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AGREE II	Advancing guideline development, reporting and evaluation in health care
CPGs	Clinical practice guidelines
Com Serve	Community service
DoH	Department of Health
HPCSA	Health Professions Council of South Africa
HRD	Human resource development
OPM	Operational nurse manager
SANC	South African Nursing Council
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting; now changed to NMC (Nursing and Midwifery Council)
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Induction and professional development support for newly qualified professional nurses is said to facilitate their transition from being a student nurse to a professional nurse, as well as their professional socialisation (O'Shea & Kelly 2009:1534). During the first six months of practice, newly qualified professional nurses focus mainly on learning their new roles and the policies and procedures of the practice setting (Ferguson & Day 2007:107). It has been suggested that support should continue beyond the initial formal period of nursing education (Dearmun 2009:159).

It is important that newly qualified professional nurses receive induction into their new role. The goals of induction are to: help the nurses to understand their role, provide clear guidance as to where they fit within the organisation, and enable them to work safely and effectively within the new work environment (Leigh, Douglas, Lee & Douglas 2005:508 and Wangensteen, Johansson & Nordstrom 2008:1877). An effective induction period helps the newly qualified professional nurses to become confident and competent more quickly. Effective support systems help to ensure that they are prepared and supported in their professional role (O'Shea & Kelly 2009:1534).

Nurse managers should create supportive practice environments that facilitate newly qualified professional nurses' integration into the public health institutions. The induction process should consist of the core induction phase and the role-specific phase. The core induction phase should consist of orientation, health and safety aspects and human resource aspects. The role-specific phase focuses on the clinical practice issues and competencies necessary if one is to be effective in the role of professional nurse (Leigh et al 2005:509). The newly qualified professional nurses need to be more skilful and confident with unit routines and procedures. This will enhance autonomy and control over practice, leading to job satisfaction and retention of staff (Hatler, Stoffers, Kelly, Redding & Carr 2011:91).

Community service forms the first formal work experience for the newly qualified professional nurse in South Africa (SANC 2007:2). For this first impression to make a positive impact on these nurses and leave good memories, the health establishment has to provide a systematically structured formal transition programme that will significantly improve productivity and retention. To ensure the smooth transition, newly qualified professional nurses need clinical learning support from the organisation. Organisational support influences their effectiveness and job satisfaction (Hatler et al 2011:89). Hatler et al (2011:91) also state that the first three to twelve months of employment are stressful; the experiences of this period profoundly influence the careers of newly qualified professional nurses.

A formal, structured induction and professional development support for newly qualified professional nurses doing community service across the provinces of South Africa (SA) could be a positive professional socialisation experience that could produce confident, competent, independent and safe nurse practitioners. It might even reduce the high attrition rate of newly qualified professional nurses that South Africa is facing.

1.2   BACKGROUND TO THE RESEARCH PROBLEM

Remunerated community service in South Africa was introduced in 1998 with 26 doctors (South Africa Department of Health 2006:1). Dentists and pharmacists followed in 2000 and 2001 respectively. Clinical psychology, dietetics, environmental health, occupational health, physiotherapy, radiography and speech, language and hearing therapy started community service in 2003. Nurses commenced with community service in 2008 after the Nursing Bill was promulgated into the Nursing Act, Act 33 of 2005 (SANC 2007:1). The National Department of Health decides which health professions perform community service, when and for how long. Nurses and doctors perform compulsory remunerated community service for a period of one year before their final registration with the South African Nursing Council (SANC) or Health Professions Council of South Africa (HPCSA).

Newly qualified professional nurses who seek registration with the SANC for the first time as South African citizens are required to perform their remunerated community service for a period of one year at a designated public health institution according to Regulation R765 (SANC 2007:1). Community service was introduced in South Africa

because of the shortage of health care personnel in public health institutions. It has been stated that it will improve access to quality health care for all South Africans, especially in previously under-served areas (South Africa Department of Health 2006:1). The newly qualified professional nurses carrying out community service are allocated to all areas of need, in all provinces of South Africa, these mostly being remote rural area institutions with a severe shortage of personnel (Makhakhe 2011:3).

The newly qualified professional nurses register with the SANC in the category of Community Service Practitioner (Nursing Act, Act 33 of 2005, section 40(2) (South Africa 2005). The public service conditions of service apply to the newly qualified professional nurse, who is now a Community Service Practitioner while performing the community service (SANC 2007:2). A report is written to the SANC upon completion of the community service by the nurse manager of the institution and the provincial coordinator of community service for nurses, to accompany the application for final registration in the category of Professional Nurse with the SANC. The newly qualified professional nurse who is on a community service post for a period of one year has to apply for a permanent post in the same or another health institution, in either the public or private sector, upon completion of community service. Before completion of the community service period, and final registration with the SANC, the nurses cannot go to work abroad or in the private sector as professional nurses (South Africa Department of Health 2006:1).

The conditions of service in the public service entitle all health care personnel to support in terms of training and development. This is done to facilitate effective and quality patient care. Induction of the newly qualified professional nurse performing community service is one of the entitlements. The purpose of induction for the newly qualified professional nurse is to facilitate the transition from being a Student Nurse to a Professional Nurse (Ferguson & Day 2007:107), by enhancing development of nursing expertise in clinical practice. Dr Percy Mahlathi, the Deputy Director-General for Human Resources for the Department of Health in 2006, stated that community service provides the young professionals with an opportunity to develop skills and acquire knowledge, behaviour patterns and critical thinking that will help them in their professional development (South Africa Department of Health 2006:1).

1.3 STATEMENT OF THE RESEARCH PROBLEM

The transition period from student to newly qualified professional nurse where nurses are adjusting to their new role and consolidating their knowledge and skills can be stressful. It is a time where many newly qualified professional nurses are left feeling inadequately prepared, overwhelmed and contemplate leaving the profession (Edwards, Hawker, Carrier & Rees 2011:2215). There is lack of confidence, feelings of incompetence and no sense of belonging (Baxley, Ibitayo & Bond 2016:82).

Twenty-three percent of community service professionals are said to be migrating from South Africa annually, citing lack of support and poor working conditions in the public sector as a primary reason for leaving (HRH SA 2030, 2011:9). Kruse (2011:1), in a study titled *Retaining community service nurses in the Western Cape public health sector*, reported that 28 percent of the newly qualified professional nurses considered leaving the public health sector. Twenty percent considered leaving the following year, whereas eight percent considered leaving upon completion of community service. Tsotetsi (2012:93) found that there was no formal structured mentorship/preceptorship support and guidance for the newly qualified professional nurse during community service. Even for those working in specialised areas, the guidance and support that they received differed according to the individual professional nurse that they worked with from time to time. Orientation of newly qualified professional nurses during community service in the same province, is said to vary from institution to institution, with some not being orientated at all. They even worked mainly without supervision during night duty (Tsotetsi 2012:92). Research has indicated that young health professionals are more likely to move on if they are not supported in their work (Mooney 2007:79; Leigh et al 2005:508 and Stagniti 2010:504). Makhakhe (2011:3) agrees that there is a need to support the newly qualified professional nurses during the transition from student nurse to professional practitioner in order to enhance their competence and to retain them.

There is limited research published in SA regarding the induction and professional development support given to newly qualified professional nurses during community service and how to implement the required support to enhance the transition from professional education to clinical practice (Eraut 2007:422; Mooney 2007:78; Paterson 2012:33).

1.4   RESEARCH QUESTION

How are newly qualified professional nurses supported in terms of induction and professional development during community service in South Africa?

