrated in the following comments from **RN D**:

‘... I wasn’t selected here ... to further my studies by them here, so now they won’t take me to be a registered nurse here. Because now they said that they are taking their nurses – whom ... they have ... have trained them, so those nurses ... they are automatically having their spaces here. So ... those who haven’t trained here they should wait ... for about nine to twelve months ...’ **TD/2/12**. (Provincial hospital).

Later in the interview **RN D** again stated:

‘... they won’t employ me as a registered nurse – because there was a circular which said that if you are being trained outside of this hospital ... we won’t take you – we take people who are being trained by this institution ...’ **TD/25/301**. (Provincial hospital).

This practice of not employing those who upgraded their qualifications privately in their registered and professional capacity was confirmed by **RN G** who worked at the same hospital as **RN D**. **RN G** additionally noted that this situation affected all categories of nursing personnel, and further noted that while the staff had complained about this situation to their hospital management the situation had yet to be resolved:

‘... you don’t get straight answers ... [as to] ... why they don’t employ them – we don’t know, we are still waiting ... they told us that they are going to consider it ... but we don’t understand why they didn’t – because some of them it is over a year that they are staff nurses [or registered nurses] but they are still working as assistants – as enrolled nursing assistants [or working as staff nurses]...’ **TG/6/72**.

RN S, a registered nurse in a private hospital was in a similar situation to her colleague in the Provincial hospital, but the rationale for her situation was different. **RN S** had recently completed the bridging course and had studied privately, however on qualifying had been informed that there wasn't a post for her at the hospital. She had subsequently applied for posts elsewhere while continuing to work as a staff nurse/ bridging course student on the unit:

'... I haven't started here as a sister as yet – I'm starting next month at another hospital ... when I told them that I am getting the post – then they said that they are not going to take me as a sister for one month ...' **TS/11/143**.

Most of the participants from the Provincial hospitals voiced their frustration and anger at not being paid for overtime worked. Although those who worked overtime were given their 'hours' back, it was felt that when overtime was worked it wasn't usually at the convenience of the staff member concerned, and therefore when a staff member asked for their credit hours these should be primarily at the convenience of the staff member concerned. This was not happening. Moreover when overtime was worked on weekends and public holidays, there was no 'time and a half' or 'double time' credit in respect of hours worked – as there would've been and had been in the past for paid hours. It was simply an 'hour for an hour' in respect of time given back. The fact that nursing personnel had no choice in this matter – i.e. in respect of being paid for overtime or getting their hours back, was found to be a particularly contentious issue for **RNs M** and **Y**:

‘... They will call you, they will phone you on your cell to come and help. So... but I ... I have been refusing ... the only thing that [they do to compensate you for this] is your hours back, not money. They even refuse to ... to pay you for overtime. So you come into your unit on your day off just to work and so you can [just] get your hours back ...’

TM/3/26.

An additional labour practice that directly compromised patient safety was raised by one of the participants, **RN S** – on **RN S**’s unit, a general neurology ward, the hospital management had opened a two bed ‘high care’ unit. Patients admitted to the ‘high care’ unit require 24 hour specialist observation and care, necessitating the full time nursing service of at least one staff member. **RN S** noted that no provision had been made for suitably trained staff to staff the ‘high care’ unit:

‘... at the moment we are also running a high care - a two bed high care ward in our ward, and **we are not** high care trained, and during the day when they come [when high care patients are admitted into these beds] we are just allocated there – we just have to deal with it ... like today there is a student – a student that is doing the bridging course, but she hasn’t worked in a neuro ward before with trachy patients -what does she know really what is going on..?’ **TS/7/92&96.**

4.4.1.7 Sub-theme: Racism

Four participants felt that their work situations were complicated by racism. Three of these were employed in Private hospitals and one was employed at a Provincial hospital. The allegations of racism were from all race groups. In the Provincial hospital in question, it was felt by **RN F** (who was Xhosa) that certain staff received preferential treatment based on their ethnic identities:

‘... they do things according to their favourites... and there is a racial thing as well ... the Zulu staff receive better appraisals/ opportunities for post basic courses and other things ... as compared to the Xhosa staff ...’ **TF/1/5**.

In the Private hospitals some of the workplace tensions were attributed to racism and racist attitudes; for **RN H** an altercation in the trauma unit when she was assisting a medical practitioner with a patient left her feeling traumatized and violated:

‘... he [medical practitioner, private hospital] was shouting and screaming at me, and he actually swore at me – and um basically called me a racist because of my surname – because I have a Afrikaans surname ... but I am not Afrikaans - but because of my surname he thought that I was a racist, and so he called me all sorts of names...’
TH/7/37. [Private hospital].

In addition to having to cope with the above situation, **RN H** noted that at times the racist attitudes were evident on the behalf of patients who not only expected you to drop whatever you were busy with in order to attend to them immediately (non-emergencies) but who were quite open about communicating their disdain:

‘... they ... you know click their tongue at you, and swear at you under their breath in their own language so they think that you can’t understand ... and ... ja ... they basically spit on the floor and expect you to clean it up. I can’t handle that anymore..!’ **TH/15/88**. [Private hospital].

For **RN N**, her experiences of racism were in respect of feeling not included in the team, and of being excluded.

‘...They [the medical staff and nursing personnel] don’t want to accept people, you know when people come, and they are new in their institution - they don’t want to ... to accept them that these people are new... I do feel [there is a degree of racism]. I do feel that the racial part we are not yet past it – we are still in it - I mean racism and all that ... even the colleagues and all..!’ **TN/8/44&50.**

RN W’s experiences of racism had largely been related to her trying to exercise her responsibilities and duties as the RN in charge of her shift. Where patients and their relatives didn’t get their own way in respect of some issue or another e.g. being asked not to use their cellular telephones in a cardiac unit, or to restrict the number of visitors around the patients bed to the regulation two or four at a time, then invariably the patient or their relatives would ‘pull the racism/ racist card’- i.e. accuse **RN W** of being a racist:

‘... they think because they are in a private hospital that they are in a 5 star hotel, [that] they call the shots. And you have got to be very careful what you say to them and how you say it – um ... because of litigation. I have been reported a number of times ... and of course the ‘racist thing’ comes in... take for instance:- ... at visiting time ... you have hordes of visitors in particular rooms, and if you go and tell them to go out ... you know ask them to please ...have only ... four visitors per bed, and you start ... asking them to move out – [then] they ‘don’t like the tone of your voice’ or ‘you’ve said to us and you haven’t said it to that one’ ... and it is like a blanket thing [it is a regulation]. I have got to the stage now where I just leave it. I don’t even bother about the ... um visitors anymore because it is too much stress on me. I am asking them to leave for ... for the good of the patient because sometimes ... in our bigger wards that have 5 beds in them – and sometimes we may have three fresh bypasses that have just come up from the unit that day – and the 20 visitors per bed leave [us] ... saddled with patients who can’t breath, who are feeling hot ... who are all um ... anxious ...’ **TW/6/61&63.**

RN W maintained that this experience of hers was not isolated and that it occurred throughout the hospital in varying degrees; a consequence of management not dealing objectively with these situations was that the authority and control of the registered nurse was undermined, and further culminated in a lack of respect and consideration by the patients, their relatives and the medical staff for the nursing personnel.

4.4.1.8 Sub-theme: Performance appraisals

Performance appraisals are used by both Provincial and Public hospitals to assess specific aspects of a registered nurse's competence and efficacy with regard to the delivery of nursing care. These performance appraisals are vicariously known as JPM's (Joint Performance Management tool), reports, performance appraisals, and as the 'Personal Profile'. With the exception of one participant, all the participants were unhappy with the performance appraisal system in place at their institution. Many voiced the opinion that the process of performance appraisal was flawed, subjective, biased and not a true reflection of their abilities and competence. This critique was uniformly evident between institutions and across the Provincial and Private institutions. The process was considered to be flawed and not a true reflection of their competence because in most cases the actual appraisals were carried out by unit managers who were not familiar with the staff member and their work. This is illustrated by the following comment from RNs X and N:

'... I don't think that it is fair – for this reason. I think the person who ... should do that assessment or evaluation is someone that you work with more. Like our second in charge – we have um a unit manager, then we have a second in charge who has spent a lot of

time with in the unit with us – receiving patients, transferring, doing admissions etc. ... whereas our unit manager was most of the time out – at meetings, or conferences - and at the end of the day she does your evaluation and if she says “...I haven’t seen you take the initiative to do the safety board...” for example - but she hasn’t been there! ... Whereas if you say “...but I did it and so and so knows [that I did it]” – it doesn’t make a difference to her ... It is what **she** feels and **she** didn’t see you do it –I think somebody who has more contact with you - everyday should actually do your JPM’s...’ TX/9/99. [Private hospital].

‘... I don’t think that it is true and accurate do you know why? Because the person that does it is the unit manager and most of the time she doesn’t work hand in hand with us. Unlike the shift leader – the shift leader is always on the floor, she is hands on, she knows what is happening ... she runs the shift. But with her [the unit manager] ... she has got so much paper work to do she sits in her office most of the time, she does come around and all that, but I don’t think that she would really have a 100% clue as to what my capabilities are...’ TN/14/98. [Private hospital].

The participants from the Private hospitals noted that performance appraisals were supposed to be conducted two to three times per year for all nursing personnel and that they were linked to potential salary increases. Good scores on performance appraisals were equated with above average increases when annual increments were awarded. Since uniform salary increases are not given in Private hospitals, performance appraisals were evidenced as being a contentious issue for these participants - especially where it was perceived that the process was subjective, and biased. Allegations of favouritism, racism and inconsistency were the predominant concerns in this area.

In the Provincial hospitals performance appraisals are routinely carried out every three months over a year for newly qualified and/ or new staff. Thereafter it is supposed to be done at least yearly, however many of these participants indicated that performance appraisals were not done regularly or at all. Given that these performance appraisals are not linked to salaries, and that annual increments are determined at government level, and are implemented uniformly, dissatisfaction and unhappiness in this regard was linked to the Personal Profile system in operation at both of the Provincial hospitals.

The 'Personal Profile' was considered to be an adjunct to the annual reports by these participants, the difference being that a potential for a financial gain over and above the annual increment existed with the 'Personal Profile' system. A 'Personal Profile' was described by the participants as being a personal record or log of one's activities and achievements in the workplace. At times these personal logs would be reviewed by 'the matrons', and if 'good enough' then the staff member in question would receive a once off cash bonus. The chief dissatisfaction with the 'Personal Profile' system related to its implementation by the hospital management, and to how profiles were evaluated. Most of the participants believed that the system was corrupt in that there was a lack of transparency regarding the criteria for the awarding of the cash bonuses, that there had been insufficient in-service training with regard to the documentation required and procedures to be followed when submitting the profile. A further concern was that there was no feedback to personnel regarding profiles submitted, nor any explanations given when their 'application' to have their profile considered was unsuccessful. The 'Personal Profile' system was labeled as being divisive by the participants, and was regarded as

being a significant contributor to workplace tensions between nursing personnel. This point was emphasized by RN Y:

‘... **Personal Profile! That is what I am talking about!** Uh ... now I don’t understand that whole situation where one person gets R18 000, and another person gets R3000... or what ever. But to me it makes sense – rather give everybody R1000, 00 than giving one person R18 000 and another R3000 and somebody else nothing. Where you are [now in respect of this practice] encouraging ...uh ... staff dissatisfaction...’ **TY/5/48.**

RN Y additionally noted that he had been the recipient of a ‘Personal Profile’ cash bonus in the past and that his complaints about the system was not because of ‘sour grapes’ – i.e. because of jealousy. He further explained his position on the ‘Personal Profile’ system as follows:

‘... The thing is my relationship is not the same with that person [who has received a Personal Profile cash bonus]. It ... it affects our working relationship ... to see that **I do exactly** what that person does, work **just as** hard, make the same decisions ... and go home with a couple of thousand or a thousand rand short in my salary ... it is **not** on. Definitely ...not on ...[not okay]’ **TY/6/58.**

The participants further felt that the ‘Personal Profile’ system was not an accurate reflection of their abilities and competencies. This was because the ‘Personal Profile’ was not about documenting their daily work activities in terms of their scope of practice, but was perceived to be about the documenting of ‘extra-ordinary events’ – by which it could be evidenced that they had gone the ‘extra mile’ and ergo deserved the cash bonus. In this regard it was felt that the system was widely abused by some staff members who falsely

documented their participation or management of extra-ordinary events or incidents. This was well illustrated by **RN D**:

‘...You just write something which you **never** saw ... [because you must] ... write something which is extraordinary... it is supposed **not** to be your duty. If you write something where you said “... no that this thing is [was] beyond your scope of practice...” how do they know how you do these things below [within] your scope of practice? You don’t know what are you writing actually ... you just write – [you think to yourself] “... ai ... maybe I will be lucky if I said that I pick up the person ... the patient across the robots ...” But now they don’t want your scope of practice ... they just want ‘extraordinaries’! You see! How are you going to get that those ‘extraordinaries’? ...’
TD/18/207 & 209.

At one of the Provincial hospitals, one of the participants, **RN G** – explained that the widespread reluctance to conduct performance appraisals was out of a concern for one’s personal safety:

‘... to be honest with you we have to be followed [continually reminded] to do that really [to do performance appraisals] ... because at times you have to hide some of the things, ... I mean you talk to a person – you reprimand that person – for example some people are just like **that** [difficult individuals] – and at times for your own ... safety you have to keep quiet – you do understand what I mean..?’ **TG/16/221, 227 & 231.**

According to **RN G**, accurate performance appraisals were something of a misnomer in that caution had to be exercised when doing a performance appraisal in case there were repercussions from the staff member concerned. It was thus easier to either delegate the task to someone else or to ‘forget’ to do the appraisal.

4.4.2 Experiential theme: Salary, remuneration and other structures

With the exception of participant, **RN P** - all of the participants across both the Private and the Provincial sectors were dissatisfied with their current remuneration. Multiple reasons for this dissatisfaction became evident over the course of the interviews conducted. A predominant grievance regarding salaries was that of being underpaid - salaries were regarded as being insufficiently market related and not commensurate with individual qualifications, levels of responsibility and accountability, and years of experience. This view was encapsulated in a comment by **RN Y**:

‘... somebody can study a 6 month course out there ...[learning] how to fix computers or whatever and earn ‘megabucks’ – and we study for **four** years ... basically learning to save lives ... and you get a pittance ... I can’t correlate the two. It doesn’t make sense ...’ **TY/7/70**. [Provincial hospital].

4.4.2.1 Sub-theme: Transparency

The lack of transparency with regard to matters pertaining to salaries – e.g. salary scales, notch progressions and factual information about how increments were awarded (as opposed to vague references about these being linked to performance appraisals in the private hospitals) was of concern to all participants. In the private hospitals it was felt that one’s salary depended largely on how well you were able to negotiate for yourself on being interviewed and on whether or not there was ‘someone there’ to lobby for you and to ‘make sure that you got a good salary’ (**RNs N and K**). **RN K** – a unit manager

confirmed that there was a lack of transparency regarding salary issues – apart from the fact that it was widely ‘known’ that a new RN would start with a salary of approximately R6500, 00 actual salaries paid to nursing personnel on any one unit usually varied greatly- this was further explained as follows: when management offered a new employee (not necessarily a newly qualified employee) a salary, they looked at all the salaries of the staff employed on the prospective unit that the employee was to be drafted to, and at their associated qualifications. If the new employee was better qualified or more experienced than most of the others in the unit then they would be offered a slightly better than the average salary, if they were not better qualified or as experienced then they would be offered slightly less than average.

An additional issue of contention in the private hospitals related to the differences in salaries paid to nursing personnel between ‘sister hospitals’ within the same group. This was in respect of staff that were in possession of the same qualifications and years of experience e.g. newly qualified RNs. As **RN Z** noted:

‘... all of the company’s hospitals across the board –whether you are Jo’burg or whether you are in Cape Town [or Durban] ... all salaries should be made to be the same ... across the board - because some people that work here [their] basic is this, and other people working at another hospital in the same group get a higher basic – newly qualified people in the same group as us ... we are all Durban based - yet we are all getting different starting salaries ...’ **TZ/15/201 & 203.**

It was felt by **RN Z** that inexplicable discrepancies in salaries resulted in division, and poor morale within the nursing workforce.

Apart from annual adjustments to salaries in terms of ‘performance appraisal’ related percentages, participants from the private hospitals felt that they had no recourse to specific mechanisms by which their salaries could be reviewed e.g. in terms of applying to move up a notch on a salary scale or progress to a senior grade. In respect of RNs C, Z and X - RNs whose salaries lagged significantly behind that of their peers with similar qualifications and experience, repeated requests to hospital management to review their salaries were ‘fobbed off’ and postponed by management who promised to look at it again when ‘they did the next annual increment’. This is evident in the following comment by RN X:

‘... I have been to management on a few occasions asking for my salary to be reviewed, and [asking] when is it going to be done, and it was always like “... when everybody has their increment in January we will look at it...”. Every time January came ... it was always that little 3.5 % or 4 % ... and it never got to where I wanted it to be... because it never got like put onto scale and then an increment ...’ RNX/14/156.

4.4.2.2 Sub-theme: Capped salary progression

For the majority of the participants from the Provincial hospitals, the comparatively recent abandoning of the rank promotion system by the provincial health care structures was felt to have had a significant and negative impact on their salary progression. In the past the rank promotion system meant that after specific time periods, a registered nurse (professional nurse) would be able to progress to the rank of senior professional nurse (SPN), and then on to attain the rank of chief professional nurse (CPN). Each rank

progression would have been accompanied by a corresponding increase in salary – now that rank promotion had been abandoned, progression up the ranks and ergo to better salary scales was not possible unless a vacancy for a specific post was advertised, applied for and awarded. At the level of the practical situation, the abandoning of rank promotion for these participants meant that they would be staying at the rank of PN – with its corresponding salary for an indeterminate period of time; i.e. they would be ‘stuck’ at a particular salary grade with no opportunity to ‘upgrade’. For those participants who had already reached CPN level (prior to rank promotions being abandoned), it was felt that they had now reached ‘a ceiling’ in terms of salary advancements and progression. For **RN T**, this stagnation in terms of remuneration had been a significant source of frustration:

‘... I see on their [soon to be new employer’s]... salary scales ...it is ... in fact it is at the level where I am here. I have worked [here] for **fifteen** years ... I am ... a chief professional nurse - and the salary that I saw [there] it is just eh ... for a plain professional nurse **but** it is at the same where I am ...’ **TT/3/31**.