Sub questions

- What is the induction and professional development support given to newly qualified professional nurses during community service to enhance their clinical competence and professional socialisation?
- What are the experiences of the newly qualified professional nurses in terms of induction and professional development support during community service?
- What are the experiences of the operational nurse managers regarding professional development support of the newly qualified professional nurses during community service?
- What role do the coordinators of community service play in the induction and professional development support of newly qualified professional nurses?
- What recommendations could be implemented to enhance the induction and professional development support of newly qualified professional nurses during community service?

1.5   RESEARCH PURPOSE

The purpose of this research is to determine the induction and professional development support given to, and that which is required by, newly qualified professional nurses to enhance their transition from novice professional nurses to competent professional nurses. The information obtained was used to develop induction and professional development support guidelines for newly qualified professional nurses in SA.

1.6   RESEARCH OBJECTIVES

- To explore the induction and professional development support given to newly qualified professional nurses during community service in the designated public health institutions
- To describe the experiences of newly qualified professional nurses regarding their induction and professional development support during community service
- To explore the experiences of the operational nurse managers in induction and professional development support of the newly qualified professional nurses during community service
- To determine the role of the coordinators of community service for nurses regarding the induction and professional development support of newly qualified professional nurses during community service
- To determine the support needed by newly qualified professional nurses in terms of induction and professional development
- To develop guidelines for induction and professional development support of newly qualified professional nurses
- To validate the guidelines through nursing experts in practice and academia.

1.7   THEORETICAL/METATHEORETICAL GROUNDING

Benner's Novice to Expert model (1984) was used to guide the study. The model consists of a continuum of development from the lowest level of novice to the highest level of expert. The levels are novice; advanced beginner; competent; proficient; and expert (Benner 1984:403). This study is about newly qualified professional nurses, who can be equated with the first three levels of development as follows. The *novice* level is the nurse newly graduated from a nursing education institution and starting community service up to the second month of community service. *Advanced beginner* would be the newly qualified professional nurse from the third month of community service to the fifth month of community service. The *competent* level would represent the newly qualified professional nurse from six to twelve months of the community service.

The study is concerned with the induction and professional development support of the newly qualified professional nurses through the first three levels of the model.

1.8   RESEARCH DESIGN

The design is a mixed-method, concurrent triangulation approach. Andrew and Halcomb (2009:143) explain concurrent triangulation as quantitative and qualitative data of a single study collected at the same time, with the purpose of validating findings generated by each method through evidence produced by the other. In the quantitative phase of the study, a survey was conducted where the newly qualified professional nurses who had recently completed community service answered questions describing the induction and professional development support they had experienced.

In the qualitative phase of the study, a descriptive phenomenology was used, where the operational nurse managers described their experiences of providing induction and professional development support to the newly qualified professional nurses during community service in focus groups. The coordinators of community service for nurses described their role in induction and professional development support of the newly qualified professional nurses. The mixed method was chosen for complementarity, practicality and enhanced validity (Polit & Beck 2012:604). Qualitative and quantitative methods were used in an integrated way. Data collection was concurrent and integration occurred at interpretation of findings (Gray 2010:204). The methodology is described in detail in chapter 3.

The paradigm for the study is pragmatism, because it encourages a pluralistic view (both induction and deduction are important) and it is practical (Polit & Beck 2012:604). The practical aspect is explained by the authors Polit and Beck (2012:604), stating that "whatever works best to arrive at good evidence is appropriate". In this paradigm, researchers have a freedom of choice regarding methods, techniques and procedures of research that best meet their needs and purposes (Creswell 2013:28).

1.9   DEVELOPMENT OF GUIDELINES

The researcher used both inductive and deductive reasoning in the process of developing the guidelines. Inferences were drawn from the literature, and the synthesis of the qualitative and quantitative findings of the study. Guidelines were proposed from specific themes and codes of the research findings that strongly indicated the type of

support that can be given to the newly qualified professional nurses. The Delphi technique was used to validate the guidelines.

1.10 DEFINITION OF CONCEPTS

- **Community service practitioner.** This is a person registered with the SANC in the category community service (South Africa 2005:76). In this study, **community service practitioner** refers to the newly qualified professional nurse on community service or having recently completed community service and awaiting final registration with the SANC as a professional nurse. The community service practitioner is also referred to as "community service sister"; "community service professional nurse" or "com server" in the participants' verbatim quotations.

- **Compulsory remunerated Community Service.** This term refers to remunerated community service performed for a period of one year by citizens of South Africa intending to register for the first time to practise a profession in a prescribed category (South Africa 2005:76). In this study, **compulsory remunerated community service** refers to remunerated community service performed for a period of one year at a public health institution by newly qualified professional nurses of South Africa who intend to register with the SANC for the first time as professional nurses. This is subsequently referred to as community service in the study and sometimes as "com serve" in the participants' verbatim quotations.

- **Induction.** This is the process of introducing someone to an organisation or establishing them in a position (Soanes & Hawker 2006:516). In this study, **induction** refers to training that takes place following the orientation of a new individual with the aim of reducing anxiety, creating a positive attitude towards the institution, assisting the new employee to become fully productive and creating realistic work expectations.

- **Mentorship.** Mentoring is a voluntary, intense, committed, extended, dynamic, interactive, supporting, trusting relationship between an experienced person and a newcomer (Harrington 2011:168). In this study, the experienced person will be the experienced professional nurses (mentors) in the clinical areas, while new comers are the newly qualified professional nurses (mentees). The **mentorship** relationship has to be formal and supported by the public health institution.

- **Newly qualified professional nurse.** A newly qualified professional nurse is a person who seeks registration with the South African Nursing Council (SANC) upon completing and meeting the requirements prescribed in the *Regulations Relating to the Approval of and the Minimum Requirements for the Education and Training of a Nurse (General, Psychiatric and Community) and Midwife leading to registration*, published in Government Notice No 425 of 22 February 1985, or any subsequent regulation made to replace it (SANC 2007:4). In this study, **newly qualified professional nurse** refers to a nurse who has been registered under the category community service practitioner in the Nursing Act, Act 33 of 2005 and is doing community service or has recently completed community service. **Recent completion of community service** in the study refers to a period from one month to twelve months after serving the compulsory remunerated community service. In this study it refers to professional nurses who completed community service in the 2013/2014 and 2014/2015 cycle.

- **Orientation.** According to the online free dictionary, orientation is defined as a programme introducing a new situation or environment (http://www.thefree dictionary.com/orientation). In this study, **orientation** is when the newly qualified professional nurse is introduced to the public health institution where she will serve the community service. The operational nurse manager or experienced professional nurses introduce her to the physical layout, the various clinical departments, services provided, routine and other personnel.

- **Professional development.** This refers to all types of educational programmes to maintain competence, enhance professional practice and support the achievement of career goals. It incorporates staff development, continuing professional education and career development (Kotzé 2010:227). In this study, **professional development** refers to orientation, mentorship, in-service training (including relevant workshops and short courses), assessment of gaps in clinical competence followed by enhancement of clinical skills and supervision of the newly qualified professional nurses by experts proficient in clinical practice.

- **Professional nurse.** This refers to a person registered with the SANC under this category, being duly qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed. The person should be capable of assuming responsibility and accountability for such practice (South Africa 2005:61). In this study, a professional nurse refers to a person who

duly complied with the requirements of nursing education as in the same way as defined in the nursing Act, Act 33 of 2005 above.

- **Public Health institution.** This is a health establishment that is owned or controlled by an organ of state (South Africa Department of Health 2003:16). In this study, **public Health Institution** is a health establishment that is controlled by the National Department of Health and designated for community service. The institutions are subsequently referred to as "public health institutions". These are all levels of hospitals, community health centres and clinics.

- **Support** is help or encouragement given to someone (Soanes & Hawker 2006:1041). In this study, **support** is encouragement, guidance and professional socialisation provided to the newly qualified professional nurse.

1.11   SIGNIFICANCE OF THE STUDY

The findings provided the latest information about the state of induction and professional development support of the newly qualified professional nurses during community service in SA. The findings were used to develop guidelines which might be utilised by the National Department of Health (DoH) to structure the induction and professional development support of the newly qualified professional nurses during community service.

1.12   SCOPE AND LIMITATIONS

The study gathered information from newly qualified professional nurses who had recently completed community service; provincial coordinators of community service and operational nurse managers who were responsible for their supervision, induction and professional development support during community service.

There are areas that could not be explored which have an influence on the induction and professional development support of the newly qualified professional nurses. The human resource managers in the various public health institutions were not part of the study. There was no guarantee that all the questionnaires would be responded to and returned for analysis. Not all the operational nurse managers could be interviewed, only those sampled from the various health institutions who participated.

1.13   EXPOSITION OF THE RESEARCH PROGRAMME

Chapter 1:   Orientation to research

This chapter forms the basis of the study. It describes the background and the research problem, explains the research objectives and defines the main concepts of the study. It also indicates the research purpose and includes the exposition of the research programme.

Chapter 2:   Literature review with regard to induction and professional development support of newly qualified professional nurses during community service

This chapter gives an overview of compulsory community service for health care professionals in other countries and describes compulsory remunerated community service for health professionals in South Africa. It also describes the newly qualified professional nurse in South Africa. The chapter further discusses induction and professional development support for newly qualified professional nurses by describing research conducted by others in the field.

Chapter 3:   Research methodology and the theoretical framework guiding the study

This chapter discusses the theoretical framework that forms the basis of the study and the research methods.

Chapter 4:   Description of the quantitative data analysis results

The researcher employs descriptive and inferential statistics to report the results of the orientation programmes and the quantitative part of the survey.

Chapter 5   Description of qualitative data analysis – focus groups, interviews and the survey

The researcher describes findings from the focus groups, interviews and the qualitative part of the survey.

Chapter 6:   Discussion and Interpretation of the data analysis

The researcher revisits the purpose, questions and objectives of the research; and discusses and interprets the results, indicating the relationships and the convergence of the results. The discussions are supported by the literature.

Chapter 7:   Formulation of the guidelines and validation by nursing experts

The researcher describes the guideline formulation and validation process.

Chapter 8:   Conclusion and recommendations

This chapter discusses the summary of the study, conclusions and the recommendations.

1.14   CONCLUSION

Nursing education prepares student nurses through theory and clinical practice to meet the minimum practice requirements of the regulatory body, the South African Nursing Council (SANC). They cannot easily get off to a 'flying start' when they commence their community service in the designated public health institutions.

Some newly qualified professional nurses get allocated to health institutions that are new to them; they have never obtained their clinical experience in them and all surroundings and personnel are unfamiliar. They have to start from scratch to adapt to the environment and the culture of that institution. They need a formal induction and professional development support to enhance the knowledge and skills that they bring along from nursing education into the practice setting.

The literature review follows in Chapter 2.

CHAPTER 2

LITERATURE REVIEW

2.1   INTRODUCTION

The purpose of this chapter is to describe the knowledge base of the topic and to clarify the research problem using the literature. Various authors have conducted research about the transition from student nurse to professional nurse; retention of newly qualified professional nurses; enhancing the clinical competence of the newly qualified professional nurses; and the need for support in terms of induction and professional development, while others have reported on the experiences of the newly qualified professional nurses concerning their support, using various methods, qualitative and quantitative.

The researcher used the Unisa library electronic resources to search for full-text peer-reviewed academic journals from Scopus, CINAHL Plus with Full Text, Medline and Ebsco Host. The following terms and subjects derived from the topic of the research were used for the search: *community service; community service for nurses in South Africa; compulsory remunerated community service; compulsory community service for health professionals; induction of new nurses; mentorship; mentoring new nurses*; *orientation of new nurses; professional development; professional development support; supporting new nurses;* and *supporting newly qualified professional nurses*.

The search was initially limited to qualitative, quantitative and mixed-methods research articles from 2011 to 2015, when the results yielded 269 articles. When reading the abstracts, the researcher found that most articles were a duplicate and only 12 articles were relevant to the study. The search period was extended to 2005 to 2010 then 2020 articles were found from the search engines. The researcher downscaled the articles to those most relevant to the topic, and 39 articles were found to conform to the criteria. Information about *community service for nurses in South Africa* was very scanty; the search period on that subject was extended to include *community service for health professionals in South Africa up to 1998*. This was done because compulsory remunerated community service for health professionals was introduced in 1998 in

South Africa, starting with the medical doctors, progressing to the other health professions up to nurses in 2008. The oldest sources in this study are those of Benner (1982) and (1984); and Hanson and Hilde (1989). The sources by Benner (1982/1984), were referred to when discussing her Novice to Expert Model, which is the theoretical framework guiding this study. Hanson and Hilde (1989) were found to be the most relevant source about mentorship in a rural community setting.

Relevant unpublished theses from university repositories and relevant publications of legislation within South Africa were included. This was done to search for additional information on community service relevant to the study that has not yet been published. Legislative publications were obtained from the SANC website and Google Scholar. Each publication was evaluated for relevance, meaning, and supporting or refuting the need for support of the newly qualified professional nurses through induction and professional development. Legislative documents yielded supporting information about community service and the training of nurses in South Africa.

2.2 THE STATUS OF PROFESSIONAL NURSE TRAINING IN SOUTH AFRICA (SA)

Nursing education in South Africa that leads to registration with the SANC as a nurse (general, psychiatric, community) and midwife, is currently undertaken at an institution of higher education, be it a nursing college for a diploma or university for a degree. This training is regulated by the SANC, R425, for both the diploma and the degree. The minimum requirement for clinical practice is 3000 hours combined for general nursing, community nursing and psychiatric nursing; while midwifery is 1000 hours, thus totalling 4000 clinical hours (SANC 1985:3). This training was promulgated under the repealed Nursing Act, Act 50 of 1978. The student nurses undergo the same training in the same curriculum at different nursing education institutions (NEIs), a nursing college or university.

The students are placed at health institutions for clinical nursing practice and to meet the SANC minimum required clinical hours of 4000 in four years, preparing them for nursing practice as professional nurses (Leong & Crossman 2009:29). Clinical accompaniment is done by the nurse educator from the nursing education institution, and also by professional nurses in the clinical areas where the students are placed for

experiential learning. The experienced professional nurses in the clinical areas, supervise the general patient care and clinical skills performance, as well as conducting formative assessments, while the summative assessment of the clinical skills is done by the nurse educators from the NEIs.

The student nurses undergo summative assessments of both theory and clinical skills at the end of each year for promotional purposes to the next level of training or completion of the qualification in the fourth year. Successful student nurses are registered with the SANC as community service practitioners, serving the compulsory remunerated community service in designated public health institutions (SANC 2007:2).