4.4.2.3 Sub-theme: ‘Scarce Skills’ allowances

Significant dissatisfaction with the Department of Health’s recently introduced rural ‘Scarce Skills allowance’ incentive was verbalized by the majority of the participants at the Provincial hospitals. While the rural ‘Scarce Skills allowance’ was deployed in order to retain staff in hospitals in the rural areas, it was felt that the actual deployment of the programme and determining of who was actually entitled to receive a scarce skills allowance was flawed. According to the participants at one of the Provincial hospitals, a

sister Provincial hospital nearby had been classified as being 'rural' because it received a large proportion of patients from rural areas, and because it was in ostensibly in an under developed area of the Durban Metropolitan Area. This was problematic for these participants since this sister hospital was not perceived by them as being in a 'rural' area, and because their hospital too received a large number of clients from outlying and rural areas. It was further argued by these participants that in addition to being an unfair distribution of a financial resource, the implementation of the allowance had further contributed to the shortage of staff in their institution because of staff leaving to go and work at this sister hospital in order to get the allowance. As **RN G** states:

'... we are short staffed but um ... most of personnel they are going overseas, and because of instances ... you know we are in the center of a town, you know most of the hospitals are bringing to this hospital, even the surrounding hospitals ... e.g. [the sister hospital], they are bringing to this hospital, rural areas they are bringing to this hospital, and with incentives [the Scarce Skills Allowance] there are ... there is a problem – because like [the sister hospital] ... they have created this rural allowance ... so I understand [their matrons] ... motivated for them to get because they are working as far as rural areas, which is the same with us – but you see, it is another issue which has created problems because people - they move from here to that hospital. Previously people didn't want to work at that hospital, but now because of the incentives ... because they get this rural allowance, they do want to go there. So then they even prefer to go rural areas ... as far as northern Zululand...' **TG/5/66**.

An additional source of frustration with regard to allowances pertained to those allowances paid to nursing personnel in specialty areas e.g. ICU and theatre. The current practice regarding specialty 'Scarce Skills Allowances' is to pay allowances to those who have undertaken post basic training in a specialty area and who are in possession of the

relevant course(s). Of those participants who were working in specialty areas in the Provincial hospitals none were in possession of the relevant post basic course and none were receiving a specialty allowance despite having extensive experience in the area. For two of the participants (RNs Y and M) this situation was further compounded by the fact that they were working as shift leaders on their respective units and were entirely responsible and accountable for the shift. This situation is encapsulated in a comment from RN M:

‘... I was abused in ... in my department, eh ... because as I say I am still a professional nurse now - **but** I am experienced in ICU. So what has been happening ... I have been a shift leader ... since early ... last year. I have been a shift leader. So ... other registered nurses who came later than me have been reporting to me - because I know exactly what goes on in ICU – so they have been reporting to me. Even the admissions ... the patient that has to come to the unit - I have to ... analyze the blood gas before the patient comes...but that is the responsibility of a person who is ICU trained, and in this case a chief professional nurse. I have been doing that but I have been getting nothing out of it ... all the people that are working in ICU and theatre – who are ICU trained and theatre trained ... they have been getting a Scarce Skills allowance ... but for us who are not ICU or theatre trained, we are not getting that money. So they are also making us to be shift leaders but whereas we are not getting anything ... out of it. So it is really ...um heartbreaking...’ **TM/3/22-24.**

RN Y (also a shift leader on a specialty unit) explained that the issue of ‘Scarce Skills Allowances’ had been instrumental in contributing towards tension in the workplace:

‘... Now what they [management] have in actual effect done ... is increasing that divide [between nursing personnel] ... that gap – is making me worse off than when I started because now my morale is down. Because that person that I am working next to everyday is getting a thousand rand more than me for doing exactly what I am doing..!’ TY/24/273.

In contrast to their colleagues in the Provincial hospitals, the participants who worked on specialty units in the Private hospitals still received a unit allowance in recognition of added occupational stressors - even if they were not ‘trained’ in the specialty i.e. in possession of the necessary certificates. This unit allowance was not equivalent to the full ‘Scarce Skills Allowance’ paid to the ‘trained’ staff who worked in these areas, and this discrepancy was not perceived as being problematic by these participants.

4.4.3 Experiential theme: Interpersonal relationships in the workplace

4.4.3.1 Sub-theme: relationships with nursing and hospital management

With the exception of RN P – who was from a Provincial hospital, the remaining participants were vicariously dissatisfied with aspects pertaining to nursing and hospital management structures. Participants in the Provincial hospitals described management structures as hierarchically organized, autocratic and disempowering. This structuring was perceived as contributing to workplace tension and as perpetuating relationships that were not collegial, not equal and which were pedagogical in nature. It was felt that the management was still very ‘old school’ (rigid, autocratic and dictatorial) in their attitudes towards nursing personnel:

‘... it is still ... the way ... where it has to be obvious that ... you are her **junior** ... where it **has to show** ... ja it has to show that you are her junior, [and that] she is your senior. The way she talks to you, the way she comes to the ... department ... [convey this attitude]...’ **TM/12/111**.

Pedagogical attitudes and policies towards the nursing personnel were additionally found to be a cause of dissatisfaction in the Private hospitals. For **RN H**, who was moving out of the nursing profession, the prospect of being acknowledged and treated like an adult was liberating:

‘... [I will] be ... treated like a normal person and not like a child ... I am so used to the way of nursing that is so rigid, and if you don’t do something you ‘get into trouble’ ... you know ... or you might get a written warning because now you ... have done something wrong or something like that. Whereas now I will be totally on my own - accountable for every thing that I do [and] not ... treated like a school kid...’ **TH/3/18**. [Private hospital].

While both the Provincial and Private hospital management ostensibly have ‘open door’ policies which intimate that they are available to their staff to discuss any matters, issues or problems, it was felt that this was hampered by rigid channels of communication and the need to follow ‘due procedure’ prior to being able to gain access to the relevant manager. This was a source of considerable frustration for certain participants who felt that their concerns were marginalized and inefficiently dealt with by immediate line managers and other middle management structures. In the Private hospitals it was felt that the ‘open door policy’ and ‘open lines of communication’ were superficial, subject to the exigencies of the ‘business’ and not supportive of nursing staff:

‘... although we in our hospital have ... say open communication with senior members in management [nursing] –I have found most of the time, if there were problems and things, um ... the nurses were always made to be at fault. Although we communicated openly – if a problem did arise at the end of the day you had to be the one to apologize, or you were wrong ... I don’t think they really stood behind you as they should – as senior nursing staff should...’ **TX/6/70**. [Private Hospital].

Participative decision making was additionally considered to be a farcical notion by the majority of participants – this was encapsulated by the following comments from **RNs M** and **X** respectively:

‘... well what they [nursing management] do, [is that] they give you chance to choose - but in most cases you will find that they are just making that [a show] ... but they know what they are going to do. They won’t ... consider, they won’t consider what, like what you suggest. They will **pretend** as if they are listening to you ... [and you] tell them all your problems about why you want this done that way ... whereas **they know what they will do..!**’ **TM/13/115**. [Provincial hospital].

‘... we often have meetings - which they call green areas ... the unit manager leads the meeting and at the end of it she asks everybody for their input or suggestions and ... we do have a say... [But] ... ohhh (sighs) how can I say this ... we were given a chance to offer our ...just like thoughts or ideas, but they were very, very rarely put into action or tried out. So ... we were given a chance to say what we want ... what we think should be done, but it **never** ... got done the way we wanted it to ...’ **TX/13/137-140**. [Private hospital].

In addition to the above, it was felt by certain participants at the Provincial hospitals that the nursing management were not suitably qualified to occupy the posts that they did:

‘... in other institutions, if you go to [the] matron’s complex, if you look to the matrons – their epaulettes, you will see that these people deserve to be in matron’s complex, they have admin, they have done administration, they have education. You will find that most of them ... like if you go to other hospitals ... they have ... five bars. So that person has done administration ... if she does administration [then] she does something she knows ... something [that] she has learned... Our management – most of them have one bar, they have only done midwifery. So ... the thing they have is experience – sometimes uh ... the decisions [that] they make when it comes to administration is not right. You ... you can see that they lack that education, they have experience for work – but ... but education wise ... they are not good...’ **TM/11/105**.

Those in managerial positions who were without the academic qualification of ‘Administration / Nursing Management’, were believed to be ill-equipped to make efficient and / or effective decisions regarding the management of nursing personnel e.g. in terms of correct decisions regarding labour relations, in terms of being able to negotiate on behalf of the staff, and terms of their not having developed their people management skills.

A lack of knowledge about exactly what it is that their nursing personnel actually **do** was additionally cited as a frustration by **RN T**. The lack of knowledge about the needs and requirements regarding the activities in **RN T**’s unit meant that she continually had to motivate and explain routine aspects of her work to management. This situation was further compounded by the tendency of management to issue blanket policies which disregarded the special needs of her unit, and which were not appropriate to her unit. This situation generated a significant amount of tension between **RN T**, and further contributed to an already heavy workload.

In one Provincial hospital and one Private hospital a number of participants voiced their dissatisfaction with the 'Batho Pele - Good Governance' programme, and with the accreditation process/ quality management programmes respectively. While it was understood and accepted that the goal of such programmes was to monitor, maintain and improve the efficiency and efficacy of the standard of care delivered to the community, it was felt that these programmes were implemented without due regard or consideration of the nursing personnel. It was felt that the nursing personnel were expected to do all the ground work in respect of carrying out the objectives of these programmes - in addition to the care responsibilities of full patient loads which are already compromised due to the shortage of staff, nursing personnel are delegated additional and cumbersome administrative duties that take them away from patient care and which are a significant source of frustration. This is encapsulated in a comment from **RN K**:

'... it has just become very, very admin ... [administration] orientated but yet you are still expected to be on the floor looking after patients ... like for example we are now doing this accreditation thing, I have to make new policies, new files, everything is new - I don't even know what is happening on the floor some days, but yet I am expected to be up there, get the files going (claps hands to show that these things need to be done quickly) ... everyday we are getting something new from management '...this must be done, this must be done ... new standards...' [and the] clinical facilitator is on your back, [in respect of] this new policy ... we have got to get this policy going. You are so busy up top ... I promise you I have been solidly busy with all this for three weeks now... I haven't even gone to help and turn a patient ..!' **TK/3/28**. [Private Hospital].

Certain participants at the Provincial hospital felt that their nursing and hospital management were overly focused on achieving accreditation ratings - that in respect of

all the awards and trophies that had been won, that they had forgotten who actually got them there and that it was the nurses who had made the difference. This is illustrated in a comment by RN Y:

‘... the thing is ‘Batho Pele’ – they want us to practice it ... all very well and good – but **we** [the nurses] **don’t get the same**. When we visit our departments, we don’t get the same respect and treatment, and uh ... what is the point? I feel ... that this hospital has won a lot of awards and done a lot of things, but I feel that it is a façade ... because it hasn’t come down to me. It hasn’t translated in anything different for me ... it hasn’t made a difference to my life. I mean our hospital manager now looks like ... the best thing since boiled water or whatever. But uh ... what does that mean for me ... as one of the people that does the work that [the manager] gets the credit for..?’ **TY/25/286**.
[Provincial hospital].

4.4.3.2 Sub-theme: relationships with medical colleagues

A marked difference in the workplace relationship of nursing and medical staff was evidenced between the Provincial and Private hospitals. Participants in the Provincial hospitals described relationships that were more egalitarian and which enjoyed mutual respect while participants in the Private hospitals did not. Notwithstanding tense circumstances that usually precipitated a terse exchange of words e.g. such as that which would occur during a resuscitation in a Trauma Department, it was apparent from the narratives of all the participants from the Private sector that mutual respect and collegial relationships with medical personnel were not uniformly or routinely enjoyed.

This disregard for the professionalism of the Registered Nurse [nurses] was manifest in paternalistic, dictatorial attitudes and in verbal abuse – often in front of patients. Not only were these incidents demoralizing and frustrating for the nursing personnel who felt that they had no recourse to action to address the situation, it was additionally noted by the participants that this had a negative impact on nursing personnel psychologically.

The participants had a variety of attributions for the behaviour of medical personnel: racism, sexism (since most of the abuse was perceived to be perpetrated by male doctors and directed towards a predominantly female nursing staff), and classism. It was also believed that the attitude of the hospital management in the private sector reinforced the abuse of nursing personnel by medical staff – by being unsupportive of nursing personnel in respect of respecting their professionalism and knowledge, in respect of indiscriminately ‘siding’ with medical personnel in conflict situations irrespective of the facts of the situation, in terms of the pedagogical attitudes of management towards nursing personnel and because of the attitude ‘doctors generate profits while nurses generate costs’.

While the participants agreed that not all medical personnel were rude and abrasive, it was noted that significant workplace tensions and psychological discomfort were the outcome of their experiences in respect of those medical personnel who were.

4.4.3.3 Sub-theme: relationships with nursing colleagues

It was felt by all the participants that the working relationship that one enjoyed with one's nursing colleagues on a unit contributed not only to the overall climate within the unit, but also to one's overall experience of satisfaction or dissatisfaction in the workplace. The concept of teamwork – goal directed and mutually supportive activity, was repeatedly emphasized by all participants in respect of maintaining a psychologically healthy workplace environment. Not all of the participants however enjoyed good working relationships with their colleagues, and this was cited as being responsible for a large proportion of their dissatisfaction in the workplace.

For **RN N**, constant harassment and undermining of her professional judgement by certain of her colleagues led to her feeling excluded from the team, and to feeling like 'an outsider':

'...With the staff basically ... I would say I am still 'new' in their team. Because you are new they don't trust you. They ... they are not sure if ... you are even able to take a temperature or something ... eh... I mean that is how I feel, they don't trust you. And they ... do funny things, they treat you ... (sighs) I don't know ... they will tell you the obvious things – I mean things that you knew – because you can see if you look at them - you can see that they have got that fear that they are not sure if you know these things and all that. So ...uh ... to me I like my environment to be so pleasant – ok, so I feel that it doesn't – it really doesn't work with me ..!' ; '... I am a professional nurse, I might be **new** in the ICU environment, or even in this hospital ... but ... that does not change the fact that I am a qualified nurse ..!' **TN/7/43** and **TN/3/26**. [Private hospital].

RN W's workplace experiences with her colleagues had precipitated her decision to resign – not only had she experienced 'kangaroo court' (an informally organized meeting with disciplinary intent; no notice given to the target, and no provision made for representation – not necessarily evidence led), style treatment at the hands of her colleagues on a specific occasion, but their treatment of her had resulted in considerable psychological distress and in a nervous breakdown. While RN W had tried to remediate her situation and to resolve her workplace difficulties, she experienced little concrete support from the nursing management, and this in itself had resulted in making her work situation untenable. RN W's frustration at her situation is clearly evident in the following comment:

'... You talk about problems that you have, you bring them to notice ... but nothing gets done of it / done about it. You have just got to be like an old donkey, and put your head down, swaying along ... and just try and do what you can possibly do... and this old donkey is tired... (voice quivers, tearful)...' TW/8/67. [Private hospital].

4.4.3.4 Sub-theme: relationships with patients

A number of participants were ambivalent in respect of their relationships with their patients. This was because while one's patients were ostensibly the 'raison d'être' for nursing and a source of satisfaction when care outcomes were successful, negative attitudes and behaviours e.g. a disregard for the nurse's humanity and dignity, by patients were a source of dissatisfaction and frustration:

‘... people ... don’t appreciate anything that you do ... They walk in straight away with a chip on their shoulder [i.e. with a bad attitude]... and you ask them “...hi there, can I help you..?”... You can see straight away that they are going to be trouble, straight away they just got a chip on their shoulder and they are not actually here for anything but to cause misery for you. You have those types of patients [that believe] ...‘that **we owe them** something’, you know they walk into the hospital and now we must bow down to them! ... type of thing, and you get people like that who don’t appreciate a flipping thing that you do, and it doesn’t matter what you do – they will have a cocky comment or ... they will ... they think that you are there for them right away, you have got to drop what you are doing... and it doesn’t matter that other patients have been there ...before them and ... they report you for all sorts of things that are not true ... You think to yourself“... jis you know ... you come to work everyday to help people, and they just kick you in the teeth basically...” – and that is what I can’t handle ...’ **TH/14/86**.

Despite being ill treated by certain clients, the participants expressed the view that it was the patient contact and interaction with the patients that had provided them with the most job satisfaction.

4.4.4 Experiential theme: Nursing and the nursing profession

4.4.4.1 Sub-theme: contemporary nurse training

Dissatisfaction with the calibre of nursing personnel currently employed and /or in training was voiced by six of the participants – from both Provincial and Private hospitals. It was felt that those that were entering the nursing profession were getting into nursing for the ‘wrong’ reasons [financial gain /just to have a job] (**RNs C, S, T, W and Z**), and that the selection process in terms of recruiting students was flawed (**RN P**).

These views are illustrated by the following quotes respectively:

‘... Nursing requires a person who is dedicated. You don’t just choose it because you feel “...aw, I can do it...” It needs you to be dedicated ... it needs you to be that passionate person – being able to handle people, and being able to understand people from whatever diversity. You just need to understand people. But ... you do see people that ‘ay ... this one – s/he just came because s/he was desperate for a job...’ **TT/12/138**.