New nursing qualifications have been promulgated under the current Nursing Act, Act 33 of 2005. Under this act, the diploma nurses will train for three years, leading to qualification as a staff nurse (SANC 2013a:3). The degree nurses will train for four years, leading to a qualification as professional nurse and midwife (SANC 2013b:3). According to the SANC Circular 11 of 2014, nursing education under the nursing act in use currently (Act 33 of 2005) will commence when the SANC R425 of 1985 legacy qualification stops after the intake of January 2018 (SANC 2014:2).

The researcher acknowledges that the actual professional nurse as promulgated in the categories of the current nursing act (Act 33 of 2005), is still to be trained under the regulation R174 of 2013 (SANC 2013b:2). However, the transitional arrangements of section 14.(1)(a) of the SANC regulation R195 version 2.0, as amended, on 08-03-2013, affirms that the nurses who trained and qualified from the SANC regulation R425 of 1985, can be referred to as professional nurses. When quoted verbatim, section 14.(1)(a) of the SANC regulation R195 states that: "in order to facilitate transitional arrangements, the following must be done by the Council: A person who prior to the commencement of the Act was registered or eligible to be registered as nurse (general, psychiatric and community) must be transferred to the category professional nurse in the register for nursing practitioners" (SANC 2008:12). Thus the researcher used the term 'professional nurse'. The community service regulation (R765), also states that upon successful completion of community service, the nurses should be registered as professional nurses (SANC 2007:3).

2.3   COMPULSORY COMMUNITY SERVICE

In this section, the researcher describes compulsory community service, its presence in other countries, and the background of the programme in South Africa. This serves as a description to help the reader understand that newly qualified professional nurses and other health professionals in South Africa have an obligation as citizens to serve in the public health institutions of the country upon completion of their training (SANC 2007:1). This information will pave the way for the understanding that the government could institute formal mentorship programmes during this period while the newly qualified health professionals are employed within the public sector, serving their community service.

2.3.1   Compulsory Community Service: an overview

According to Frehywot, Mullan, Payne and Ross (2010:364), compulsory community service for health refers to a country's law or policy that regulates the compulsory deployment and retention of a health professional in an underserved or rural area of a country for a certain period of time.

Compulsory community service programmes can be classified as:

- Conditions of service/state employment programme
- Compulsory service with incentives (financial, non-financial or bundled)
- Compulsory service without incentives

There are over 70 countries that have compulsory community service for health professionals, though in some countries it is called by different names, and many more with different types of community service other than for health professionals (Frehywot, Mullan, Payne & Ross 2010:364).

Frehywot et al (2010:367) and Lehmann, Dieleman and Martineau (2008:19) cite the following countries as having or having had compulsory community service: Australia, Pluri-national state of Bolivia, Canada (some parts), Cuba, Ecuador, Ethiopia, Ghana, Haiti, India (Meghalaya, Orissa & Tamil Nadu), Indonesia, Iran, Japan, Kenya, Lesotho, Malaysia, Malawi, Mexico, Mozambique, Mongolia, Myanmar, Namibia, Nepal, New

Zealand, Nigeria, Norway, Pakistan, Peru, South Africa, Soviet Union, Thailand, Turkey, Venezuela, Vietnam, Zambia and Zimbabwe.

Compulsory community service programmes change as laws of the countries change; for example, South Africa started with the programme for doctors only, but then progressed to other health professionals over the years (South Africa Department of Health 2006:1).

2.3.2 Compulsory community service in South Africa

In South Africa, compulsory community service started in the military sector as compulsory military service, or conscription, for white males aged between 17 to 20 years under the National Party Government which came into power in 1948 (Du Plessis, Van der Westhuizen & Liebenberg 2012:144). The recruits served for a period of nine months until 1967, when the Defence Act was amended and they served for two years from 1968 (Du Plessis et al 2012:145). The compulsory military service was abolished in 1991, but recruits volunteered for service until 1993, just before South Africa became a democracy in 1994 (Du Plessis et al 2012:163).

Compulsory remunerated community service for health professionals was proposed in a meeting of the then South African Medical and Dental Council (SAMDC) during April 1989 (later renamed Health Professions Council of South Africa (HPCSA). The rationale for the proposal was to address the shortage and attrition rate of health professionals in the public health institutions (Wynchank & Granier 1991:532). Compulsory remunerated community service was signed into law by the first state president of the democratic South Africa, President Nelson Mandela, on 12 December 1997 through the Health Professions Amendment Act (Act 89 of 1997).

The first cohort of health professionals to perform compulsory remunerated community service in South Africa, in July 1998, were medical doctors (South Africa Department of Health 2006:1; Reid 2001:329). Dentists and pharmacists followed in 2000 and 2001 respectively. Clinical psychology, dietetics, environmental health, occupational health, physiotherapy, radiography and speech, language and hearing therapy started in 2003. Nurses commenced with community service in 2008 after the Nursing Bill was promulgated into the Nursing Act, Act 33 of 2005 (SANC 2007:1). The national

Department of Health (DoH) decides on which health professions serve community service, when and for how long. Nurses, doctors and allied health professionals serve compulsory remunerated community service for a period of one year before their final registration with the SANC or Health Professions Council of South Africa HPCSA respectively.

Newly qualified professional nurses who seek registration with the SANC for the first time as South African citizens are required to perform remunerated community service for a period of one year at a designated public health Institution (SANC 2007:1). The compulsory remunerated community service is referred to as compulsory community service further on.

The DoH declared that compulsory community service was "service and not training" (Reid 2001:330). Gericke and Labadarios (2006:8) reported that the DoH further declared that compulsory community service created an opportunity for the inexperienced health professional to gain knowledge and skills. This has been asserted through a study by Visser, Marais, Du Plessis, Steenkamp and Troskie (2006:17), who indicated that dieticians reported full competency on completion of their community service. They also reported improved knowledge and skills. However, Wranz (2011:1) has a differing view; his study indicated that newly qualified health professionals raised concerns regarding shortage of personnel and absence of mentors and supervision.

The objectives of the DoH for starting compulsory community service for health professionals in South Africa were to:

- improve the provision of health services for all citizens of South Africa
- improve the clinical skills of newly qualified health professionals
- address the lack of doctors and other health professionals working in the public service rural hospitals
- increase the human resource capacity in the public sector (Bhayat, Yengopal, Rudolph & Govender 2008:1135; Bhayat, Yengopal, Rudolph, Naidoo & Vayej 2008:8; Gericke & Labadarios 2006:6; Reid 2001:329)
- give the newly qualified health professionals an opportunity to be socialised within the profession and to acquire critical thinking that would aid in their professional development (Ross & Reid 2009:249)

However, Ross and Reid (2009:249) dispute the objective of addressing the lack of doctors and other health professionals working in the public service rural hospitals. They conducted a descriptive cross-sectional study, using qualitative and quantitative methods, over Limpopo, KwaZulu-Natal and the Eastern Cape provinces of South Africa, the population being health professionals serving compulsory community service and those who had recently completed the programme. They found that compulsory community service is an effective recruitment strategy for underserved areas, using legislation as reinforcement, but is not a retention strategy. They even stated that exposing a new group of graduates yearly to the public service does not guarantee their retention after the obligatory period. Kotzee and Couper (2006:3) agree that compulsory community service for health care professionals has improved the staffing situations in some areas, but they also point out that it is not a retention strategy.

The newly qualified professional nurses are not allowed to study during the compulsory community service year and cannot work anywhere else other than in the designated health institution(s) they are allocated to in a particular province. They receive full SANC registration as a professional nurse upon completion of compulsory community service, with the SANC having received the relevant application and proof of successful completion of the compulsory community service (SANC 2007:4)

2.4   CHALLENGES DURING THE TRANSITION PERIOD FROM STUDENT TO PROFESSIONAL NURSE

2.4.1 Transition from student to professional nurse

The progression from nursing student into the professional nurse role poses a lot of challenges and remains difficult for most newly qualified professional nurses. Reality shock continues to affect their transition as they transit from nursing education to nursing practice to be the workforce (Hoffart, Waddell & Young 2011:334). Challenges faced by newly qualified professional nurses during the transition period include: job stress, deficits in organisational/managerial skills, clinical skills and ability to deal with new experiences (O'Shea & Kelly 2007:1538); lack of knowledge and confidence; heavy workloads; little or no support; inadequate skills of time management and critical

thinking; and inter-professional conflict (Spiva, Hart, Pruner, Johnson, Martin, Brakovich, McVay & Mendoza 2013:25).

Some newly qualified professional nurses, in a qualitative study by Mooney (2007:1612), reported that they had limited learning opportunities and inadequate clinical exposure during their training to prepare them for their role as professional nurses. The problem is confirmed by Gerrish (2000:474), as well as Spiva et al (2013:25), who state that there is a gap between the knowledge and skills acquired by students and those needed in clinical practice, leading to many newly qualified professional nurses entering the profession being inadequately prepared to function as professional nurses.

According to Leong and Crossman (2009:30), the newly qualified professional nurses (generation Y nurses) are challenged upon taking professional practice. They are expected to assume greater responsibility and accountability while they are still developing their own clinical expertise. They need to relate theory to practice more intensively than when they were students in a protective environment, where they were carefully supervised by a clinical instructor (Leong & Crossman 2009:30).

Moriarty, Manthorpe, Stevens and Hussein (2011), upon reviewing the literature about the mismatch between expectations and reality, found that upon qualification, "nurses emerged with a coherent and strong set of ideals around delivering high quality patient-centred, holistic and evidence based care which is usually thwarted by professional and organisational constraints before implementation" (Moriarty et al 2011:1349).

2.4.2 Enhancing clinical competence

Competence is defined as the ability to consciously and deliberately plan based upon analysis of the situation, and the ability to prioritize and manage effectively (Benner (1984:25). The literature suggests that newly qualified professional nurses need support, approval and supervision until they gain independence. Some of them are expected to practice independently, with minimum or no supervision or guidance (Spiva et al 2013:27; Tsotetsi 2012:93). In a survey among the general public about preparation of nurses, conducted by Sprinks (2012:7), the public recommended that nurses should be taught how to communicate effectively and efficiently. Unruh and

Nooney (2011:573) also reported unacceptable communication patterns of newly qualified professional nurses, in addition to their "having too much to do within a given time".

Forbes, While and Dyson (2001:32) suggest that the newly qualified professional nurses should rotate through the clinical placement areas of the health institution to gain a grounding in nursing practice. The mentorship has to continue to ensure that they maintain up-to-date practice skills (Clark & Springer 2012:e5).

2.4.3 Role awareness

Newly qualified professional nurses need to appreciate their role, and understand and relate to the roles of other team members (Forbes et al 2001:30; Thomas, McIntosh & Mensik 2016:96). In a study about the role of the practice facilitators supporting newly qualified staff, Widlake (2002:22) found that the newly qualified professional nurses who went through the rotational programme were able to clarify expectations from them and highlight areas in which they needed development. The practice facilitators of the rotational programme helped them to cope with the clinical practice by providing an opportunity to offload their stressors about the workload and shortage of staff. This was also found to reduce the feeling of being alone and unsupported (Widlake 2002:23).

2.4.4 Need for emotional resilience

Maxwell, Brigham, Logan and Smith (2011:428) refer to emotional resilience as the individual's ability to transform stressful experiences into opportunities for increased growth. Bates (2005:32), however, reflects that newly qualified professional nurses are being let down by understaffed health institutions, thus "throwing them into the deep end" and expecting them to cope.

2.4.5 Lack of professional development support

There is poor retention of graduates by the public health sector in all health disciplines in South Africa. Tsotetsi (2012:93) indicates that there is no formal structured mentorship/preceptorship support and guidance for the newly qualified professional nurse during compulsory community service in South Africa. Even those working in

specialised areas receive guidance and support that differs according to the individual professional nurse with whom they work from time to time. Orientation of newly qualified professional nurses during community service is said to vary from institution to institution, with some not being orientated at all. It was found that they even worked mostly without supervision during night duty (Tsotetsi 2012:92).

Research by several authors has indicated that young health professionals are more likely to move on if they are not supported in their work (Mooney 2007:79; Leigh et al 2005:508; Stagniti 2010:504). Makhakhe (2010:3) agrees that there is a need to support the newly qualified professional nurses during the transition from student nurse to professional practitioner in order to enhance their competence and to retain them.

2.4.6 Generational gap challenges

Generational gap challenges lead to differences in values between the generations. Many experienced professional nurses and operational nurse managers working with newly qualified professional nurses perceive them as having a lack of commitment and being irresponsible and difficult to work with (Morrow 2009:281). Implications of the generational gap are that generational characteristics must be considered when addressing issues of the staff.

Table 2.1: Generational characteristics between operational nurse managers, experienced professional nurses and newly qualified professional nurses

Generation	Characteristics
Millennial generation (born after 1980)	They are techno-savvy, ensure a balance between work and home; are much more affluent, educated and ethnically diverse than other generations; they are loyal to the profession of nursing, not necessarily to the employer/unit, as compared with earlier generations.
Generation Xers (born 1965–1980)	They are ethnically diverse, tolerant of alternative lifestyles, comfortable with technology, do not have the same organisational commitment, accept an uncertain job market and create a balance between work and home.

Generation	Characteristics
Baby Boomers (1946–1964)	They are driven, dedicated and accept a gruelling work pace.
Veterans (1925–1945)	They are loyal, practise within strict rules and guidelines and prefer authority to be clear and respected.

(Source: Morrow 2009:281)

Table 2.1 indicates the generational characteristics to be considered when addressing personnel issues in order to be objective. Morrow (2009:282) indicates that some issues arising between the personnel are as a result of generational gap, exacerbated by the differing generational characteristics.

2.5   PROFESSIONAL DEVELOPMENT SUPPORT

Professional development refers to all types of educational programmes to maintain competence, enhance professional practice and support the achievement of career goals. It incorporates staff development, continuing professional education and career development (Kotzé 2010:227). This section of the discussion will focus on enhancing clinical competence and professional development support of the newly qualified professional nurses.

Newly qualified professional nurses need support in terms of professional development to ensure that vulnerable populations have access to skilled personnel (Aussault & Franceschini 2006:12). Various studies found that the newly qualified professional nurses had the following varying degrees of clinical competence:

- Perceived clinical competence (Ross & Clifford 2002:545; Unruh 2011:580).
- Expected clinical competence (Gerrish 2000:474; Hollywood 2011:667; Widlake 2002:22).
- Actual clinical competence (Hollywood 2011:668; Spiva et al 2013:25).

The newly qualified professional nurses have their perceived views of their level of competence, as individuals based on their strengths and weaknesses, while the supervisors in the areas of allocation experience the actual clinical competence of the newly qualified professional nurses.

The public health institutions have certain expectations of the newly qualified professional nurses, based on their having met the minimum requirements of obtaining the qualification, thus being declared competent by the regulatory body, the SANC (SANC 1985:4). The management, professional nurses and other ward staff need newly qualified professional nurses who can assume responsibility and "hit the ground running" (Maben, Latter & Macleod Clark 2006:472).