‘... if you come here employed as a nurse and starting now you have got patients that are incontinent of faeces, incontinent of this ... CVA etc... **if** you did not choose to be a nurse you will feel ‘...eeuw ...eeuw...’ [demonstrates an offish attitude] ... because you are thinking about what you had thought you would be as you were studying. And if your parents failed to cope ... with the finances ... maybe you [decided that you] can come nursing because nursing – you get into nursing and they pay you first... etc, and you say ‘...let me go into nursing...’... You had done your A’s - times 7 A’s and whatever ... and they will take you first, but the person [who really wanted to be a nurse] that had done the 20 points will fail to get into nursing because the points are less than yours. And you, as you are doing nursing are sitting with the hope that now ‘... if I can get another job I will leave this nursing...’ This is how you will find that now most of the time nurses are leaving – not the country as such – but leaving nursing for something else ... We sit and talk to each other ... we know the fault but because there is nothing we can do ...(clicks tongue in disgust) ...’ **TP/18/191**.

RN P - a professional nurse with many years of experience in nursing was particularly vocal about the selection and recruitment of nurses, and was of the opinion that high academic achievers would not be content to stay in nursing due to their having further and different career aspirations. All of the above participants agreed that patient care was sub-optimal when nursing care was delivered by nurses who were not dedicated to the ethos of nursing. Most of the participants were of the view that not just anyone could be a

nurse, that nursing required commitment, dedication and a passion for working with people (RN Z).

For RN W – who was working on a cardiac unit, the disinterest in nursing displayed by colleagues and students was additionally problematic because it resulted in potentially dangerous situations at the practical level – by not being interested in one’s patients and their conditions, by not applying oneself to attain the necessary knowledge about specific conditions, and by not even taking cognizance of even the basics (e.g. the significance of a tachycardia or a bradycardia when a patient’s observations were done and of the necessity of reporting this to the charge nurse), these nurses were unwittingly placing their patients in a dangerous situation. Inevitably this tardiness by certain staff members would only come to the fore at a later stage e.g. when RN W was doing her ward round or going through the reports. This inefficiency and disinterest thus further contributed to workplace tensions and conflict.

4.4.4.2 Sub-theme: Morale

The majority of participants described their morale in respect of nursing and the nursing profession as low. There were a variety of attributions for the low morale: poor salaries, being short of suitably trained staff, the reliance on session staff for unit coverage and ergo being responsible for their actions, lack of support from management on a variety of issues and negative workplace experiences and working conditions. All of the participants reiterated that it was not nursing per se that was responsible for the low morale – this was illustrated in the following comments from RNs D, N and G:

‘... I like nursing ... but the way things have happened to me! It makes me feel ... I have developed hatred for the seniors [management]. You see. I don’t like them because now the way they are doing things it is not fair. It is not fair – when I am thinking where I am coming from. It is not fair...’ **TD/11/121**. [Provincial hospital].

‘... I like nursing but trust me ... working here has made me to think about it. Do I really need to be a nurse..!’ **TN/12/78**. [Private hospital].

‘... There is nothing wrong with the profession ... I still like being a nurse – I must be honest with you, uh ... the problem is the institution where we are working...’
TG/14/191. [Provincial hospital].

In respect of **RNs G, N and D**, it was evident that their workplace experiences and conditions had a definite bearing on their morale and that their morale had been negatively affected by their respective workplace experiences.

Certain of the participants had ambivalent feelings about nursing. For **RN H** nursing represented a ‘dead-end’ job on the one hand (poor long term prospects in respect of ever earning a decent salary, limited opportunities for advancement and no recognition), and on the other hand, nursing training provided the individual with vital life skills and knowledge, potentially opened doors for international work experience and ‘assured’ the individual of employment throughout their working years:

‘... I mean it is not a bad job – it really isn’t, it is just a dead end job. You know you are just a number and you do work hard ... and you have to study hard to get your qualifications, and in a way it is good because you can go overseas. You can go and work

anywhere in the world – you are always wanted ...; ... it [nursing] gets you by ... it does pay the bills, **but** not all of the bills...’ **TH/22/153** and **TH/23/171**. [Private hospital].

It was apparent that the morale of the participants was additionally affected by differences within the profession too. These differences primarily related to ‘old school’ versus ‘new school’ attitudes and behaviours in nursing i.e. essentially generation gap tensions and conflict, and to professional jealousies regarding qualifications. For **RN G**, in addition to the negative workplace experiences that had affected her morale, stereotypical notions of the ‘nurse’s place’ [subservient, obedient, and unquestioning], and ‘old school’ attitudes about nursing and nurses had further contributed towards tension and conflict in the workplace:

‘... We need to communicate with our managers – so stereotyping also I think affect our profession. Because like most of our managers are like people who trained in olden days ... so ... they expect us to behave the way they were trained: you don’t have to communicate with them, if you ask questions – they start looking at you [and asking] why? Why are you asking all those questions? You know, and if you are becoming more educated you know what it is supposed to be like – if you ... show them your knowledge ... they look at you [and think to themselves] ‘...**oh!** This one thinks she knows...[it all]...’ **TG/14/203**. [Provincial hospital].

For **RN N** (a RN in her mid twenties with the four year diploma qualification), the need to be accepted and respected as a qualified and contributing team member by her colleagues on the floor was important:

‘...(long pause and silence) mmm, I was going to say [that] people they need to change their attitudes – because especially in a unit like this, it does have a big impact. They

have to ... they have to change ... I mean the fact that somebody has been here for 20 years, and is trained and have all the experience in the world ... it doesn't give them a reason to disrespect you. I think ... we need to ... accept nursing professionalism and all, we have to go to the basic things: respect, being honest with each other and just being friendly, it won't kill you...' **TN/18/146**.

It was additionally important to **RN N** that colleagues who had been nursing for quite some time acknowledge and accept that nursing, nursing education and practices had evolved. **RN N** felt that professionalism (as opposed to paternalism) should be apparent in the behaviours and attitudes of all staff, e.g. as in the deployment of constructive criticism, and supportive teamwork.

In contrast to **RN N**, **RN P** (an RN with a three year diploma qualification and midwifery) attributed aspects of workplace tension and conflict to differences in training:

'... Another thing too with the nurses ... [they] ... don't have respect for the old ones. Besides the age ... I was trained in the 1960's – and I have got the one 'bar' right? ... These sisters that have got the three 'bars' [referring to 4 year comprehensive course trained RNs], they feel that now that the people that have got one 'bar' are useless or else that they know less than them... whereas the one 'bar' people feel that now that these nurses that have got three 'bars' know less than them! And I can tell you now it is because of the time: they do 6 months this, 6 months that and 6 months this [and] 6 months that and within this period they have done everything...' **TP/20/199-201**.

The constant tensions regarding the 'validity' and 'seniority' of qualifications versus years of experience were responsible for negative attitudes, behaviours and power dynamics and these further impacted on the morale of nursing personnel (**RN W**).

4.4.4.3 Sub-theme: Burnout

Of the participants interviewed, about a quarter indicated that they had either experienced an episode of burnout and /or were currently feeling ‘burnt out’.

RN W had previously experienced burnout in 1989 while working in a Provincial hospital. At the time she had been working night duty for three years, and was working in a high stress specialty area with little support at the level of the practical situation (4 bed ICU and 17 bed general ward; one sister and two nurse aids to cover the unit – on occasion a second sister had been allocated to help out). In addition to the work stress, family responsibilities concerning aged parents had compounded her situation. At the time of participating in this study, **RN W** indicated that she was again on the brink of a nervous breakdown, and that she had reached a point where ‘nursing was detrimental to her physical and mental health’.

RN W attributed her state of burnout to workplace tensions (a difficult relationship with her colleagues and unit manager who treated her like ‘a broomstick with epaulettes on’), to negative workplace experiences (verbally abusive doctors and patients), and to unsupportive management who ignored her repeated requests for additional and suitably trained staff on her shift (at the time **RN W** was working night duty on a cardiac unit that received bypass patients after their tenure in cardiac ICU; her total staff complement was herself – as the only registered nurse, one staff nurse and three care givers for a 32 bed unit). **RN W** noted that this staff complement did not cater for the needs of the patients on the unit and that her ability to deliver quality nursing care was compromised. **RN W**

felt that the situation had been compounded by a shortage of experienced and suitably trained staff:

‘... you can’t even trust the staff nurses to come and tell you that ‘...so and so’s pulse’ is not right or what ever – you know ... I would ... at 2 o clock in the morning when I eventually got a chance to go through the notes and things like that, I would get surprise after surprise after surprise. And [I would] think ‘My God – I hope that is all right...’ And then it ended up that I was taking on **more** and **more**, and **more** on myself – so that I knew that it was right [i.e. that what needed to be done actually got done]... Ja ... and it has just got to the stage now where ... I am actually asleep on my feet when I hand over in the mornings. And I am talking about the biggest load of hog wash [that] you can wish to hear. I am talking about cakes in ovens and boxes on shelves and all sorts of things. And (crying) I am going to die if I don’t go... I have done my asking [for more staff] and it has come to this now – it is too late (crying- goes to bathroom to blow nose)...’

TW/19/163-169.

RN C indicated that she had already experienced an episode of burnout (a nervous breakdown in 2001) although she did not feel that she was ‘burnt-out’ at the moment. **RN C** attributed her burnout to an inability to manage stressful situations effectively and added that she had subsequently seen a clinical psychologist who had coached her with regard to strategies for coping with stress, and who had also treated her with antidepressants.

Lewis (1988) notes that stifled professional growth in terms of lack of opportunities for promotion and continuing education contribute to burnout in personnel – **RN C** had been in nursing for 21 years and prior to 2001 had not been afforded the opportunity to

continue her nursing education, and had been kept in a relatively junior position within the organisation.

RN H also described herself as ‘burnt-out’ – this was attributed to her increasing concerns regarding her personal safety in the workplace in respect of her increasing exposure to the HIV (**RN H** worked on a trauma unit), and to the increased and increasing workload that her unit was subject to. This increase in client volumes and turnover was a significant stressor for **RN H** – both physically (because of being short staffed) and emotionally. This is encapsulated in the following comment from **RN H**:

‘... you don’t get a chance to ... to really catch your breath, some days you might have 2 resuses (resuscitations) or so in day, and you have to deal with the families – so it is emotional stress as well as physical stress, and some days you see a lot of traumatic uh things as well and you don’t really get to talk about it because ... your family is not involved in that type of thing and you ... can’t really discuss things like that with your children ... ja ... and you have just got to carry on – so I think I need a little bit of a breather, I need a change of scenery – um and I need a break ...’ **TH/5/28-30**.

4.4.5 Experiential theme: Resignation – recourse to enact personal and positive change

4.4.5.1 Sub-theme: Trigger incidents

A total of eleven participants indicated that their decision to resign had been precipitated by specific incidents that been the ‘final straw’ for them and which had ‘pushed them to the edge’. In both Provincial and Private hospitals, these incidents predominantly involved either the management in respect of: denied opportunities for continuing

education and development (RNs C, S, M, Y, and F), salary disagreements (RNs C, and X), difficulties with posts and promotion (RNs D, G, T, S), lack of support on a variety of issues (RNs W, and N) or unresolved difficulties with colleagues (RNs W and N).

Increased family responsibilities that were incompatible with hours of duty and shift work were additionally cited by certain participants as being precipitating of their resignation (RNs K, H, P, X and Z).

All of the participants agreed that their decision to resign had not been taken lightly.

4.4.5.2 Sub-theme: continuing education and staff development

Nine of the participants – in almost equal proportions between Provincial and Private hospitals, indicated that the decision to resign had been significantly influenced by their need to continue with and further their nursing education.

The participants from the Provincial hospitals noted that there was no transparency regarding the selection criteria for various post-basic courses – and that it seemed as if the criteria for admission to a course ‘changed all the time’ - i.e. that they were vicariously administered by those over-seeing the selection process.

In one of the Provincial hospitals, the participants felt that there were degrees of racism, favouritism and nepotism involved when it came to determining ‘who’ was selected and admitted to particular courses. RN D said that she had repeatedly submitted applications to be admitted to the bridging course to upgrade her qualification from staff nurse to

registered nurse over a period of ten years. Not only had her applications been unsuccessful, but she had never been interviewed nor was any rationale given as to why her applications had been unsuccessful. **RN D** said that she had felt humiliated by this process and especially so because the ‘letters of regret’ had always been unceremoniously handed to her by clerks who already knew their content.

While **RN D** had finally financed and upgraded her qualifications privately, she noted that there were inconsistencies in the selection of those who actually did get onto the course e.g. nurses who had resigned and then returned a while later, and newly qualified staff nurses – i.e. those with less than two or three years of experience, who were taken ahead of those who had ‘waited patiently’. **RN D** further noted that the inconsistency and lack of transparency regarding the selection of candidates for post-basic courses had both frustrated and angered the nursing personnel throughout the hospital:

‘... they [those selected] have passed **all** those people who have passed before them – who are in the list. There is a list – that ‘if you are interested in midwifery, just write your name here’. But now there are people who have wrote their names see – but now you see ... that unfairness [by the management]... they have said that the people who have passed ... who wrote their exam in July [i.e. new graduates] ... they are going to start in March. Ai - **this** March! But now unfortunately for them or for whom, because the sisters now they are **very** angry – the ones who were having there names down there first – they are very angry – they said they are going to ... [strikes the table] ... complain, yebo ... they are going to ‘tools down’. Ja ... it was **not** fair, because there are people who are in their list ... hundreds of sisters who are waiting in that list, but now they just took the people who are fresh from the college, and they put them in midwifery ... it was not fair...’

TD/14/169-171.

RN F, who was employed at the same hospital, corroborated the above situation and noted that admissions to post-basic courses were fraught with procedural irregularities – she had been denied the opportunity to apply for a post-basic course in 2004 because ‘management wouldn’t give her the forms’. She had been told by the matron overseeing the applications that ‘she must go and do some introspection ... to go and look who at **who** she was on the unit and thereby determine if it was really necessary for her to do the course’. **RN F** worked in an ICU, and was not ICU trained despite having worked on the ICU for over six years. **RN F** maintained that the proper procedure with regard to applications was not followed and that she should have been permitted to apply even if it was only to receive a formal ‘letter of regret’ at a later stage. In 2005, her application was again thwarted because the hospital management said that they were not sending anyone on the course in question because they were too ‘short staffed’. **RN F** went on to say that she had subsequently found out that staff who were junior to her, and who had no previous ICU exposure had been selected to do the course and that this has led her to believe that favouritism was driving the selection and recruitment process. In terms of the selection criteria for being admitted to the course, she stated that every year there was a new policy:

‘... for example one year they will take those who have been on the unit the longest and who are more senior, then the next year that criterion no longer applies and juniors with no previous ICU exposure are taken ... **you will never know what the criteria are...** they just take haphazardly...’ **TF/F/1/2**.

RN F further attributed her difficulties in gaining admission to the post-basic course in question to racism:

‘... they do things according to their favourites... and there is a racial thing as well the Zulu staff receive better appraisals/ opportunities for post basic courses and other things as compared to the Xhosa staff...’ **TF/1/5**.

At the second Provincial hospital, **RNs M and Y** had experienced similar difficulties in securing admission to their respectively desired post-basic courses. **RNs M and Y** had been on a waiting list for quite some time and were due to commence with their courses in March 2005. This was deferred to September 2005, and then they had been subsequently informed that the hospital would not be sending them on course because they were too short staffed. Given that **RNs M and Y** worked in specialty areas (ICU and CCU respectively) that required specialist knowledge, that they were in senior positions on their respective shifts, and that neither was in possession of the certification required to work in these areas, both **RNs** felt ill equipped to deliver safe, effective and quality care to their patients. **RN Y** stated that he felt particularly frustrated at this situation because as the senior on the shift, he carried the full weight of responsibility for decisions taken on the shift. Both **RNs M and Y** reiterated that the formal training courses empowered the individual to make educated and accurate decisions regarding client care.

The participants in the Private hospitals verbalized similar difficulties with gaining admission to post-basic courses. While the participants accepted the practice of ‘bonding’ the staff to the hospital for a set period of time in lieu of any training undertaken at that

institution, it was felt that this was not uniformly applied to all staff members. In principle, those who have just completed a course of training funded by the institution have to 'pay back' the institution - usually by working at the hospital for a specified length of time before applying and /or being selected for additional education and training courses. **RN C** noted:

'... well at the moment – I wanted to do ... the trauma course and I got told by my unit manager that I couldn't do it because I owe the hospital back 2 years. I have since learned that girls that have qualified **with** me in other departments are actually going to do other courses - **this** year after paying back not even a year. So ... I am actually like quite ... [annoyed and angry] about that...' **TC/9/110**.

While matters pertaining to continuing education had not been an overt source of dissatisfaction for **RNs H, T and Z**, all of these participants indicated that significant professional growth and development opportunities had been offered to them on their taking up of their new positions – opportunities that had not been available to them in their current situations. **RN Z** noted that her new employers offered an allowance for skills development and/ or continuing education as part of her 'package' and that she had complete autonomy with regard to its utilization. For **RNs H, T and Z** these new opportunities suggested to them that their new employers valued them as professionals who had significant contributions to make to their organisations.

RNs S and C respectively noted that their resignations were tendered on their being offered an opportunity to continue their education at other institutions. Continuing one's professional education was seen to be a necessary investment in one's career – in terms

of attaining specialty specific knowledge which served to enhance practitioner competency in the delivering of nursing care, and in terms of career advancement opportunities and better remuneration. This prospect of positive change was encapsulated in the following comment by **RN S**:

‘... the salary is more or less the same ... but after I ... get through ...the high care course I **will** get an increase of R900, 00...’ **TS/2/16**.

All the participants indicated that there were clear differences between staff development programmes i.e. hospital run courses e.g. HIV/ AIDS update courses, Batho Pele courses, TQM (Total Quality Management/ Quality Excellence) courses and formal continuing education opportunities i.e. post-basic certificated/ diploma or degree courses.

4.4.5.3 Sub-theme: Promotion opportunities

Six participants noted that the lack of promotion opportunities available to them had been a significant factor in their tendering of their resignations. Five of these participants were from Provincial hospitals – **RNs M, Y, T, G, and F**. The lack of promotional opportunity was uniformly attributed to the discontinuation of the rank promotion system by the Provincial health care authorities. This is illustrated by the following comment from **RN M**:

‘... it is difficult now ... there is this system which was used by the Government – before ... automatically after completing three years [of service] ...I am meaning after like finishing the course, you only worked for two years and then automatically they

promoted you to be a senior professional nurse. And after two years – meaning after 5 years ... you will also get promotion to be ‘chief professional nurse’, but now they got rid of that. Now you can be a professional nurse for ten years or more than that because they have destroyed that ...’ **TM/2/16**.