Newly qualified professional nurses in South Africa have undergone training in the same curriculum, but there are other factors that will lead to varying levels of clinical competence, the most common being that they are unique individuals, who will not respond the same way. The common denominator in their training is that they have met the SANC minimum requirements to obtain the qualification and they have been declared by the head of the nursing education institution (NEI) to possess clinical competence above the minimum requirements as set by the SANC (SANC 1985:4).

O'Shea and Kelly (2009:1538) and Ross and Clifford (2002:549) using qualitative interviews and quantitative questionnaires, studied a group of nurses' transition from student to professional and found that the transition was very stressful for some newly qualified professional nurses, while many felt that they were inadequately prepared for their new role. South Africa coerces the newly qualified health care professionals, who are inexperienced, to perform compulsory community service in rural areas, often without adequate guidance and support (Marrais, Wilson, Couper, De Vries, Reid & Fish 2009:9). Marrais et al also mention the possibility that the newly qualified health professionals, being forced by the situation to practise outside their scope and competence, may be left leaving them open to litigation.

Hollywood (2011:661), in her qualitative study of the lived experiences of newly qualified children's nurses, found that the presence of support, in terms of professional development, facilitated a smooth transition period from student nurse to professional nurse. This was also supported by a survey that was conducted by Unruh (2011:580), which found that organisational support and professional socialisation ease the transition period. Professional development support can be a combination of clear guidelines on orientation, induction, mentorship (Leong & Crossman 2009:32), preceptorship, supervision, in-service training and buddy systems.

Most studies hail induction and mentorship as important for the professional development of the newly qualified professional nurses; but Forbes et al (2001:33) found that the experienced professional nurses who mentored the newly qualified professional nurses in one community health setting had different views. They were concerned that they spent a lot of time developing, training and supervising the newly qualified professional nurses, who would leave after the community service period; thus their investment of time and energy diverted from their core work would not yield good returns.

The findings of the interviews conducted by Baille, Allen, Coogan, Radley and Turnbull (2003:37) summarise the needs of the newly qualified professional nurses for professional development support as follows:

- The need for comprehensive support systems (formal and structured induction, preceptorship or mentorship).
- The need for career guidance and structured opportunities for development.
- The opportunity to rotate around a variety of clinical areas to gain experience.

Leong and Crossman (2009:32) place the responsibility for evaluating the strategies for improving the experience of role transition from student to professional on organisational nurse managers.

2.5.1 Orientation and induction

Induction is the training given to individuals who are newly appointed in the post (Moriarty et al 2011:1342). Several studies label the transition from student nurse to professional nurse as being stressful for the newly qualified professional nurse. The newly qualified professional nurses need a formal, comprehensive orientation and induction programme, as well as continued support in their new role beyond the initial programme of support (Baille et al 2003:36). Participants in the study conducted by Wolff, Pesut and Regan (2010:189), held the perspective that it was the responsibility of the practice sector to become accountable for adequate orientation and induction of the newly qualified professional nurses to the specifics of the workplace.

O'Shea and Kelly (2007:1541) recommend an orientation programme for a period of three months and an induction programme which will focus on managerial skills, clinical skills development and other aspects of the professional nurse's role. O'Shea and Kelly (2007:1541) also recommend that newly qualified professional nurses should not be allocated to supervising student nurses during the first three months post registration. Wolff et al (2010:191), reported that workforce shortages, fiscal restraint, complex healthcare organisations, increasing patient acuity, the explosion of education and technology, and the ever expanding role of nurses in healthcare, all influence the successful preparation, transition and integration of newly qualified professional nurses.

2.5.1.1   Transition needs of the newly qualified professional nurses

Wangensteen et al (2008:1880), in a qualitative study about the experience of growth and development of the newly qualified professional nurses, found that they were uncertain about their skills and their work environment. They needed a supportive environment with a formal induction programme and they needed recognition through timely feedback acknowledging what they had done well or the need for correction. Spiva et al (2013:24) also acknowledge that nursing orientation alone does not provide the necessary skills to make the transition from student to professional.

Identification of core skills has to be done, to include them in an induction or orientation programme. The core skills and procedures of each unit of rotation should be identified and the newly qualified professional nurse should have readily access to the procedure manual of the unit of allocation (Forbes et al 2001:30). Wolff et al (2010:191) state that the time has come to stop the debate about responsibilities and accountabilities regarding the practice readiness of the newly qualified professional nurses, but to focus more on transitional plans to enhance their clinical competence.

2.5.1.2   Recommended content for induction and orientation

Spiva et al (2013:25) recommend that newly qualified professional nurses attend monthly educational sessions on transition to professional nursing (professional development) for a period of twelve months. They also suggest that an experienced professional nurse and a nurse manager be allocated to monitor the induction process. Orientation should include record keeping, organisational policies, procedures for reporting incidents and handing over during shift change (Spiva et al 2013:29). In their

study about medication errors, Unver, Tastan and Akbayrak (2012:317) state that mentors should teach newly qualified professional nurses about acts and omissions to prevent errors, and teach them the institution's procedures about procurement of medications and their management and use.

2.5.2 Preceptorship and mentorship

2.5.2.1 Preceptorship

Preceptorship is a process whereby an employer supports practitioners newly registered with the Nursing and Midwifery Council or Health Care Professions Council to develop their confidence in the chosen field of practice, to consolidate their knowledge and skills and to allow them to gain strength from professional socialisation with colleagues (McCuster 2013:283). Health care institutions that understand the transition of newly qualified professional nurses provide better support, in addition to orientation, to increase the retention rates (Roberts & Kelly 2007:227; Spiva et al 2013:24).

Table 2.2:   Mentoring versus role modelling, precepting and coaching

Mentoring	Role modelling	Precepting	Coaching
Includes role modelling, precepting and coaching; thus it is bigger than any one of them	It is a passive process of identification that ends when the new nurse becomes skilled. New nurses merely copy behaviours without understanding their rationale. It can occur without any formal relationship,	It takes place when an inexperienced individual works with an experienced person. Their relationship is task-oriented, short term, assigned and less intense than mentoring. Precepting outcomes are skill and knowledge attainment, anxiety reduction and safe practice. The relations are active but only the experienced member teaches and supervises	Coaching results when peers or supervisors 'train' a person while working on a short-term project, assignment or challenging situation. It is usually spontaneous and relates to a problem-solving activity. Coaching is often a management technique used to help employees fulfil job description expectations and includes performance evaluations and analyses.

(Source: Differences from Smith, McAllister & Crawford 2001:102; Gibson & Heartfield 2005:52)

Table 2.2 differentiates between mentoring, role modelling, precepting and coaching. The literature indicates that the terms are interrelated (Smith, McAllister & Crawford 2001:102; Gibson & Heartfield 2005:52).

2.5.2.2 Mentorship

"The term 'mentor' comes from Homer's *Odyssey,* when Athena, the Goddess of Wisdom, disguised herself as an Ithacan noble named Mentor. When Ulysses was away in the Trojan War, Mentor served as the surrogate parent to Telemachus, Ulysses' son. Mentor then guided, coached, taught and protected Telemachus, because he was to be the future king" (Harrington 2011:168). Smith et al (2001:101) define the word "mentor" as a person who serves the role of a master, supporter, friend, guide, teacher, parent, coach and confidant. Mentors in the current context are expected to guide, coach and teach newly qualified professional nurses because they are going to be the future professional nurses and nurse managers. North, Johnson, Knotts and Whelan (2006:16) are in agreement with Smith et al (2001:101), in that mentors are master clinicians, role models, facilitators, preceptors, coaches, advisors, catalysts and educators.

Seekoe (2014) describes the purpose of mentoring as "capacity building, empowerment and development of competencies in order for the mentee to function effectively in their own environment". Mentoring encompasses both personal and professional growth towards excellence. It is a developmental, empowering relationship, which extends over time, and in which mutual sharing, learning and growth can occur in an atmosphere of respect, collegiality and affirmation (North et al 2006:16). The purpose of mentoring can be achieved if the interaction between the mentor and mentee is participatory (Seekoe 2014).

Muldowney and McKee (2011:207) are of the opinion that all nursing staff should be involved in the teaching relationship. Other authors state the need for formal mentorship relationships in which mentors take responsibility (Hollywood 2011:667). Mentors need to be given orientation, guidelines for mentorship, documentation of mentee progress and organisational support of the mentorship process.

The orientation will help mentors to be interested in the process, to acknowledge their responsibilities and to take the opportunity to clarify their roles. Spiva et al (2013:31) actually suggest that mentors should attend workshops to prepare them for their role.

2.5.2.2.1   Mentoring models

Mentoring models and functions need to be clearly identified in order to develop a mentoring programme for newly qualified professional nurses.

In the literature searched, two articles describe mentoring models. Smith et al (2001:101), describe the following mentoring models:

The first is a mentoring process with three phases; namely, recognition and development, limited independence, termination and realignment. The second model is the traditional one-to-one mentoring model. This model identifies the mentor as an expert nurse – someone with the answers. The third model was described as a multiple mentor experience model, where the mentees have access to several experienced, supportive persons. There might be a primary mentor, who presents a total commitment to the mentee, and a secondary mentor, who is more of a role model or preceptor.

Other models of mentoring are described by Harrington (2011:169) as: apprenticeship, competency, reflective or informal. Mentoring relationships may be either formal or informal.

Apprenticeship is defined as guided supervision, much like that of a trainee.

In the **Competency model,** the mentor coaches, observes practice and evaluates a definitive set of behaviours or competencies. The competencies are developed and known within that specific professional arena.

In the **Reflective model,** the mentor guides the mentee by dialogue with a more experienced practitioner. The model enables mentees to develop their professional identity through more than just completing tasks or attaining professional competency. It encourages professional development through personal growth.

The **Informal model** can be integrative and combine any or all of the other models. This model acknowledges that mentoring is not a static activity; it allows adaptation over time to the needs of the mentee. There is no contract between the mentor and mentee (Harrington 2011:169).

Formal mentoring institutions implement a formally recognised mentoring scheme, with or without tangible rewards for the mentors. Formal mentoring schemes have a clear rationale; measurable goals and outcomes; mechanisms for assessment and selection of mentors and mentees; and accountability. The formal relationship is set up through an organisation and the mentor and mentee are matched. There is formal training of the mentor and mentee, formal objectives and programme activities. Results are monitored (Gibson & Heartfield 2005:52).

2.5.2.2.2 *Implementation of a mentorship programme*

Public health institutions have to plan for and implement professional development support structures to develop a comprehensive mentorship programme to support the newly qualified professional nurses. Newly qualified professional nurses who went through support schemes for a period of six to twelve months were reported to be more confident, felt they were competent practitioners and felt valued by the organisation (Harrison 2006:12).

The operational nurse managers and experienced professional nurses should be trained to be mentors, in order to provide maximum support to the newly qualified professional nurses (Lee, Tzeng, Lin & Yeh 2009:1219). Patient care, administration, patient safety assurance, patient education provision, effective communication, workload organisation, professional development maintenance and mentee coaching are listed as core competencies that can provide a framework for the mentor's job description (North et al 2006:16).

Table 2.3: Responsibilities of mentors

Mentors should:
- Listen to the mentee.
- Help mentees to be part of a team.
- Aid with adjustment to nursing tasks.
- Be happy to instruct and teach.
- Not discuss performance of mentee in front of patients.
- Give mentees a breakdown of political and social barriers in the mentorship relationship.
- Share their values, dreams and vision with mentees.
- Continuously provide feedback.
- Have a trusting and caring relationship.
- Advocate for mentees within the public health institution and nursing profession.
- Have an open, accepting relationship with mentees.
- Give mentees challenging opportunities to demonstrate skill and knowledge.
- Provide coaching and counselling to the mentees.
- Discuss problems and solutions with the mentees.
- Empower, encourage and inspire mentees.
- Employ expert questioning and challenging to stimulate critical thinking.
- Have focus, be friendly and show tolerance.
- Provide mentees with freedom to take risks and allow them to be gradually independent.
- Role-model and socialise mentees into leadership roles.
- Support mentees as people and professionals.

(Source: Lee et al 2009:1222; Smith et al 2001:103)

Although the relationship between the mentor and the mentee has to be voluntary, the mentors and mentees have responsibilities to ensure the success of the mentorship relationship. Table 2.3 indicates the responsibilities of the mentor, while table 2.5 indicates those of the mentee (Lee et al 2009:1222; Morrow 2009:282; Smith et al 2001:103).

Mentors need to have certain qualities that will promote the success of the mentorship process. An older source, Smith et al (2001:102), clearly summarise the qualities of a mentor by saying that: mentors need to be self-assured, confident, and clinically competent in order for a good mentoring relationship to occur. Mentors must be willing to spend time and emotional energy in order to establish a long-term relationship with a new or inexperienced nurse. Mentors need to be supportive, caring, giving, accepting, knowledgeable and sensitive to the mentee's needs, ideas, feelings and situation. Mentors need political savvy, a sense of humour and a keen ability to lead. The mentor must be able to suggest, counsel, role-model risk taking and criticise constructively as

well as effectively. Mentors support and stimulate mentees towards leadership roles while giving advice, help and guidance as needed. They must be available to really listen and hear what the mentees tell them. This will create open communication and a gradual movement of responsibility from mentor to mentee (Smith et al 2001:102). The versions of newer sources are given in Table 2.4.

Table 2.4:   Desired qualities in a mentor

Milner and Bossers (2004:104):
Experienced and knowledgeable, provides guidance and support, encouraging, good communicator, trustworthy, respectful, role model, leader, dedicated, enthusiastic or passionate, willing to share ideas and perspectives, willing to learn from mentee as well, mentor has a balance between work and home life, open-minded, creative, thought-provoking, successful, nurturing, coaching, non-judgemental, available, same area of practice, flexible, optimistic, disciplined, caring and a facilitator.
Harrington (2011:169):
Can promote the mentoring experience, can optimise the mentoring relationship to promote successful transition for a newly qualified professional nurse.
McNamara, Fealy, Casey, O'Connor, Patton, Doyle and Quinlan (2014:2536):
Having knowledge, skills, positive attitudes and experience.
Being motivated, caring, mentee being able to discuss anything with mentor, always available.

The literature states that mentees should have desired characteristics and responsibilities for the success of the mentorship relationship.

Mentee characteristics were stated as having to be sincere, honest, have respect, warmth and empathy (Smith et al 2001:102). See Table 2.5 for mentee responsibilities.