For **RNs M, Y and G**, the discontinuation of ‘rank promotion’ was a contentious issue. **RN M** was a professional nurse and ‘senior’ staff member in charge of a shift in a specialty area. As the ‘senior’ he was responsible and accountable for all decisions taken on the shift but he was not officially recognized for this either by means of rank or financially – he had not been afforded the opportunity to continue his education in this specialty field and hence did not qualify for the specialty’s unit allowance.

At the time of discontinuation of rank promotion, **RN G** had attained the rank of senior professional nurse – at her interview she stated that she was working as a unit manager and that this was a post usually reserved for a chief professional nurse. She felt that she was being ‘used’ by management because her contributions - in terms of the responsibility that she carried as the unit manager; her years of experience and achievements in respect of her academic qualifications (she had a held a BCur degree in nursing education and nursing administration) were not recognized.

It was understood by the researcher that promotion now depended on vacant posts being advertised.

For **RN Y**, whose situation was similar to that of **RN M**, poor communication in respect of advertised posts led him to believe that there were elements of favouritism in the recruitment process and selection of candidates:

‘... it seems like you have got to know somebody in the right place to get a promotion because what is happening is that we have got people who are uh ...have got experience and who are doing the jobs. And when people are being employed into ... into the hospital they are coming in as chief professional nurses, and senior professional nurses – whereas we who have been here all the time are not recognized at all! And ...and it just seems totally unfair and a total waste of time. I mean ... if you give me the opportunity to even apply for that post that is one thing, but just the next thing you hear is that someone is coming as a CPN, taking up a post and you have been here all along and **you didn’t even know** there was a post available...’ **TY/3/34**.

Poor communication about the discontinuation of rank promotion was additionally cited by **RN F** as being a source of frustration and dissatisfaction for her – she had been among the first group of professional nurses to be affected by this and noted that they had not been consulted about the discontinuing of rank promotion, that there had been no notification that this practice was going to be abandoned and that no satisfactory alternative had been offered to them. **RN F** said that ‘they were just told when they went to staff office to enquire about their rank promotion’.

Rank promotion had held several different meanings for the participants. Apart from being a form of recognition and valuing, progression up the ranks was uniformly perceived as being a means by which one’s salary could be improved. All of the participants noted that the discontinuation of rank promotion had a negative impact on

their salary progression and felt that they had reached a ceiling in terms of their salaries. This was evident for **RN T** who noted that her starting salary with her new employer (albeit at the rank of professional nurse) was the same as the salary that she was earning with her current employer where she attained and held the rank of chief professional nurse. Her new employment situation – apart from offering better hours of duty and further professional growth and development opportunities, additionally offered her the opportunity to improve on her salary since over time she would then progress ‘up the ranks’ there.

RN X was from a private hospital, and had worked on an ICU. She had felt stifled in her position as a senior professional nurse and had not advanced career wise over the last eight years. For **RN X** promotion to a charge position – in addition to offering a better remuneration package, would have meant that she would have been able to work ‘better hours’ since the shift pattern associated with a charge post was normally from 07h00 – 16h00. ‘Better hours’ in turn meant that she would have been more able to manage her family responsibilities (**RN X** had three young children). This was evident in the following comment by **RN X**:

‘... jis ...I think for me ... um ... my main, main problem was the 12 hour shifts. And um ...If I could have been offered a seven to four shift anywhere in the hospital – as much as I love ICU, ... um if I could have been given ... um a charge post in a general ward – for the hours – yes I would have taken it...’ **TX/13/142**.

While none of the participants was in effect resigning to take up an immediate more senior position elsewhere, the potential for them to advance their respective careers by means of promotion opportunities offered by their new employers was evident.

It is interesting to note the similarity between this finding and that of Booyens' (1985) study. In Booyens' (1985) study two thirds of her respondents indicated that they were unhappy about there being insufficient promotion opportunities available to them. In the twenty years since Booyens' (1985) study, the lack of opportunities for the promotion of nursing personnel are still a cause of dissatisfaction and unhappiness in the workplace.

4.4.5.4 Sub-theme: Autonomy

A number of the participants noted that their autonomy as practitioners was stifled and undermined in their current work situations. **RN W** noted that her authority as a registered nurse in charge of her ward was constantly undermined by management in situations of conflict with 'over-the-top and bolshy' [over demanding and unreasonable] patients and their relatives. **RN W** said that there was limited or no support for the nursing staff irrespective of the facts of the matter or of 'who was right or wrong', and that management then 'came down' on you [enacted a course of action or discipline] without hearing your side of the incident. 'Bolshy and over- the-top' patients and their families who made extravagant demands and allegations were 'sweet talked' by management who told them anything to keep the peace – even if it meant 'running down' [patronizing and humiliating] the staff member concerned. **RN W** noted:

‘... management’s stock answer for everything is that ‘the customer is always right’ and that they are not prepared to stand up for us at all because they are afraid of losing custom (business) either patient wise or doctor wise ... the customer is **not always right** ...’

TW/F/3/22. [Private hospital].

For **RN N** her autonomy as a registered nurse was constantly eroded by colleagues on the unit that she worked in – she felt that there was a ‘power struggle’ between herself - as a younger and fairly recently qualified registered nurse, and more senior colleagues e.g. her shift leader who was intent on ‘throwing her weight around’ and stamping her authority on each and every situation. Being acknowledged, trusted and respected as an equal and professional colleague was very important to **RN N** – the constant unnecessary checking and re-checking of her work and ‘nit picking’ about insignificant details had left her feeling exceedingly frustrated and unhappy:

‘... but this is one thing that is pushing me [to resign] ... I feel the person who is my supervisor is like eh ... following me [into] every corner that I go ... so I cannot work like that...’ **TN/6/33.** [Private hospital].

For **RNs T and Y**, their new situations meant that they would have more control over their work experiences and be fully autonomous and ergo fairly accountable and responsible for their actions and decisions taken. For **RN Y**, who was moving into the primary health care field, this was encapsulated in the following comment:

‘... That is what I trained for ... to have the leeway to make decisions within my scope of practice ...’ **TY/F/2/10**.

Matters pertaining to autonomy were enmeshed with certain participant’s drives to continue their professional education. This was particularly evident for **RN D** whose repeated applications to continuing her nursing education and training at her institution had been inexplicably rejected. These rejections had not only been a source of frustration for **RN D**, but had additionally affected her self esteem, undermined her confidence in nursing and assaulted her dignity as a human being - by continually being passed over for selection with regard to the bridging course she had felt disadvantaged and disempowered by the prevailing power dynamic in operation on the unit i.e. always teaching new and junior staff who then became her seniors after a year or two.

Even though **RN D** had subsequently financed and successfully completed the bridging course – she still felt angry at not having been recognized by her colleagues and senior staff at having the potential to continue with her nursing education - as is evident in the following comments:

‘... I was working with them for so many years while other matrons – other matrons were sisters ... senior sisters in their wards, I was working with them. But now when they are there [in management positions] ... they don’t recognize me. So I think they thought that I am not capable – my brain has shrunk! [That] ... it is not working ... it is not functioning! How can they employ me those people ...really! ...They thought that I am eh disabled ...upstairs in my brain; ... the main problem is that one ... they didn’t recognize me as a... they didn’t recognize that I am a human being with brain cells! They thought my brain cells are not functioning...’ **TD22/263 and TD/24/287**.

Despite her dissatisfaction with her current status quo, **RN D** was determined to forge ahead and to become 'somebody one day' - to have her professional qualifications and contributions recognized and respected. For **RN D** professional recognition and ergo autonomy was an important part of job satisfaction.

Conceptualisations of autonomy were additionally linked to the practice of 'sessioning' by a number of participants (**RNs F, K, and Y**).

RN K, a unit manager noted that there was an increasing tendency for nursing personnel to work part-time or as 'session' staff. **RN K** noted that:

'... It is hard because the reality is that not everyone wants to be a permanent staff member anymore, they all want to stay sessioning ... although they don't get all the perks and benefits, they just don't want to be committed ... I think they just like to do their own thing ...(pauses) they are all so scared of all the ...the ... you know what happens when they join permanent staff [organisational bureaucracy, pettiness and micro management] – I think that they feel bound, to an organisation, whereas they ... if they are doing flexi ... they can work here and when they get tired of this place they can move to the next place... . Whereas I think that if you are permanent then you know that this is where you will stay and that is how it will be...' **TK/17/118-122**.

Thus sessioning and part-time employment preferences were attributed to an increasing determination by nursing personnel towards maintaining their autonomy with regard to their work experiences – in terms of shifts and hours worked and in terms of having a choice of whether or not to 'put up with' unacceptable behaviour from colleagues, management and medical personnel. Part-time employment and session work were

regarded as providing an opportunity for the registered nurse to assess and explore the prevailing working conditions at an institution (RN Y). RN Y noted:

‘... It [the sessioning] was just to check out the experience – I have never worked in a private hospital before ... so I went to a private hospital ... it wasn’t a bad experience ...’
TY/31/347.

For all of the participants in the study, autonomy in the workplace – i.e. the latitude to make professional decisions regarding patient care, and being acknowledged and recognized as health care professionals were important aspects of job satisfaction. The lack of autonomy in the workplace has been identified as a source of dissatisfaction for nursing personnel throughout the literature e.g. as in Booyens’ (1985) study. Geyer (2004b) argues that having the latitude to exercise one’s professional judgement is an important factor in maintaining the motivation and ergo retention of nursing personnel.

4.5 CONCLUSION

In this chapter the experiential themes and sub-themes that arose from the data collected were presented and discussed. The researcher has identified and explored the hospital workplace experiences of Registered Nurses in the Durban Metropolitan Area and this has been augmented by using the participants’ own words to illustrate their hospital workplace experiences.

CHAPTER FIVE

DISCURSIVE ANALYSIS, INTERPRETATION AND CONCLUSIONS

5.1 INTRODUCTION

The objectives of this study were:

- To explore why Registered Nurses in the Durban Metropolitan area were resigning from their posts; and
- To explore the hospital workplace experiences that contributed to the decision making by these Registered Nurses to resign from their posts.

In order to achieve these objectives, five broad research questions were explored with study participants:

- What are the experiences of Registered Nurses in the Durban metropolitan area in respect of their nursing work experience?
- What are the experiences of Registered Nurses in the Durban metropolitan area in respect of their working conditions and environment?
- What experiences are associated with the decision making by Registered Nurses to resign from their employment?
- Why are Registered Nurses in the Durban metropolitan area resigning from their posts?
- How could the retention of Registered Nurses be improved?

In this chapter each of these research questions are considered definitively against the findings presented in Chapter Four.

5.1.1 The experiences of Registered Nurses in the Durban Metropolitan Area (DMA) in respect of their nursing work experience.

In this study 'work experience' was operationalised as referring to both the non-material experience of nursing (the act of nursing itself – i.e. clinical practice and interaction with one's patients), and to the material aspects of being an employee within an organisation (physical working conditions, supervisory and professional support and basic conditions of service). This question primarily examined the non-material aspects of the nursing work experience for the DMA participants in this study. While the majority of participants voiced that they were dissatisfied at the way they were treated by patients and members of the public, most of the participants noted that it wasn't nursing itself that was driving them from the profession. This finding echoed the findings of Colavecchio (1982) as cited by Booyens (1985) and Callaghan (2003) both of whom noted that it was not nursing, or the nursing of sick and dying patients that was driving nurses from the profession.

In contrast to the findings of Colavecchio (1982) as cited in Booyens (1985) and Callaghan (2003), the participants felt that while 'other aspects of the job' were responsible for their dissatisfaction in respect of their nursing work experiences their non-material experiences of nursing were increasingly being tainted by societal attitudes, perceptions and stereotyping of nurses and nursing. The participants noted that while they delivered a 'civil service' to society in the form of nursing services, there was a generally held misconception that they were 'civil servants' – little better than domestic workers. This negative stereotyping of nurses and negative attitude from the public was interpreted

by the participants as representing a fundamental lack of respect for the professionalism and autonomy of the registered nurse, the nursing profession and for the basic humanity of the nurse as a fellow human being.

5.1.2 The experiences of Registered Nurses in the Durban metropolitan area in respect of their working conditions and environment.

5.1.2.1 Physical working conditions

In this study a marked difference in the physical working conditions and environment between participating institutions was noted. As noted in Chapter Four, basic facilities for the maintenance and well being of nursing personnel while on duty (e.g. clean toilets, a quiet rest area / tea lounge in which to enjoy a cup of tea or one's lunch, a safe place in which to lock up personal effects, and security services) were lacking or markedly sub-optimal in the Provincial hospitals. Minor considerations that had communicated a valuing and respect of nursing personnel by their institutions e.g. the provision of tea, coffee, milk and sugar for 'on-duty' personnel, have been removed from the Provincial hospitals. While seemingly insignificant, and punted by management as being a 'cost containment measure', this 'minor consideration' had also served to sustain the personnel who had left home in the early hours of the morning to catch public transport to their workplaces – often without breakfast or a packed lunch/ dinner.

5.1.2.2 Equipment and supplies

Unlike nursing colleagues in the Private institutions in the DMA, a shortage of basic equipment (e.g. baumanometers and glucometers) in the Provincial DMA institutions, and a tendency by hospital management to sanction the ordering of 'cheap', and inferior quality surgical supplies, has negatively impacted on the everyday work routines of Provincial nursing personnel. This situation has negatively affected the ability of nursing personnel to deliver a quality service to their patients. The nurses are reduced to having to improvise and to reuse 'single use' disposable items (after cleaning them or sterilising them as possible).

5.1.2.3 Management Styles

Most of the participants in the Provincial hospitals, and in one Private hospital noted that their experiences of their workplace were negatively affected by autocratic and dehumanising management styles. Management structures in both the Private hospitals were perceived to be fixated on the 'generating of profits' at the expense of their nursing personnel. This was evidenced through persistent short staffing despite requests for additional qualified staff, and also through management's reliance on inaccurate acuity ratings that are incapable of quantifying exactly what it is that a registered nurse does in the delivering of a nursing service (e.g. how does one quantify the psychosocial and counselling aspects of nursing care – given that nurses are expected to provide a holistic service taking all the client's needs into account?). This short staffing, and the accompanying expectation that the remaining staff must shoulder the burden results in certain categories of nursing personnel acting beyond their scope of practice, places a

considerable supervisory burden on the remaining senior staff and results in chronic fatigue and burnout (Brewer and Kovner, 2001). This lack of ‘caring for the carer’ is documented as being one of the biggest factors contributing to compassionate fatigue and burnout among nurses (Geyer, 2004a).

5.1.2.4 Continuing Education and Promotion opportunities

Stifled professional growth with regard to the lack of opportunities for promotion (the abandonment of the rank promotion system in the Provincial hospitals) and continuing education were regarded as significantly dissatisfying aspects of their work situations by most of the participants, some of whom felt that they had reached a ceiling in terms of professional growth and ergo salary advancement.

5.1.2.5 Salaries

Most of the participants felt that their remuneration was not commensurate with their years of training and experience. Apart from their being no transparency with regard to how salary scales and notch increments were awarded (particularly in the Private hospitals), most of the participants noted that their salaries were not comparable to those of other health professionals in the health care services and that any increases were invariably below that necessary to keep abreast of inflation. Scarce skills allowances, while much valued by those who held them, were perceived by the majority of the participants as being divisive of the nursing workforce – this was particularly so for the rural allowance currently being used by health authorities to encourage staff to work in rural areas.

5.1.3 Experiences associated with the decision making by Registered Nurses to resign from their employment.

Chapter Four encompasses the lived experiences in respect of hospital workplace experiences for the participant Registered Nurses in the DMA – however while these experiences in themselves have contributed to individual experiences of the hospital workplace environment, the actual decision to resign for all the participants inevitably arose in reaction to a trigger incident that compounded an already negative situation – i.e. that which rendered an untenable situation unbearable. Most of the participants expressed a deep regret at having to resign and noted that the decision to resign had not been undertaken lightly. The experiences associated with the decision making to resign are summarized as follows:

- Unsupportive management structures
- Autocratic and dehumanizing management styles
- Negative stereotyping of nurses and the nursing profession
- Lack of autonomy in the workplace
- Professional jealousies and fractures within the profession
- Sub-optimal physical working conditions and shortage of staff, equipment and lack of appropriate surgical supplies
- Concerns regarding occupational safety e.g. the increasing exposure of health care personnel to HIV and AIDS.
- Lack of opportunities for promotion or continuing one's professional education
- The experience of workplace violence – predominantly in the form of verbal and psychological abuse
- Inaccurate systems of performance assessment (Joint Performance Management, Reports, Personal Profile systems) – compounded by favouritism and racism.
- Inadequate remuneration

The following section discusses the trigger incidents that have precipitated the participants' resignations.

5.1.4 Reasons given by Registered Nurses in the Durban metropolitan area for resigning from their posts.

Given that the decisions to resign by the participants in this study were not undertaken lightly, and that much of what has been described above and in Chapter Four could be argued as being endemic to nursing in South Africa, it was of interest to note that the decision to resign for each participant had been set in motion by specific incidents.

Trigger incidents ranged from unresolved disagreements with shift leaders, colleagues and management on a variety of matters (e.g. supervisory and professional boundaries, the undermining of the authority of the registered nurse in respect of professional care decision making and disagreements with members of the public, denied promotion/ continuing education opportunities, and excessive micro management attitudes) to those that related to family responsibilities (the birth of a new baby, having to care for a young family – hours no longer suitable) and transport difficulties. While most of the participants agreed that inadequate salaries and remuneration were problematic, the salary issue alone had not been sufficient to drive them from the workplace. Trigger incidents capped already complex, untenable and unbearable situations.

5.1.5 Retention of Registered Nurses.

Given that multiple factors allied to the hospital workplace experience have been found to be closely enmeshed with the decision to resign by the respective participants in the study, and given that these experiences have been varied and complex, the strategies that need to be devised in order to retain the services of Registered Nurses in the DMA need to be multi-focused.

This section commences with a selection of the participants' views regarding that which could possibly have encouraged them to reverse their decision to resign, and is followed by Sections 5.2, 5.3 and 5.4 which suggest recommendations pertaining to the retention of Registered Nurses for Provincial and Private health care authorities, hospital management structures, and the nursing profession respectively. In response to being asked how the nursing services of Registered Nurses could be retained, the responses from the participants were varied. This is encapsulated in the following comments by participants **RNs P, K and M** respectively:

'... they [the health care authorities] training more nurses every day so they will have enough nurses for the hospitals ... that is not the aim! Because the more they train them the more they go! ... So what is ... to be done? It is pointless stopping them from going across – **the point is they need to correct the money problem!** [Each word enunciated and emphasized]. Because they [the government] **are** very much aware – it is not that they don't know that the nurses are leaving for better money – pay. They are the one's that are talking about going for green pastures. **So we expect the green pastures in our country!** Oh! (exclamation and throws hands up into the air to convey her exasperation at the situation)...' **RNP/25/248** [Provincial hospital].

‘... I don’t want my baby to be brought up in an environment that I can’t see him or have anything to do with him. And I have made it **very** clear to management that if they had a crèche on site I would have stayed...’ **TK/2/18** [Private hospital].

‘... If I was given the promotion – a promotion I ... deserve... I am a shift leader... at least I am supposed to be a SPN – a senior professional nurse...at least ...but in most cases shift leaders are chief professional nurses. It is the responsibility that I have been given to lead the shift but they are not getting [giving me] a promotion. If I got a promotion I **was not** going to resign...’ **RNM/18.162**. [Provincial hospital].

5.2 Recommendations for Provincial and Private health care authorities

The recommendations summarized below have been derived from the findings presented in Chapter Four. The Health Care Authorities should:

- Implement a significant increase in the salaries of Registered Nurses – such that these are comparable to those of health care workers in the allied health care professions, and such that the professional nurse’s education, training, experience, accountability and responsibility in the delivery of health care services are acknowledged. [Rationale: promotes the nursing profession as a viable profession to both men and women and to the youth – in terms of financial reward and associated remuneration, encourages those in the profession to stay in the profession, will also discourage ‘moonlighting’ by personnel who are attempting to ‘make ends meet’ from a financial point of view].

- Implement 'Scarce Skills Allowances' in an equitable manner – while recognition of those who have achieved additional qualifications in specialty areas is important, all those who actually work on a specialty unit/ or whose expertise is utilized in a high care area/ dependency unit should be acknowledged and receive the appropriate remuneration for additional responsibilities carried.
- Ensure that accreditation processes take cognizance of the physical working conditions for all personnel in the hospital – not just of patient care facilities and services available to the community. The provision of basic equipment and surgical supplies should be critically examined.
- Appoint appropriate human resource - quality control agents who independently monitor the following: the physical working conditions of nursing personnel, acuity ratings that determine staffing, and ergo the ratio of registered nurses to patients.

5.3 Recommendations for Hospital Management structures

Hospital management in both Provincial and Private hospital groups should:

- Adopt more ^{Transformational} democratic styles of management – it is imperative that dictatorial, ^{Transactional} autocratic and pedagogical practices be identified and condemned (e.g. inflexible attitudes towards shifts and hours of duty, pedagogical attitudes towards ^{channels} channels of communication, stereotypy of nurses, being overly concerned with one's own rank and status within the organisation, favouritism, and racism).
- Implement participative decision making in a genuinely consultative and respectful manner – nursing personnel are health care professionals, not just employees in an organisation.
- Adopt policies that promote transparency regarding salary scales and structures, ^{decision ma} e.g. display the salary scales available for the different categories of staff with a detailed explanation of how ^{OSD} a grading is awarded; clearly explain this to prospective employees and indicate clearly how progression up a salary scale works, how notch increments and annual increments are awarded. Clearly explain any financial ramifications pertaining to an employee's annual performance appraisal and /or report.

Nurse Leaders are 2 effectively

must value

- Visibly demonstrate their support and valuing of their nursing personnel. With reference to the Private hospitals, this support and valuing should be clearly evidenced to both medical personnel utilizing the facilities and to the public. Nursing personnel must be well educated regarding grievance procedures and be assured of management's support in the face of workplace violence and / or discriminatory practices.

Education

- Implement systematic and transparent policies regarding continuing education opportunities and selection procedures. Continuing education opportunities together with the relevant selection criteria, must be advertised timeously and all staff must be given the opportunity to apply – notwithstanding the practice of 'bonding' staff for a period of time after a study opportunity has been awarded, those who meet the selection criteria should be awarded the opportunity on a 'first come first served basis'. Waiting lists for courses should be displayed and updated bi-annually.
- Explore alternative means of performance assessment for nursing personnel. Performance assessments should be conducted by those who actually work with the employee on a daily basis e.g. the shift leader. Peer review should be considered as an adjunct to traditional modes of performance assessment. 'Personal Profile' systems need to be closely scrutinized and implemented with a greater degree of transparency. Personnel must be trained and educated regarding that which is required when compiling a 'Personal Profile' and incidents must be

witnessed. Performance assessment tools must be reliable and valid – that is they must consistently measure that which they are supposed to be measuring, and not be open to subjective interpretation by either the assessor or the individual being assessed.

- Should be cognisant of the increasing incidence of HIV and of the ongoing and evolving nature of the HIV epidemic (Abdool Karim and Abdool Karim, 2003). Given that all health care workers will face ongoing workplace tensions and anxieties with regard to HIV and their exposure to the disease, it is imperative that management ensure that nursing personnel have access to psychological support and counselling services. Education regarding occupational safety e.g. needlestick injury and post exposure prophylaxis treatment, and support services in this regard must be initiated and maintained.
- Implement a more flexible approach to shift patterns and hours of duty such that the individual's family responsibilities and transport difficulties may be accommodated. This may require the employment of additional staff.
- Be committed towards delivering a service to their nursing personnel such that the nursing personnel are encouraged and empowered to deliver quality nursing services to the public.

Management

5.4 Recommendations for the Nursing Profession

With reference to the lived experiences of the participants in Chapter Four, the nursing profession should:

- Unite and demonstrate a visible solidarity – both within the workplace and without. This may be achieved through joining an appropriate union that efficiently and adequately represents the interests of nurses in the workplace, by taking an active part in consultative forums and by attending the relevant professional body meetings.
- Be cognizant of / become educated regarding matters pertaining to basic conditions of service and the labour law, and be informed about their rights both in the workplace and constitutionally e.g. be informed about grievance procedures – when the procedure may be employed, how it is initiated and the course that follows until resolution of the matter at hand has been achieved.
- Be supportive of each other and not condone workplace violence in any form – e.g. the verbal abuse of a colleague by another, demeaning jokes, gossip, slander and innuendo. Silence both condones and perpetuates abuse, and there is nothing professional about being a doormat.

- Acknowledge that nursing and nurse training has changed in order to better meet the needs of our society – hence older nurses need not feel threatened by the training and education received by younger nurses and younger nurses need to acknowledge the expertise and experience of the older nurses. Together everyone achieves more – teamwork needs to be promoted.
- Ensure that nursing curricula deliver the appropriate life skills training – assertiveness training, anger and stress management courses.
- Engage in a marketing campaign to promote the profession and encourage the youth to enter the profession, stereotyping of the profession by the media should be challenged since this negatively affects public perception of the nursing profession.

5.5 Recommendations for further Nursing Research

The following recommendations for further nursing research have additionally been drawn from the findings and discussion in Chapter Four:

- Notwithstanding the current shortage of nursing personnel, and given that current systems of determining unit staffing (acuties and acuity ratings) neither satisfactorily nor safely cater for the delivery of quality patient care, Government health authorities should initiate research into mandatory minimum staffing ratios.

Minimum staffing ratios devised should be in line with international standards that recommend that there should be a minimum of one registered nurse for every four patients in addition to the other categories of nursing staff. The rationale: mandatory minimum staffing alleviates excessive workloads, and would reduce the likelihood of compassionate fatigue and burnout (Geyer, 2004a); further prevents the abuse of the Registered Nurse in Private health care settings due to cost containment exercises, promotes quality care and patient safety in that other categories of staff are not expected to practice outside of their scope of practice, and enables students to be afforded the opportunity to be students and learn through observation and supervised practice.

- Given that the rank promotion system in the Provincial hospital services has been discontinued and that promotion opportunities have been evidenced as being contentious issues that are closely tied to job satisfaction and remuneration, further research into the area of promotion for nursing personnel should be undertaken. A satisfactory alternative and /or equivalent to the rank promotion system needs to be investigated.
- Herzberg (as cited by Owens, 1998) argues that job satisfaction is the outcome of number of interacting factors - research into that which would be regarded by nursing personnel as being significantly motivating should be carried out. Given that 'Good Governance Awards', 'Carer' of the month photographs on corridor walls and 'You're a star motivational cards' have been evidenced as not being

motivating of personnel towards ownership, productivity, and service delivery and additionally detract from the professional status of the nursing profession and Registered Nurses, further research in this area may well reveal meaningful motivating factors and incentives. With reference to the Private hospitals these incentives might be in line with those offered to the allied health professionals e.g. quarterly profit sharing incentives. For Provincial hospitals the incentive could be in the awarding of a monthly 'Long service' allowance for those who have an unbroken service record of five years or more.

5.6 CONCLUSION

Herzberg, in terms of his Motivator-Maintenance theory (as cited by Owen, 1998) argues that the removing of sources of 'dissatisfaction', e.g. poor salaries, sub-optimal working conditions, autocratic and pedagogical management attitudes and policies, does not lead to motivation or job satisfaction for the employee, and ergo will not lead to the retention of personnel in isolation. Herzberg notes however that these variables are essentially maintenance factors which serve only to prevent job dissatisfaction, and he further notes that the maintenance factors (despite not being able to motivate people to achieve job satisfaction) must be present before the motivational factors can be effective. The conditions (motivational factors) that give rise to motivation, and ergo job satisfaction are: achievement, recognition, the challenge of the work itself, responsibility, advancement and promotion, and personal and professional growth (Owens, 1998). Thus

job dissatisfaction may be argued as being linked to the characteristics of the organisation, and to the organisational climate (Owens, 1998).

In terms of the findings of this study the participants' lived experiences in terms of their hospital workplace experiences indicated that neither the maintenance factors nor the motivator factors were optimally represented, experienced or enjoyed in their respective workplaces. In terms of Herzberg's Motivator-Maintenance theory, the registered nurses who participated in this study may be described as being 'not satisfied' and 'dissatisfied'.

Awases et al (2004) have argued that in order for countries to be able to develop interventions that serve to mitigate their losses in respect of their human health care resources they need to have '... a clear regional picture about the movement of health workers...' (Awases et al, 2004, p. 62). The researcher notes that having a clear regional and localized picture about the hospital workplace experiences of registered nurses (nursing personnel) further facilitates the development of interventions to retain the services of nursing personnel. This study clearly describes, interprets and localizes the hospital workplace experiences of registered nurses in the Durban Metropolitan Area, and identifies the reasons behind the resignations of registered nurses in the area.

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7. APPENDICES

7.1 APPENDIX ONE

Interview Schedule

Setting the scene:

Ensure private venue for interview.

Establish rapport, greet participant, thank participant for agreeing to be interviewed.

Discuss the study and briefly summarize the research study objectives, discuss the matter of confidentiality, remind the participants that participation is voluntary and that they may end their participation at any time. (Obtain written consent). Prior to turning on the tape recorder, allow participant to choose a pseudonym that will be used throughout the interview and in the study.

This is a semi-structured interview. The research questions (in bold print) have been included on this document as a guide for the researcher, and the prompts are intended to elicit information from the participants in respect of answering each research question. Please note that the participant will **not** be asked the research questions.

It is important to start with some 'less sensitive' questions so that the participant does not feel threatened or uncomfortable. These questions would take the form of 'verifying' questions e.g.

- How long have you worked at hospital x?
- What is your area of specialty?

Thereafter the primary '**trigger**' question – 'Tell me about your decision to resign from your post at hospital x?' will be asked, followed by a 'prompt/s' if appropriate. If the interview appears to stall, the researcher will employ the use of a prompt/s.

Why are nursing personnel in the Durban Metropolitan Area resigning from their posts?

PROMPTS:

- Tell me about your decision to resign from your post?
- Is there anything else that has affected your decision making in this matter?
- What has contributed towards your resigning from your post?
- How do you feel about leaving?

What factors are associated with the decision by nursing personnel to resign from their employment?

PROMPT:

- Are there specific items or incidents that come to mind in respect of your decision e.g. workplace violence/ bullying?

What are the experiences of nursing personnel in the Durban Metropolitan Area in respect of their work experience?

PROMPT:

- What aspects of your work have you found to be satisfying?
- Would you say that you enjoy coming to work each day?
- Are there any aspects that you found to be dissatisfying?
- What is the morale like in your profession (nursing)?
- What is your morale like?
- What is your current status in the organisation (RN, SPN, CPN, team leader)?
- Have you been promoted into a more senior position within the last 5 years?
- How is your work performance assessed – and how has your work performance and achievements been recognized over the past year?
- What are your feelings in respect of the performance appraisal process?

What are the experiences of nursing personnel in the Durban Metropolitan Area in respect of their working conditions and environment?

PROMPT:

- Tell me about your work experience.
- What is your area of speciality?
- How have your work needs been met? (maintenance factors – physical working conditions, resources, supplies, staffing ratios, salary structures, fringe benefits: medical aid, provident fund, crèche facilities, etc).
- How would you describe your work environment – physical conditions and atmosphere?
- Do you feel that you receive the necessary (competent and knowledgeable) supervision when you need it?
- Generally – how have you experienced the attitudes and policies of management towards nursing personnel in your organisation?
- Tell me about the opportunities for growth and development within your organisation?
- Are you responsible for the work that you do/ are delegated to do and do you accept this responsibility?
- Participative decision making – are nurses involved in the decision making processes in respect of decisions that affect them within your organisation?

How could the retention of nursing personnel be improved?

PROMPT:

- What could have been done to have encouraged you to reverse your decision in respect of your resignation?
- How could your working conditions/ environment have been improved?
- What could have been done to make you stay?
- Do you regret having chosen nursing as a career? Why?
- Would you encourage a member of your family to go into nursing?

Thank participant again for their time and participation. Ask if there is anything else that they would like to add to the interview, schedule a follow up interview to clarify and check information obtained in this interview.

7.2 APPENDIX TWO

BRACKETING OF RESEARCHER PRESUPPOSITIONS

Bracketing (phenomenological reduction) is the process whereby the researcher identifies and sets aside any preconceived ideas, beliefs and opinions that he or she has about a phenomenon being studied. In this research study 'bracketing' of the researcher's presuppositions is necessary to avoid any 'researcher bias' effects in the analysis of the data collected and in reporting the results of the study.

The phenomenon being studied is that of the turnover of nursing personnel in the hospitals in the Durban area. The researcher's own experience of having worked in both the public and private sectors, both nationally and internationally has lead to the belief that the turnover of nursing personnel is directly proportional to the management styles and work conditions in operation at an institution. Where poor employee/ employer relationships exist, and where nurses are subject to less than satisfactory work conditions, it is inevitable that job dissatisfaction and migration of personnel results. The researcher firmly believes that financial gain is not the sole motivator in precipitating migration across sectors and /or out of the nursing profession. The researcher additionally believes that the traditional view of nursing as a 'woman's profession' has done irreparable damage to the profession and its practitioners. This is especially so in a patriarchal and divided society like South Africa where women (and nurses) are still regarded as social inferiors – despite a progressive Constitution that espouses equality between men and women. Nurses are treated with contempt and disdain by their medical colleagues and others in health care disciplines, and this further exacerbates the current low morale evident in the profession.

7.3 APPENDIX THREE

- **Example of Transcript - RN M**
- **Example of Follow up interview – RN M**
- **Example of Field note – RN M**

TRANSCRIPT OF RN M

HOSPITAL: PHC (Provincial hospital C)

DATE: 17-02-2005, Thursday

TIME: 08h10 – 09h30

INTERVIEWEE: RN M

Interviewer: well first of all, thank you. I know that it is incredibly early in the morning so thank you for agreeing to take part. I do appreciate your time ... especially on a day off.

RN M: mmm

Interviewer: um ... what I have done with all the other participants is that we have chosen a pseudonym – a name that [I am going to use to] refer to you throughout when I transcribe ... and with all the others – I have just taken a random letter of the alphabet ok... some letters have gone already, but I am just going to ask you to choose randomly ... any letter of the alphabet and if it is available then we will use that one, or else we will try and find another one.

RN M: ok ... you call me Mr. M. mmm hmmm.

Interviewer: M? Ok ... I am with Mr. M. at PHC hospital. Um ... I am just going to start with a few general questions ok... um how long have you been at this hospital?

RN M: mmm, actually I started my training here in uh ... the January of 1997 ... when I was starting my course – four year course, and after qualifying here I also worked here as a registered nurse.

Interviewer: when did you qualify?

RN M: it was eh ... it was 2001 ... June.

Interviewer: and what is your area of speciality?

RN M: mmm ... at the moment I have been working in ICU ja... but after qualifying I worked in a trauma casualty for about a year, and then I worked in a surgical ward and then they moved me to ICU. And I am staying in ICU ...

Interviewer: ok ... and are you / do you have the ICU course as well?

RN M: no I only have ... I am only experienced in ICU ...

Interviewer: So now you have been here a fair bit of time and you said that this was your training hospital...

RN M: yes

Interviewer: um ... what has prompted your resignation ... what is your reason for resigning?

RN M: eh ... it is difficult now you see... there is this system which was used by the Government – before automatically after completing three years [of service] ... I am meaning after like finishing the course, like me I am a registered nurse, you only worked for two years and then automatically they promoted you to be a senior professional nurse. And after two years – meaning after 5 years ... they ... you will also get promotion to be ‘chief professional nurse’, but now they got rid of that. Now you can be a professional nurse for ten years or more than that because they have destroyed that, so even money you don’t get it ... you don’t get enough money. Eh ... Right now the salary I am getting – I am getting the salary ... [for example] these ... these people were students like when I was doing my final six months before starting the course, they are earning the same salary now as me! So it is really not nice... not nice.

Interviewer: mmm, mmm ok – um ... to ask a slightly personal question, ok - your salary bracket is that between 6 and 7 thousand rand or 7 and 8 ... just roughly, I don’t really need to know the exact salary.

RN M: it is between R6000 and R6500.

Interviewer: ok – all right and that is with [since] having qualified in 2001?

Interview interrupted by cleaner who is intent on sweeping floor. Tape recording stopped, participant indicates that he is happy to continue with the interview with the cleaner in the room.

Interviewer: ok starting up again ... ok we have just clarified um ... a salary bracket, moving on...um were there any other issues surrounding your reason for resigning now, apart from the salary issues and the promotion issues at the moment?

RN M: now what happened [is that] I ... I applied because uh ... obviously the main problem now was my ... position in my department where I been covering... but I can say that I was abused in ... in my department, eh ... because as I say I am still a

professional nurse now - **but** I am experienced in ICU. So what has been happening ... I have been a shift leader ...uh since er ... last year, a shift leader in ... early ... since early ... at the end of February last year. I have been a shift leader. So ... other registered nurses who came later than me have been reporting to me - because I know exactly what goes on in ICU – so they have been reporting to me. Even the admissions ... the patient that has to come to the unit – that has been [is] discussed by [with] me, so I have to ... analyze the blood gas before the patient comes...but that is the responsibility of a person who is ICU trained, and in this case a chief professional nurse. I have been doing that but I have been getting nothing out of it ... so it is really, it has not been nice.

Interviewer: ja ...ja. Do they pay you an allowance of any sort?

RN M: no ... that is the other ... that is the other problem – what they said, uh ... I am not sure whether it was last year or the year before last ... all the people that are working in ICU and theatre – who are ICU trained and theatre trained ... they have been getting a Scare skills allowance ... but for us who are not ICU or theatre trained, we are not getting that money. So they are also making us to be shift leaders but whereas we are not getting anything out – out of it. So it is really ...um heartbreaking.

Interviewer: so there is not even a unit allowance ... [for the] fact that you are working there ...nothing?

RN M: no there is no unit allowance ... because the other thing they will do – even if we are off, they will call you to come and help if there is a shortage in your unit. They will call you, they will phone you on your cell to come and help. So... but I ... I have been refusing – because you have worked ... the only thing that [they do to compensate you for this] is your hours back, not money. They even refuse to ... to pay you for overtime. So you come into your unit on your day off just to work and so you can get your hours back ...so things like that.

Interviewer: So - let me just clarify – they ...they ask you to work overtime on your days off, they won't pay you, and they want to give you back hours?

RN M: ja ... ja- they will give you back your hours ... let me say today I am off and there is shortage, maybe there are three junior sisters...then they will phone all the senior staff, for one ... if they can get one of the seniors to come and run the shift.

You will run the shift maybe from now until seven, maybe you are supposed to work tomorrow there [but] there is another senior sister who you will be working with - who is also a shift leader – so they will give you a day off tomorrow – you are supposed to work tomorrow but then they give you a day off paying back this time you used today. Ja ... it has been working like that.

Interviewer: oh ok, and what about on weekends when there is time and a half and double time ... do you get double time back?

RN M: no ... no ...no - you don't get anything out of it, working public holidays and weekends ... it is the same...

Interviewer: so it is an hour for an hour finished ...?

RN M: Ja. And what has been happening during uh ... weekends because we are only ... we are short staffed during weekends we are not so many ... so the lunch we are not allowed to go out of the department – during the weekend. But we don't get paid for that anyway ...[but] we have to remain in the department even if you are eating ... you must eat there in the department because no one will take care of your patient, everyone has his or her own patient.

Interviewer: ... that sounds quite stressful actually ...

RN M: yes ... it is.

Interviewer: ... I am going to change tack a little bit ... In the time that you have been here, ok, particularly in the department that you are in now – has there been anything that you have found to be ... satisfying ... anything that you have enjoyed the most?

RN M: ja ... the team work, the team work has been great really. And even now I am so frustrated that I am leaving, but I have to leave because of money and the things that I have mentioned to you ...but eh ... the team work has been great. And I mean with the girls that I am working with ... it has been ... that type of relationship even our sister in charge has been so supportive to us. So really – I really liked ... I really, really liked my field, I really enjoyed it ...so.

Interviewer: now conversely all right, you have already told me what you have found dissatisfying in terms of the salary, has there been anything else that you have found to be dissatisfying about working here?

RN M: ja ... recently, in most cases I have been working night duty, I don't like to work on day duty. Because in day duty sometimes you are so many, and if you are so many the other things are not done properly because one thinks the other person will do that thing - whereas at night um ... we are only...few... we are only a few. And as we are a few like that each one knows exactly what is expected of him. So sometimes on day duty sometimes there is that ducking of job. And recently they have employed the ICU registrar – sometimes ... I don't like the way he ...he works ... I don't like it.

Interviewer: an ICU registrar is a doctor?

RN M: yes, he is a doctor, I don't like the way he does things.

Interviewer: what is it about his way [that he works] ... what is it that he does?

RN M: see when it comes to the changes of ventilator or any changes ... if he wants to make any changes he has to inform you ... he has to inform the person that is looking after a patient. Sometimes maybe you go somewhere ... maybe let me say you just go to 'pee', and then when you come back [and] you are doing the next observation on the patient and you see that something has been changed on the ventilator ... and you were /are not informed about it ... and that is also not right. It is not right and uh ...and they ... we know exactly what goes on with the ventilator so if there is a problem, I don't have to go first to report to him, I ... I want to change the ventilators [as I have been doing] I have been doing on night duty because the other girls have been reporting to me – so if you have made a change – a due change – to him it is like we have done something **very** wrong ... so that is also [frustrating].

Interviewer: would you say it is a communication thing?

RN M: ja – I would say that there is a lack of communication between him and the nursing staff ... not only ...not only me ...ja. Actually all – they are all not happy. They are all not happy about that.

Interviewer: in the media recently there has been a lot of talk about um ... workplace violence and bullying, um ...have you experienced anything like that?

RN M: aw ...no! no, no... no ... not in my department.

Interviewer: ok, so you have had experienced no physical violence either from a colleague or a patient or a doctor?

RN M: no.

Interviewer: and verbal abuse?

RN M: no verbal abuse ...ai. [aikona].

Interviewer: um ... as you know I am interested in working conditions ... your actual sort of ... physical environment as well. Um of course everybody has needs that need to be met whilst you are at work. UmHow have these needs been met for you – um things like um ... safety and security, food, um ... ablution facilities um you know all that kind of thing?

RN M: um for safety – I think ai ...our department ... safety there I think it is guaranteed. Because what happens is – you can't ... you can't enter the unit. You have to - while you are outside– you have to press first, and then as you are pressing the bell will ring inside ... and then you have to identify yourself: who you are, who are you coming to see, what ... what are you here for. Then if we are not happy then we give you information on the intercom. Maybe you are looking for a patient, maybe you will say '...I have come to see patient so and so...', and we will tell you that '...no it is not visiting time now / or we don't have that patient...'. Or if we do have that patient – '...ok it is not visiting time at the moment – you come during visiting time ...'. We don't allow that ... that person to come in. But then if the person identifies himself, and they ... he tells you what comes ... what he is coming for – and you are happy then you can allow that person to enter. So it is not like in the wards where you can just find the strangers in the ward. Ja. Even for the patients I think it is safe.

Interviewer: so for your personal belongings and stuff, I mean you don't have a problem with theft on the unit?

RN M: no ... why what happened ... there are lockers there, plenty of lockers. So there is there is no theft, so even if you can leave your things in the tea lounge ...not in the lockers ...[there is] but ... no problems, no one has ever reported that something of his or her has been stolen. So. But others keep their things in their lockers ... others just leave them in the tea lounge.

Interviewer: and ablution facilities?

RN M: I beg your pardon?

Interviewer: ablution facilities ... toilets [do] they have that for you on the unit?
... and generally would you say that it is a clean, nice environment to work in ...?

RN M: a very nice ... environment to work in, they really can't complain – because they keep even the ... we have a person responsible for cleaning of the toilet, ja ... in our unit there is only toilet for staff, there is no toilet for patients because obviously it is an ICU. So it is always clean and we have got ...

Interviewer: and as far as meals go, and ... and tea breaks and stuff like that ... do you get all of those.

RN M: Ja - we do ...we do get. But sometimes if it is too busy then obviously we won't have a tea break but we don't mind ... but ... your lunch break / because anyway tea break is a just a ... a ... it is not a ... I mean it is a privilege, it is a privilege, ja so ... if you don't get it today, you ... maybe if you don't get it now you get it later, but you get it ...so.

Interviewer: mmm, ok, mmm. And do you have to provide your own food?

RN M: ja, you have to provide your own food ... I think from uh ... I am not sure, I think from 1997 or 1998, because before they were providing: milk, sugar ... and eh ... ja maybe sugar, I am not sure about bread now – I can't remember much if it ... but then they changed – so.

Interviewer: so you have to bring your own tea, and coffee and everything.

RN M: ja, ja you have to bring everything.

Interviewer: ok, now in terms of things that you need to do your job – uh linen, patient gowns, equipment, patient gowns, ventilator cables stuff like that, um ... how is that?

RN M: with the equipment everything is ok, we have uh, enough ventilators and they get serviced – they get serviced ... I don't know how often, ok we have monitors – plenty of monitors and they also service them, ja ...

Interviewer: surgical supplies?

RN M: I beg your pardon?

Interviewer: and surgical supplies ...

RN M: such as...?

Interviewer: bandages, needles ...

RN M: (clicks tongue) ...we got ... ja our sister in charge does that ... that part of order ... of ordering things, so we always have plenty of things.

Interviewer: ok, so you don't have a problem with accessing surgical supplies or linen or anything like that?

RN M: aw no ...no we don't.

Interviewer: is there anything in your work environment that could be improved ... that would make your life easier?

RN M: (long pause), um ... I know everyone likes to work in ICU, so there also has been a problem about that ... because now you ...our hospital is a ...they call it a learning hospital. We will have a person... you will teach someone [then they will] work, now maybe she will work for three or four months so then she has to rotate. She has to give... she has to go to other departments so someone else will come to learn as well.

Interviewer: is that compulsory... do you have rotate?

RN M: you have to rotate ... ja ... more especially if you are still junior, and you are on probation or when you are bridging. Ja... you have to rotate, like in ICU you can't really say that you are permanent there, because even for us that have been there for so long, they can if they want to ... they can change you.

Interviewer: oh ok, mmm. Mmm.

RN M: so now it is frustrating when you have taught someone something, then when you ... once you have taught someone something then you rely on that person. So you say '...ok even if I am busy, she will, she knows that ... she will do it...'. Then the next month you find that she is going to another department now and the new person who doesn't know anything will come to the department. You have to start afresh now teaching ...

Interviewer: mmm, all over again.

RN M: ja... and it is really problem, more especially when ... if you are admitting ... if you are admitting the critical patient or in case of a ... eh ...or if you are resuscitating a patient – if you have new staff, because they will still not know what to do.

Interviewer: ja, it has put pressure on you really.

RN M: ja –so it puts pressure on me ...

Interviewer: you mentioned earlier on that there was a problem with short staffing – that sometimes you get called in on your days' off...

RN M: yes

Interviewer: can you tell me a little bit more about the staffing situation?

RN M: mmm, during the day ...um ... others are working day duty, others are working ... I mean during the day others are working until two o' clock - and others are work until 19h00. So it is not that bad during the day if you come ... I mean like eh ... 6 people have to work 'til seven during the day ... maybe three or four will go off at two. So if maybe out these six [that] have to work until seven, maybe three will be off sick (because that is the other major problem ... booking off sick), if three book off sick then that will leave three that will work until seven. So it is not that bad during the day because they will ask those who are supposed to work until two to change their off duties and work seven ... until seven. Maybe if they don't have any commitments – they will agree to work. If they have commitments obviously they won't agree. But if a person ... if it is a person who is working eh ...night duty says I am booking off sick, she phones during the day ...that because we are only four at night ...if she says I am off sick - a senior person, there is no cover. At least during the day you can ask those working until two, but at night we are all working 7/7 – seven at night until seven in the morning, so you have to get someone who is day off to come and cover at night ... at night - and it is just to pay back the hours, no money.

Interviewer: and that person that was day off that now comes to work night duty, what if they are supposed to be working the next day? So they just juggle [the off duties to fit]?

RN M: ja , if you - maybe if you are supposed to be working during the day, you won't come during the day, they will count the hours and sometimes they will even say that you owe ...you owe them! Like in case – sometimes if a person who is booking of sick is working night duty – you are on duty already in the morning, they will ask you to go home and to come back in the evening. If they ... if they have phoned around for people who are off and they ...and they all say no they can't make it, maybe they will ask you to go and come back in the evening.

Interviewer: does it happen ... does it happen often?

RN M: no - it doesn't happen often, it doesn't happen often - but it does happen.

Interviewer: ok... um (pauses) ... I had an important question to ask you and it has just slipped my mind ... um. When you are asked to do these sorts of extra duties, or to go home and come back, or extend your shift until seven 'o clock when you are supposed to be off at two ... you said that you do ... do have a choice...but is that a real choice?

RN M: ja - it is ...a real choice.

Interviewer: so if you say 'no', then there is no problem with saying no?

RN M: no there is no problem if you say no ... **but** like ...but if you are off and they phone you - they ask ... they ask you the reason ... they ask the reason why if you say no you can't make it , they ask you the reason because there a book there in the department ...where a person who is phoning for staff ... for staff - that person has to write who he/ she phoned, and what that person say – if that person refused what was he or... what was she or ... I mean why ... why ...why the person refused. What your reason – a person uh ... gave.

Interviewer: and how do you feel about that ...having to give a reason.

RN M: I think ... it is not ... I don't like that. That it is not right that. It is not their right... it is not for them to know what you are doing during your day off. If you ... I think it is enough if you tell them 'no, I can't make it... I think that is enough, you don't have to give them reason now that uh ... '...I am not coming because I am doing this and that...' – that is personal... that is ...maybe you will be doing a personal thing- so now we have to disclose that. It is not right.

Interviewer: ... ja ... no that is a bit strangea bit odd.

Interruption: tape recorder turned off – floor cleaner comes in with polisher, participant indicates that he is happy to continue with the interview.

Interviewer: starting up again, ...um in general ... how do you feel the management's ... attitudes ...attitudes and policies are towards – how have you experienced the management of this hospital?

RN M: I think that that is one of the major problems in our hospital... for our management

(long pause while he waits for the cleaner to leave the room)

RN M: ok ... what happens in our ... in other institutions, if you go to [the] matron's complex, if you look to the matrons – their epaulettes, you will see that these people deserve to be in matron's complex, they have admin, they have done administration, they have education. You will find that most of them ... like if you go to other hospitals like --- and --- ... they have like 5 bars ... the matron. So that person has done admin, she does ... if she does admin, she does something she knows ... something [that] she has learned. If ... our management – most of them have one bar, they have only done midwifery. So ... the thing they have is experience – sometimes uh ... the decision [that] they make when it comes to admin is not right. You ... you can see that they lack that education, they have experience for work – but ... but education wise – ... they are not good.

Interviewer: ok, mmm. Mmm - do you find that they are supportive of you at all, can you go to them with any problem and discuss these things with them or ...

RN M: what ... things like?

Interviewer: uh ... let's say that you are unhappy with something in the ... on the shift or in the unit ... or you have had a problem that you needed to sort out, can they help with that ...?

RN M: ja – it depends some of them are so supportive ... because the other thing is that you have a zone matron ... you have the matron allocated to you – but that matron is not permanent because they also change. Sometimes you have a matron that is so supportive – you can go to her and explain your problem to her and she will understand and will support you. The next matron – maybe that matron [the one before] will be there for maybe six months or a year and then they will change – they will change her [and] it will be another matron, and she will come with her own attitude, ja so they are not the same, and they don't keep the same matron, they rotate.

Interviewer: and the attitudes and policies generally towards the staff here?

RN M: uh ... I think it is still the ... the way where ... where it has to be obvious that ok you are ... you are her junior ... where it **has to show** ... ja it has to show that you are her junior, she is your senior. The way she talks to you, the way she comes to the ... the way she comes to the department...see?

Interviewer: so it is still very sort of 'old school'?

RN M: ja.

Interviewer: ok, um ...one of the 'buzz words' - you know - in sort of nursing academic circles at the moment is about participative decision making, um ... when there are things that are going to be changed on the unit ... or things that have to be implemented, do you find that ... as a member of staff that you have an opportunity to participate in making those decisions ...um ...let's say that they want to change hours of duty or [implement] a new procedure on the ward or something?

RN M: ja ... well what ... what they do, [is that] they give you chance to choose - but in most cases you will find that they are just making that [a show] ... but they know what they are going to do. They won't ... they won't ... they won't consider ... they won't consider, they won't consider what, like what you suggest. They will pretend as if they are listening to you, [and you] tell them all your problems about why you want this done that way ... whereas they know what they will do!

Interviewer: so it is 'lip service' ...it is not [true participative decision making].

RN M: ja.

Interviewer: ok, when you think about your nursing career, do you regret having come nursing?

RN M: no, no – no I don't regret it.

Interviewer: and would you come nursing again? If you had to choose [again]?

RN M: no ...

Interviewer: what would you do?

RN M: ... I never planned to be a nurse when I was still at school, and I never thought that I was going to be a nurse. But at home we are 6 children – only my father was working. I actually wanted to do journalism. But my sister was at college – was in college already doing teaching, and my father was paying for her, he couldn't afford to send both of us to tertiary. So that is where I got that idea, that ok, because

in nursing you just apply, they train you ... you don't have to pay them but instead they pay you. That is how I became a nurse.

Interviewer: ok, and you say you don't regret that decision?

RN M: ja, I ... I ended up liking it ... I ended up liking it because really I am a caring person ...someone, **but** if ... I don't regret that decision because I didn't have a choice. You see ... I didn't have a choice. Right now I ... I like ...I am liking it – I am getting money – I am living out of it.

Interviewer: would you encourage a family member of yours to come nursing?

RN M: ai no ... I can't ... really I can't.

Interviewer: ok, tell me about that?

RN M: there is too much of stress involved, there is no money ...ja ...

Interviewer: ok, so how would you describe your morale in terms of nursing – given that you have said that it is very stressful, and the poor salary, just you know having considered all those factors, how would you describe your feelings about it?

RN M: ja ! I still ...ai! I still like it but I mean if they can change the ...the system – if they can bring back uh ...that old system where we you have to be promoted automatically to the next level. It was ... it was ok, because even now, eh, I don't ...my source of salary is not my institution. I also go to private hospital – to moonlight for extra cash, and in most professions ... I mean ...you don't get that chance, and the money you get there is ... it is big. But it is also ... but is stress- the thing is it is just stressful. Ja – so it is not nice, sometimes you are ... you are stressed on duty here and [then] during the days off you go to private and you are stressed, you are also stressed out there ...

Interviewer: ja, you know that is hard, because you are also not getting your rest.

RN M: ja, it is hard, you don't get enough rest.

Interviewer: how often do you session?

RN M: mmm, ai now I - this year- ai ... this year I haven't sessioned. Just said to myself let me take a rest. But eh, [when] I have been sessioning I have been working 5 days or 4 during my 7 days off.

Interviewer: oh ok, because like when you where on night duty you worked 7 on 7 off ... oh ok. Um...ok, you said that there was a problem with absenteeism in the

hospital and in the unit that you work. Why is it that you think there is such a large or high absentee rate?

RN M: ja, ja the other thing ... the absenteeism. If ... if someone is absent, not in your department, let me say in medical ward maybe there are two sisters who are absent. Obviously you are ... you are going to be affected ... so

(interruption, cleaning staff again)

Interviewer: ok – we are talking about absenteeism ...

RN M: ja, or – if someone is absent in the other department, like a sister, and you are all in duty in your department, you are going to be uh ... affected as well, because what is going to happen, maybe you – you will have a few patients in your department, the matrons will phone to cover - they will ask some of you ... some of you to go to there to those departments [that have] shortages to go and cover there. So what will happen [is that]you don't like to go there, what will happen the next day - maybe you will phone and found out 'how many patients do we have' (ok, maybe you have a few patient), let me say you have only two patient, and eh ... six of you will be on duty, so you know that if you go on duty now and there is a shortage somewhere else in the hospital – they will take you and **put** you there. And what you will do ... you are not sick, but you just phone and say '...I am off sick...', because you don't want to go and cover other department. And maybe other ... others are will also ... are also thinking the same thing, 'that ai - there are so many ... there are so few patients in my department – ai we will be sent out to help somewhere else...'. They will book off sick, maybe you will end up with only one person coming on duty! And in ... in the wards then [there is] that thing of ...of 'paying back'. Let me say: you are a sister and I ... I am a sister, we [I am] are supposed to work with you. I was supposed to work a 7/7 and you were supposed to work 7/1, and I – and I didn't come on duty, so you were alone. When ...So when it is ... when it is my ... it is your turn to work 7/7, and it is my turn to work 7/1, you will be paying back then you won't come back because it is 'sorting me out'. Ja! So you won't ... won't come on duty so I will be alone ... so I **will** feel what you felt – ja –because you work ... you worked

hard, maybe you didn't get someone to help you – maybe you ... you also had to change your off duties ... you were supposed to work until one, I didn't come – so you ended up working until seven, so when it is your turn to work ... to work a 7/7 and now it is my turn to work a 7/1, you won't come on duty...

Interviewer: oh ...ok so it is like a tit for tat kind of [thing] – ok, ok.

RN M: ja ... ja, sometimes the other thing that happens – maybe if the sister in charge of that department ... or if the zone matron is harsh to the staff - they will look, they will look at who will be in charge on that afternoon – people are normally, in most cases ... in most cases - people are booking off sick when they are supposed to work 7/7; if they are working one (7/1) they don't mind. It is very rare for people to book off sick if they are working to one. So they will look at their off duties eh ... and that person will see 'eh they are working 7/7 with RN . so and so who is so harsh ai! I am not going on duty'. That has been a contributing factor when it comes to the absenteeism.

Interviewer: ok, so these ... those three things: being farmed out to other units to cover, um. .. 'pay back', (ja) and um ...sort of difficult relationships with ... with people in charge – mostly [are the contributing factors in respect of absenteeism],

RN M: mostly ja ...

Interviewer: and would you say that is through out the hospital?

RN M: throughout ... throughout the hospital ... and then sometimes ...uh the other thing, if you have worked **so** hard the previous day, maybe it was **so** busy and you are tired and you think 'the next day I am also going to work like I work yesterday...' so ... people have that tendency of just booking off sick the next day if it was too busy the previous day...

Interviewer: ok - and if they were short ...

RN M: ja, which ... which ... ja, they [are] like that, maybe you are short staffed and you were **so** busy, then they don't think about the other people - maybe you have been three ... you were supposed to be five or six, so you worked so hard because you were short staffed. You will be tired, then the next day you see that '...ai! You worked so hard yesterday...' – you don't think about the people now [that] you worked hard with ... yesterday, and you don't think that if you book ... if you worked

hard with three- now if you also don't go there [today] it will be even harder [for those who do go on duty again], than [would be] if you do [go on duty]. So you just book off sick and that puts a lot of strain to others. And they won't take it anymore. Maybe some of ... some of those that came will decide not to go the next day. Ja ... so that is the problem.

Interviewer: ok. I am going to ask you something a little bit different again. Um ... growth and development opportunities, a chance to continue your education or anything like that – has ... have there been those sort of opportunities for you here?

RN M: eh ... what can I say? If ... if you want to further your studies, maybe if you want to – if you are ... if you are ... if you are sent by the hospital, or if you want to go with yourself?

Interviewer: um, mostly the sort of opportunities that the hospital can give you - um ... like they send you on training courses, or conferences ... or ... or ja - even if you wanted to study by yourself ...but... would they fund your studies...?

RN M: ja because even if you are study yourself they have to approve... they have to approve. Mostly you have to have a year post um ... completing your training – then if you want to do something, you want to go to UNISA, then you apply to them - then they give you the opportunity. But when it comes to mmm post working, I mean post basic courses ...like the ICU course, [then] uh ... yearly – one they send one person...[one?]. Ja ... and uh ... it depends on seniority. Ja. I mean not seniority [in terms of] as to how many years you are qualified, - seniority in the department, how long have you been in the department. It doesn't matter whether you are a chief professional nurse, a senior professional nurse or a professional nurse. But if you are a professional nurse and you came eh first, than a ... I mean you came before than a person who is a chief professional nurse, you are treated as his senior. So when an opportunity comes for the ICU course then they will send you first.

Interviewer: so first come first served kind of ...?

RN M: yes ...

Interviewer: and have you had any opportunities like that – no...?

RN M: like this year I was the one chosen, I was chosen for that course. But what ... what happens ... um a year they are supposed to send twice. They have to eh ...send

two eh people from CCU ... I mean one per ... one person from ICU [CCU] and one from ICU in March, and in September again, they have to send one person from CCU and one person from ICU – because ICU and CCU are the same thing, you do the same course. But what they are doing is that they are not sending twice a year, they are only sending once. Eh he. Like at the moment the girls that went for training in the ICU course they left in September. The course lasts for a year so they are only coming back I think in August.

Interviewer: then clearly if you were going to stay here then you would have gone...

RN M: in September, ja ... but the next group is going in March in other institutions, but only here they said ... they said ... they can't send you because ... they will be short staffed.

Interviewer: ok, all right ... I just want to have a quick look at [my notes] to make sure that I haven't left anything out ... but in the meantime is there anything that you would like to add about your decision to resign ... anything that you think that we have left out?

RN M: mmm... I don't know ... (long pause)

Interviewer: what could have been done then ... to encourage you to reverse your decision ... make you ... stay ?

RN M: if – if I was given the promotion – a promotion I .. I ... deserve... I am a shift leader... at least I am supposed to be a SPN – a senior professional nurse...at least ...but in most cases shift leaders are chief professional nurses. It is the responsibility that I have been given to lead the shift but they are not getting [giving me] a promotion. If I got a promotion I **was not** going to resign.

Interviewer: have you got a future plan – once you leave here at the end of the month? Are you going to another hospital or are you going to look around? Or ...

RN M: I have got a ... I have got a better offer, uh but ... well it is not in a hospital environment. I got a better offer and uh ...my starting salary is **really** good. Ja when ...comparing to what I am getting ...earning.

Interviewer: what sector is it in ...you say it is not in a hospital?

RN M: it is not a ... it is not in a hospital, I will be in the clinic...

Interviewer: will that be primary health care?

RN M: yes.

Interviewer: ok, then just to sum up then for yourself, your main reason for going is the lack of promotion, um because you have all the responsibility as a shift leader, you have all the experience and the number of years required, and because of this new system now, where they have stopped the promotion from professional nurse to senior professional nurse and so [in terms of]the progression, you feel that there isn't too much of a scope here for you. So now you are moving because you have been given a better opportunity else where and a better salary as well.

RN M: yes

Interviewer: um ... the one thing you didn't mention, or we didn't talk about really, is your hours of duty – although they do seem to be quite long, and they call you at regular – you know ... at odd intervals to come in on your days off. But is there anything about the shift hours that you would like to mention.

RN M: aw no ...no, no. no – I am quite happy about it – because I mean about the hours because since I came ... hours have been like that ... so I am used ... I am used to them.

Interviewer: so it is not an issue for you?

RN M: it is not ... it is not an issue.

Interviewer: so ... [your main reason for your resignation relates to] promotion ... opportunity – ok, mostly [and this] ... is tied closely to an improved salary ... would you say that that is an accurate assessment of your main reason [for resigning]?

RN M: yes ...

Interviewer: ok, anything else – that we have forgotten?

RN M: (long pause) oh ... the other thing ... you ... **you work hard**, you try everything ... to make sure that everything is ok, you take care of your patient – you come on duty, you are punctual on duty and you don't get appreciation ... you don't. You do everything right – you don't get appreciation... uh ...appreciated. You do **one** thing wrong - **it is a big issue. It is a big issue** - you see, and that is really demoralizing, it is because – if ...if ...if you have worked hard ... you have not booked off sick while others are booking off sick right, left and center. You are coming on duty ... you are coming on duty – eh ...on time. You know your work. I

... think something, something should be done as an incentive – to make you feel that you are really doing the right thing – so ... so .so you continue, you continue with that - doing the right thing. So you know, you know that I am doing the correct thing.

Interviewer: is that not taken into account as part of your performance appraisals?

RN M: yes ... things like that ... we don't have things that...

Interviewer: you don't?

RN M: no we don't.

Interviewer: are they not supposed to do performance appraisals two or three times a year?

RN M: I don't know whether it is given to certain people – but in my department ...the only thing they will do – when ... maybe when they called you - you were off – you were off duty, maybe you come ...then the only thing they will write is just – there is a paper they use ...

Interviewer: a little card ...

RN M: a little card ...

Interviewer: 'you're a star' that thing?

RN M: that is it! Only that. Only that but other than that no.

Interviewer: how do they assess your performance then if they don't do an appraisal?

RN M: eh, I don't know ... I don't know...

Interviewer: So they have never called you in to sit down with a check list, and say right - from one to five ... you know, and they score you on different things?

RN M: that is a report that ...they do that when ...

Interviewer: ok, I am calling it the wrong thing ... a report – ja.

RN M: ja, that is a report – and they are doing it ... the report but that is when you are still junior ...

Interviewer: and when you qualify now?

RN M: when last ... ai... now ... my last report when was it ... I think it was in 2002 ...ja

Interviewer: mmm, 2002?

RN M: ja – my last report was done then, up to now they haven't done any report.

Interviewer: mmm, that is so important that feedback- you know – as you say just to show some appreciation...but uh ...

RN M: ja ... so if you are doing a correct thing ... you think you are doing a correct thing and they don't appreciate [it], you start booking off sick or coming late then – that is where they will call you and tell you that what you are doing is wrong. They won't call you and tell you that '...you know what, you are doing is right ... keep up the good job...', if you are coming on duty on time, you don't book off sick, you do your work quite well – they won't call you and say '...we appreciate it...' – just ... **just** to tell you that, not to give you anything – just so ...so you also know that what you are doing is appreciated ...

Interviewer: absolutely, it makes you feel good inside too and it sort of encourages you ...any way ...as well, anyway ...

RN M: ja ... ja

Interviewer: ok, and ... anything else?

RN M: I think it is a ... just that ...but eh it is really difficult to leave your hospital ... especially your training hospital where you have worked [for] so long. See like here is like my home now, so I am really stressed out ... I will be ... I will be earning so much as I am earning right now where I am going to...oh - but I am still stressed out ... that if I ... if I got my promotion and I, and I was getting, I was going to get that money here, it was going to be marvelous. But now I am going somewhere else and I am going to be new, I still going to be taught new things ...you see ...ja.

Interviewer: but it is also exciting...

RN M: also exciting ...ja

Interviewer: I am going to turn that off...ok.

RN M: ja.

Once the tape recorder was off he spoke at length about the lack of transparency regarding the 'personal profile' self appraisal/ incidentation incentive scheme in operation at the hospital and how it's criteria were flawed, biased, and easily abused by unscrupulous staff members '...they are just lying...'. He himself had just been the recipient of a fairly large payout from this scheme (once off lump sum plus small increase in salary), and said that the scheme had caused much unhappiness among staff members and was a source of dissatisfaction for many. He emphasized that his critique of the system was not based on or because of 'sour grapes'.

He additionally spoke at length about the lack of transparency regarding salary issues; also spoke at length about the unfairness of the Government Scarce Skills allowance programme. At present the Scarce Skills allowance is only being paid to those with ICU and theatre qualifications (? Advanced midwifery). Feels that this is unfair because although he does not have the certificate, he is ICU experienced and is a shift leader on the unit ... so his experience is acknowledged but not in financial terms. He believes that those with 'no bars' earn more than those who have bars (post basic courses) and that one's education (further education and training) means nothing / is not recognized because there is no additional remuneration and compensation for this.

A further complaint is that regarding the rank promotion system that has been discontinued ... feels that the CNSM has the power to motivate at the DOH for more SPN and CPN posts but chooses not to do so, instead motivated for 9 Assistant Director Posts for 'favoured' personnel instead.

He is leaving PHC to go into the clinic environment where the salary, hours and opportunities for further growth and development are better.

The interview was terminated at 09h30. Participant was thanked for his participation, and follow up details were obtained. **Tape counter 000 -296.**

FOLLOW UP INTERVIEW RN M

Follow up interview conducted per telephone on the 28-02-2005.

Items clarified:

YEAR of qualification: 2001

Age: 29

Main reason for termination – discontinuation of rank promotion system; RN M felt this was unfair in view of the fact that as a designated shift leader on a high tech unit he carried a large proportion of the responsibility on each shift and ultimately received no recognition in respect of rank, no recognition in terms of receiving the Scarce Skills Allowance (he does not have the ICU course) and no recognition of a basic unit allowance.

Contributing factors: felt that there was **no scope for growth and development** – had been selected for the ICU course – was supposed to have started in March 2005 but was told in early 2005 that this had to be deferred to September 2005 (hospital too short staffed to send); recently informed that the hospital was no longer going to be sending anyone on the course for 2005!

Salary: no significant prospect for a better salary because rank promotion has been discontinued; again states that he feels that there is no transparency regarding salary – in terms of scales and structures. Also – no financial incentive to work overtime. Confirms that while employed at PHC that PHC was not the only source of his income – had to moonlight to make extra cash to augment his salary.

Dissatisfiers

The lack of recognition and appreciation shown towards him i.r.o his responsibilities as a shift leader in the ICU (No scarce skills, no unit allowance, no promotion)

Short staffing – being called in to do overtime on days off; especially since there is no financial incentive. Although one receives hours back these are not taken back at your convenience; also no time and a half or double time for coming in on weekends and public holidays.

Being called in on your day off to cover the unit – can be asked to cover day or night duty, on occasion you are even sent home after coming on duty am so that you can return to cover the night shift later!

Rotation of permanent staff – a problem in the high tech units because you find yourself having to train and re train ‘new’ staff constantly ... stressful and creates unnecessary pressures and tensions.

Using staff to cover other units that are short – ‘...it is not nice, you are not used to the team, you are not used to the environment – you are not familiar with the patients and

their specific requirements...'. Management says that '...we are employed by this hospital and not the unit or ward...' and therefore we must be prepared to work wherever they send us! [Nurses as interchangeable cogs]. '...It is not right – that is why you state your preferences – of where you want to work...'

Relationships with some of the doctors: '...most are bolshy – if they are telling you something it is not negotiable ... especially the surgical consultants ...they have an attitude problem...'

SATISFIERS

Teamwork with nursing colleagues.

No workplace violence issues – no bullying, verbal abuse etc.

MANAGEMENT - relationships with:

Reiterates that he feels that management are not qualified to hold their current positions from an educational point of view ... this is evidenced through inefficiency and ineptness regarding decision making.

Feels that they are very hierarchically orientated – juniors must know their place.

Believes that they do not show real appreciation for all the hard work that the staff does – the little motivational cards do nothing.

PARTICIPATIVE decision making – largely regards this as being a farce – again, you tell them all your problems etc but they already know what they are going to do. They are just going through the motions.

PERCEPTIONS of nursing – too stressful and no money.

PERFORMANCE APPRAISALS – reports; confirms that these are not done for all staff, only juniors who are on probation. Confirms that the personal profile incentive scheme is actually a source of dissatisfaction for staff members, that it is open to abuse by unscrupulous staff members.

QUESTION: when you are asked to provide a reason for not coming in to work on a day off would it be fair to say that it is a form of psychological blackmail or manipulation?

Answer : no! That is a bit strong – we are not forced to come in... there are no consequences and nobody asks you why thereafter ... but I do feel uncomfortable with having to provide a reason.

There being nothing further to discuss the interview was terminated at 20h17.

Participant was again thanked for his participation and wished everything of the best for the new job starting 01-03-20

FIELDNOTES – RN M

DATE: 17-02-2005, Thursday

TIME: 08h10 – 09h30

VENUE: Provincial Hospital C ; private lounge in the nurses' home

PARTICIPANT: RN M

STATUS: REGISTERED NURSE (qualified, 2001)

UNIT: medical ICU

GENDER: MALE

AGE: 24

RACE: B (African black)

PARTICIPANT CRITERIA:

- REGISTERED NURSE = YES
- HAS WORKED FOR HCI FOR AT LEAST 6 MONTHS =YES
- HAS RESIGNED/ IS IN RESIGNATION MONTH = YES
- HAS BEEN QUALIFIED FOR AT LEAST 1 YEAR = YES

... After introductions the participant showed me into a private lounge adjoining the reception area. A pseudonym was chosen, and the consent form was signed.

The participant was a mature and well presented individual who spoke English fluently. He was at ease with the interview process – this was conveyed throughout by means of the appropriate body language (open body posture, good eye contact, forward leaning on occasion, leaning back in a relaxed fashion.)

Once the tape recorder was off he spoke at length about the lack of transparency regarding the 'personal profile' self appraisal/ incindentation incentive scheme in operation at the hospital and how it's criteria were flawed, biased, and easily abused by unscrupulous staff members '...they are just lying...'. He himself had just been the recipient of a fairly large payout from this scheme (once off lump sum plus small increase in salary), and said that the scheme had caused much unhappiness among staff members and was a source of dissatisfaction for many.

He additionally spoke at length about the lack of transparency regarding salary issues; also spoke at length about the unfairness of the Government Scarce Skills allowance programme. At present the Scarce Skills allowance is only being paid to those with ICU and theatre qualifications (? Advanced midwives). Feels that this is unfair because although he does not have the certificate, he is ICU experienced and is a shift leader on the unit ... so his experience is acknowledged but not in financial terms. He believes that those with 'no bars' earn more than those who have bars (post basic courses) and that one's education (further education and training) means nothing / is not recognized because there is no additional remuneration and compensation for this.

A further complaint is that regarding the rank promotion system that has been discontinued ... feels that the CNSM has the power to motivate at the DOH for more SPN and CPN posts but chooses not to do so, instead motivated for 9 Assistant Director Posts for 'favoured' personnel instead.

He is leaving PHC to go into the clinic environment where the salary, hours and opportunities for further growth and development are better.

The interview was terminated at 09h30. Participant was thanked for his participation, and follow up details were obtained.

7.4 through 7.9: APPENDICES FOUR TO TWELVE

- **Ethical Clearance Documentation**
- **Letter requesting permission for the study to the Department of Health**
- **Letter granting permission for the study from the Department of Health**
- **Example of letter requesting permission for the study to a health care institution**
- **Letters granting permission for the study from the participating institutions**
- **Covering letter to participants advising them about the study and inviting them to participate and consent form**

7.4 APPENDIX FOUR

Ethical clearance documentation:



RESEARCH ETHICS COMMITTEE

Student: Lisa King

Research Title: A description of the workplace experiences of registered nurses that have contributed to their resignations in the Durban Metropolitan Area

A. The proposal meets the professional code of ethics of the Researcher:

YES NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Potential psychological and physical risks have been considered and minimised.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Provision has been made to avoid undue intrusion with regard to participants and community.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Rights of participants will be safe-guarded in relation to:	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	<input type="checkbox"/>	<input type="checkbox"/>
4.2 Access to research information and findings.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.3 Termination of involvement without compromise.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.4 Misleading promises regarding benefits of the research.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Signature of Student: *Lisa King* Date: 26.07.04

Signature of Supervisor: *A. Mchuney* Date: 26.07.04.

Signature of Head of School: *[Signature]* Date: 20/07/04

Signature of Chairperson of the Committee: *[Signature]* Date: 12/08/04
(Professor F Frescura)

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa

Telephone: +27 (0)31 260 2499

Facsimile: +27 (0)31 260 1543

Email:

Website: www.ukzn.ac.za

C:\WINDOWS\TEMP\ETHICS FORM.doc

Founding Campuses:

Edgewood

Howard College

Medical School

Pietermaritzburg

Westville

7.5 APPENDIX FIVE

Letter requesting permission for the study to the department of health:

Tel: (031) 2098406

Email: lisand@mweb.co.za

12 Rouken Glen

381 Musgrave Road

Durban

4001

02 -09- 2004

Mr. G. Tromp

Department of Health - Natalia

Private Bag X 9051

Pietermaritzburg

3200

Dear Sir

Request for permission to conduct a nursing research project in the Durban EtheKwini Metropolitan Area

My name is Lisa King. I am a post-graduate student at the University of KwaZulu-Natal, and I am studying for a Master's degree in Nursing Research. My dissertation is being undertaken as partial fulfilment of the requirements for this degree, and I would greatly appreciate your permission, and that of the Department of Health, to conduct my research in the Durban area.

The title of the research project is:

A description of the hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban Metropolitan Area

I would like to conduct my research across both the public and private sectors in the Durban area. The study aims to create awareness – at middle and senior management levels of the factors that contribute towards the turnover of nursing personnel in the

Durban Metropolitan Area, as too of those that result in nurses leaving the nursing profession.

If these experiences are accurately identified it is envisioned that the current trend (chronic shortage and high turnover of nursing personnel), might be effectively reduced.

The research would be conducted in the form of two semi- structured interviews with each participant. The interviews are to be recorded and each interview should not take more than forty minutes. Participation in the study is voluntary. Participant confidentiality (and that of the participating organisation) would be ensured by using pseudonyms throughout the interview and in the process of data analysis and discussion.

All participants have to meet the inclusion criteria of the study, and these criteria are that they:

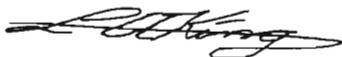
- must be registered nurses
- must have been qualified for at least one year
- must have been employed by their employing body for at least 6 months, and
- must have tendered their resignation, and thus be in their resignation month with their employing body, and/or have resigned

No costs would be incurred by participating organisations or personnel, and participating personnel would be asked to participate at a time that is convenient to both themselves and their employing body.

The anticipated benefit would be primarily in terms of the results obtained – and how these could be applied by middle and senior hospital management to the recruitment and retention of nursing personnel. Given the Department of Health's commitment to quality improvement in all spheres of health care delivery, the results of this research would be of interest to all those who employ nursing personnel in their health care services.

Thanking you in anticipation.

Yours sincerely



Lisa King

7.6 APPENDIX SIX

Letter granting permission for the study from the department of health:

PROVINCE OF KWAZULU-NATAL
HEALTH SERVICES

ISIFUNDAZWE SAKWAZULU-NATALI
EZEMPILO

PROVINSIE KWAZULU-NATAL
GESONDHEIDSDIENSTE

PRIVATE BAG X 9051
PIETERMARITZBURG
3200

TELEPHONE : (033) 395-2765



330 LONGMARKET STREET
PIETERMARITZBURG
3201

ENQUIRIES: Miss Z. Mthembu
EXTENSION: 3322
REFERENCE: 9/2/3/R

Ms L. King
12 Rouken Glen
381 Musgrave Road
DURBAN
4001

Dear Ms King

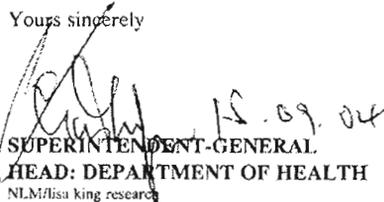
REQUEST TO CONDUCT RESEARCH ON A DESCRIPTION OF THE HOSPITAL WORKPLACE EXPERIENCES OF REGISTERED NURSES THAT HAVE CONTRIBUTED TO THEIR RESIGNATION IN THE DURBAN METROPOLITAN AREA

Your letter dated 2nd September 2004 refers.

Please be advised that authority is granted for you to conduct a research on a description of the hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban Metropolitan area, provided that:

- (a) Prior approval is obtained from the Heads of the relevant Institutions;
- (b) Confidentiality is maintained
- (c) The Department is acknowledged;
- (d) The Department receives a copy of the report on completion; and
- (e) The staff of the hospital are not disturbed and/or inconvenienced in their work and that patient care is not compromised.

Yours sincerely


SUPERINTENDENT-GENERAL
HEAD: DEPARTMENT OF HEALTH
NLM/lisa king research

7.7 APPENDIX SEVEN

Example of letter requesting permission for the study to a health care institution:

Tel: (031) 2098406

Email: lisand@mweb.co.za

12 Rouken Glen
381 Musgrave Road
Durban
4001
20 -09- 2004

Chief Nursing Services Manager

XXX Hospital

Durban

4001

Dear X

Request for permission to conduct a nursing research project at X Hospital

My name is Lisa King. I am a post graduate student at the University of KwaZulu -Natal, and I am studying for a Master's degree in Nursing Research. My dissertation is being undertaken as partial fulfilment of the requirements for this degree, and I would greatly appreciate being able to conduct my research at X Hospital.

The title of the research project is:

A description of the hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban Metropolitan Area

This research is being conducted with the permission of the Department of Health and has been approved by the University of Kwazulu –Natal's School of Nursing Research Ethics Committee. It is to be conducted across both the public and private sector in the Durban area.

This study aims to create awareness – at middle and senior management levels of the experiences that contribute towards the high turnover of nursing personnel in the Durban

Metropolitan Area, as too of those that result in nurses leaving the nursing profession. If these experiences are accurately identified it is envisioned that the current trend (chronic shortage and high turnover of nursing personnel), might be effectively reduced.

The research would be conducted in the form of two semi-structured interviews with each participant. The interviews are to be recorded and each interview should not take more than forty minutes. Participation in the study is voluntary. Participant confidentiality (and that of the participating organisation) would be ensured by using pseudonyms throughout the interview and in the process of data analysis and discussion.

All participants have to meet the inclusion criteria of the study, and these criteria are that they:

- must be registered nurses
- must have been qualified for at least one year
- must have been employed by their employing body for at least 6 months, and
- must have tendered their resignation, and thus be in their resignation month with their employing body, and/ or have resigned

No costs would be incurred by X hospital, and participating staff members would be asked to participate at a time that is convenient to both X hospital and the staff member concerned. Input required from X hospital would be in the form of permission to conduct the research on hospital premises with willing participants, and a list of staff members who are in their resignation month that I could approach with a request to participate in the study.

The benefit to X hospital would be primarily in terms of the results obtained – and how these could be applied by middle and senior hospital management to the recruitment and retention of nursing personnel. Given X hospital's commitment to quality excellence - in all spheres of health care delivery, the results of this research might be of interest to X hospital as a whole.

Please would you consider my doing this research at X hospital. Thanking you in anticipation.

Yours sincerely



Lisa King

7.8 APPENDIX EIGHT

Letter granting permission for the study from participating institution:

ENTABENI HOSPITAL

Entabeni Hospital
148 South Ridge Road
Durban 4001
P O Box 2230
Durban 4000

Ms L King
12 Rouken Glen
381 Musgrave Road
Durban
4001

Telephone 031 204-1300
Facsimile 031 261-6435
Docex DX 287 DURBAN

19 October 2004

Dear Lisa

Permission is hereby granted for you to conduct a research project at Entabeni Hospital. We appreciate that you respect the confidentiality of the interviewees and the Company.

I look forward to seeing the assignment on completion.

Yours Sincerely



Mrs A Williamson
Nursing Manager

Entabeni Hospital Limited
Reg No 1929/001783/06
Trading as Entabeni Hospital
Member of Afrox Healthcare
Directors GG Rex SP Taylor DR Archibald CJPG Van Zyl

7.9 APPENDIX NINE

Letter granting permission for the study from participating institution:



Office of the Hospital Manager

Addington Hospital
P.O. Box 977
DURBAN
4000

Tel: 031-327-2970/2568 Fax: 031-368-3300

E-Mail: reshmag@adh.kzntl.gov.za

Your reference:

Our reference:

AD/9/2/3/R

Enquiries: Dr D.K. Naidoo
Extension: 2568/2970

21 January 2005

Ms L. King
12 Rouken Glen
381 Musgrave Road
DURBAN
4001

Dear Ms. King

**A DESCRIPTION OF THE HOSPITAL WORKPLACE EXPERIENCES OF REGISTERED NURSES THAT
HAVE CONTRIBUTED TO THEIR RESIGNATION IN THE DURBAN METROPOLITAN AREA**

Your research in the above regard refers.

Addington Management grants authority for the above research to be conducted provided a copy of the research is submitted when completed.

You are wished every success in the above research.

Please liaise with Mrs Lancaster, Nursing Manager's Secretary, on telephone number: 031-327 2439 for further arrangements.

(for) HOSPITAL MANAGER

DK/npn

c.c. Matron Chinniah - Nursing Manager



7.10 APPENDIX TEN

Letter granting permission for the study from participating institution:



St Augustine's Hospital

107 Chelmsford Road, Durban • PO Box 30105 Mayville, 4058
Tel +27(0)31 268-5000 • Fax +27(0)31 201-4606
Web address: www.netcare.co.za
P.R. No. 5802582

19th November 2004

Lisa King

12 Rouken Glen
381 Musgrave Road
DURBAN
4001

Dear lisa

PERMISSION TO CONDUCT STUDY OF HOSPITAL WORK PLACE EXPERIENCES OF RN'S

Thank you for your interest in utilising St. Augustine's Hospital as a research facility.

Permission is hereby granted for you to publish your case presentation with the proviso that anonymity is maintained.

Yours sincerely



MISS B HUDDLE

Nursing Manager



Netcare Hospitals

Directors: J. Shevel; M.I Sacks; ~~G.R. Fovish~~; H.C Mackay.
Netcare Kwa-Zulu (Pty) Ltd Va St Augustine's Hospital: Company Registration No.83/04629/07

7.11 APPENDIX ELEVEN

Letter granting permission for the study from participating institution:

PROVINCE OF
KWAZULU-NATAL

ISIFUNDAZWE
SAKWAZULU-NATAL

PROVINSIE
KWAZULU-NATAL



KING EDWARD VIII HOSPITAL

Postal Address: Private Bag , Dalbridge , 4014. • Telephone: 031 3603853 • Fax: 031 2061457 •

Enquiries: Mr. A.J Seekola
Reference: KE 2/7/1 (1/2005)
Research Programming
15 February 2005

Lisa King
12 Roulen Glen
381 Musgrave Road
DURBAN
4001

Request to conduct research at King Edward VIII Hospital

Protocol: A description of the hospital workplace experience of registered nurses that have contributed to their resignation in the Durban metropolitan area.

Your application received on the 31 January 2005 is approved.

Please ensure the following:

- That King Edward VIII Hospital receives full acknowledgement in the study on all publications and reports and also kindly present a copy of the publication or report on completion.
- Before commencement:
 - *Discuss your research project with our HR and Nursing Managers.
 - *Sign an indemnity form at Room 8, Hospital Manager's Complex, Admin Block..

The Management of King Edward VIII Hospital reserves the right to terminate the permission for the study should circumstances so dictate.

Yours Sincerely

Mrs. ZG-Zola
Acting Hospital Manager.

cc Mr. BB Magubane, HR Manager (Tel 360 3002)
Mr. TE Mahlase, Acting Nursing Manager (Tel 3603026)

7.9 APPENDIX TWELVE

Covering letter to participants advising them about the study and inviting them to participate and consent form:

Tel: (031) 2098406

Email: lisand@mweb.co.za

12 Rouken Glen

381 Musgrave Road

Durban

4001

30 -11- 2004

Dear Colleague

REQUEST FOR YOUR PARTICIPATION IN A RESEARCH STUDY:

My name is Lisa King. I am a post graduate student at the University of KwaZulu -Natal, and I am studying for a Master's degree in Nursing Research. My dissertation is being undertaken as partial fulfilment of the requirements for this degree, and I would greatly appreciate your participation in my research study.

The title of the research project is:

A description of the hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban metropolitan area

You have been identified as fulfilling the following criteria for this study – in that you are a registered nurse, have worked for your current employing body for at least six months, and have recently resigned from your position with your employing body.

I intend to conduct two semi- structured interviews with each participant - in a private venue, and at a time of your choice. The initial interview will be approximately 40 minutes long, and will be recorded so that an accurate transcript of the interview can be made. The second interview is intended for follow up and clarification of material obtained in the initial interview. All recordings and transcripts are confidential. Only the researcher and an external auditor will have access to the recordings. Once data analysis is complete these will be destroyed. Your confidentiality is further assured by the use of a pseudonym that may be chosen by you, throughout the interview. At no stage will your personal details be recorded on any of the research documentation e.g. your name, identity number, or staff number.

Please note that participation is voluntary, and that by participating in this study and signing the consent form overleaf you indicate that you consent to take part in the study.

This research is being conducted with the permission of the Department of Health and has been approved by the University of Kwazulu – Natal’s School of Nursing Research Ethics Committee. Approval has additionally been obtained from the Chief Nursing Services Manager at your institution.

This study aims to create awareness – at middle and senior management levels of the experiences that contribute towards the high turnover of nursing personnel in the Durban metropolitan area, as too of those that result in nurses leaving the nursing profession. If these experiences are accurately identified it is envisioned that the current trend (chronic shortage and high turnover of nursing personnel), might be effectively reduced.

Should any participant wish to contact me about the outcome of the research once the results have been collated, I would be happy to discuss the project with them and have recorded my contact details above.

Thanking you in anticipation, and also for your time and attention.

Yours sincerely,



Lisa King

RESEARCH STUDY CONSENT FORM

I, _____ hereby consent to take part in this research study
(Name in block capitals please)

conducted by Sr. Lisa King. I understand the nature and content of the study, that my participation is entirely voluntary, and that I might withdraw from the study at any time.

I further consent to the tape recording of the interview (s) by the researcher, and understand that the recording is confidential and will not be accessed by any other person aside from the external auditor – after which the tapes will be destroyed.

(Signature of participant)

(Date)

(Witness – Sr. King)