Table 2.5:   Mentee responsibilities

Mentees must have a keen commitment to the job and mentorship project. They need to:

- Be loyal to the mentor and organisation.
- Be committed to learning.
- Believe in and respect the guidance provided.
- Have ambition and confidence in their careers.
- Consider the mentor/mentee relationship as being critically important to the mentor, mentee and the organisation.
- Allow mentors personal and social space.
- Appreciate people and resources, appreciate what has been given to them, ask for and be receptive of help when needed, have interest in the subject.
- Critically self-evaluate their strengths and weaknesses.
- Disclose frustrations and concerns.
- Form a professional bond with the mentor and public health institution.
- Help others. Listen and learn.
- Recognise problems, actively seek solutions and information.
- Spend time with the mentor. Strive for excellence.
- Trust and accept the mentor's advice.
- Use all opportunities to consult mentors and other resource people

(Source: Morrow 2009:282; Smith et al 2001:103)

Barriers to mentoring can hinder the success of the mentoring process. Barriers to successful mentoring were stated as:

Lack of access to mentors, poor rate of involvement, reluctance to mentor; potential mentors lacking mentorship skills; demands of time, time investment; and shortage of personnel (Lee et al 2009:1219). See Table 2.6 for ways to improve mentoring.

Table 2.6:   Ways to improve implementation of mentorship

If there is a lack of mentors – provide mentors with more recognition and formal training. This will encourage involvement in mentorship programmes.

Formal training for mentors should cover concepts of knowledge of learning styles, reflection techniques, legal and ethical issues. Training will improve confidence in mentoring ability.

A mentorship programme should have guidelines for participation, to ensure its success.

Mentoring needs a culture shift, from individual level to departmental level and organisational level.

Public health institutions are encouraged to increase the value placed on mentorship and support for its benefits in order to increase the 'buy-in' from potential mentors. For example, awards for excellence in mentoring, mentoring to be recognised for performance incentives or promotion.

(Source: Rhodes 2013:594)

Mentoring should be incorporated in the mentor's performance appraisal as a key performance criterion for monetary recognition (North et al 2006:16). Rewards can mitigate the possible obstacles to a successful mentoring experience (Harrington 2011:170). See Table 2.7 for non-monetary mentor recognition.

Table 2.7   Non-monetary mentor recognition

Annual awards ceremony to recognise mentors for specific accomplished goals.

A recognition plaque displayed in a highly visible area of the institution.

Mentioning of specific accomplishments in the institution's publication.

Specified office space.

Business cards.

(Source: Milner & Bossers 2004:104)

2.5.2.2.3 Benefits of mentoring

Mentorship benefits the mentee, the mentor and the organisation. Brediger (2009) was part of a team that developed a formal mentor programme with the purpose of identifying expert nurses to share their experience, knowledge, passion and professionalism with new nurses. The author attests to the benefits of mentoring to the mentee, mentor and organisation (Brediger 2009:112).

Benefits to the newly qualified professional nurses as mentees

The mentorship programme creates and promotes a positive and healthy work environment for newly qualified professional nurses by supporting, teaching and encouraging professional and personal growth (Brediger 2009:112).

Mentorship facilitates transition of newly qualified professional nurses into the workplace and social culture of the organisation (Beecroft, Santner, Lacey, Kunzman & Dorey 2006:736). Mentorship is accepted as a valid approach to supporting novice nurses during the period of transition to professional roles (McCloughen & O'Brien 2005:279). Mentees learn new skills and sharpen existing ones. Mentorship provides opportunities for promotion, career development and personal and professional development. Mentees reported increased self-esteem and an internal power of self-control, pride, confidence, inspiration and political savvy (Smith et al 2001:105).

Benefits to the proficient and expert professional nurses as mentors

Mentors benefit through a keen sense of pride and fulfilment that comes from watching a newly qualified professional nurse grow and develop (Smith et al 2001:105). Mentors also are aware that mentees are more likely to stay in a position, be more productive and exhibit greater job satisfaction. Mentees may become mentors themselves, because they have seen the value of mentoring. Mentors improve leadership skills, professional relationships and problem-solving skills and learn evidence-based practices, which lead to job satisfaction (Morrow 2009:284).

Benefits to the public health institution as an organisation

Mentoring increases staff retention by decreasing stress and promoting positive self-esteem and confidence in the newly qualified professional nurse (Gibson & Heartfield 2005:556). The retention ultimately leads to reduction in the shortage of personnel.

Mentoring can help the public health institution to use newly qualified professional nurses more effectively, which will improve quality and standards of patient care (Beecroft et al 2006:736).

2.6   CONCLUSION

In this chapter, the researcher gave an overview of the compulsory community service served by health professionals, its existence in other countries and the South African perspective. The chapter discussed the nursing education of professional nurses in South Africa under the repealed Nursing Act, Act 50 of 1978, and the envisaged transition to new nursing qualifications for the future professional nurses under the Nursing Act, Act 33 of 2005. These were highlighted because this current study was conducted with newly qualified professional nurses who had recently completed community service promulgated by the Nursing Act in use, Act 33 of 2005 (South Africa 2005:1), whereas they trained under the regulations promulgated by the *repealed* Nursing Act, Act 50 of 1978 (SANC 1985:1). Relevant literature was discussed relating to induction, orientation, mentoring and other professional development support of the newly qualified professional nurses.

Chapter 3 discusses the theoretical framework grounding the study and the research methodology.

CHAPTER 3

THEORETICAL GROUNDING AND METHODOLOGY OF THE STUDY

3.1 INTRODUCTION

Chapter 2 discussed the literature relevant to the induction and professional development support of the newly qualified professional nurse. It also described the perspectives of other researchers on enhancing the clinical competence of the newly qualified professional nurses, and their induction by the experienced and expert professional nurses, preceptors and mentors who support them.

In this chapter, Benner's (1984) Novice to Expert Model will be discussed as the theoretical framework that guides the study. The research methods used in the study will also be described in detail.

3.2 THE NEED FOR A THEORETICAL FRAMEWORK TO GROUND THE STUDY

Barnum (1994) states that "theory and research form a recycling chain in which theory directs research, research corrects theory and corrected (or confirmed) theory directs more research" (Barnum 1994:272). Patricia Benner's Novice to Expert Model (1984) will direct this research. The model is described in detail with an explanation of how it will be applied to the study.

3.2.1 The developmental levels of the theoretical framework: from novice to expert as applied to the study

Benner's (1984) Novice to Expert Model is a theoretical framework underpinning the study. It has five development levels, each level building on the previous one as the nurse advances from a neophyte level, gaining knowledge, skills, perceptions, intuition, wisdom and experience in clinical practice (Benner 2001: 20); Kaminski 2010:967). The current study is concerned with the development of the nurses through the first three levels of the model, aiming at determining the induction and professional development support given to, and that which is required by, newly qualified professional nurses who
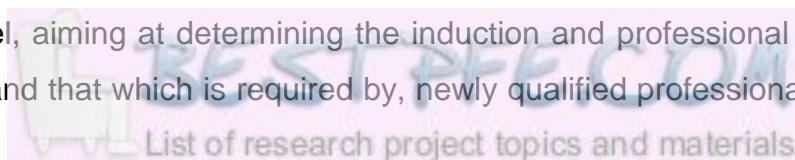
are at the novice level, moving to the advanced beginner level and proceeding to the competent level. The support is expected to be given by those at the proficient to expert level as mentors during the transition period.

The model consists of a continuum of development from the lowest level of novice to the highest level of expert. The model was initially proposed by Hubert and Stuart Dreyfus (1980) and was known as the Dreyfus Model of Skill Acquisition (Benner 1982:402; Gobet & Chassy 2008:131). The Dreyfus model of skill acquisition was later modified and applied to nursing by Patricia Benner (Benner 1982:402; Kaminski 2010:967). The levels build onto one another and can be applied to various aspects in nursing. The levels are novice, advanced beginner, competent, proficient and expert (Benner 1984:34).
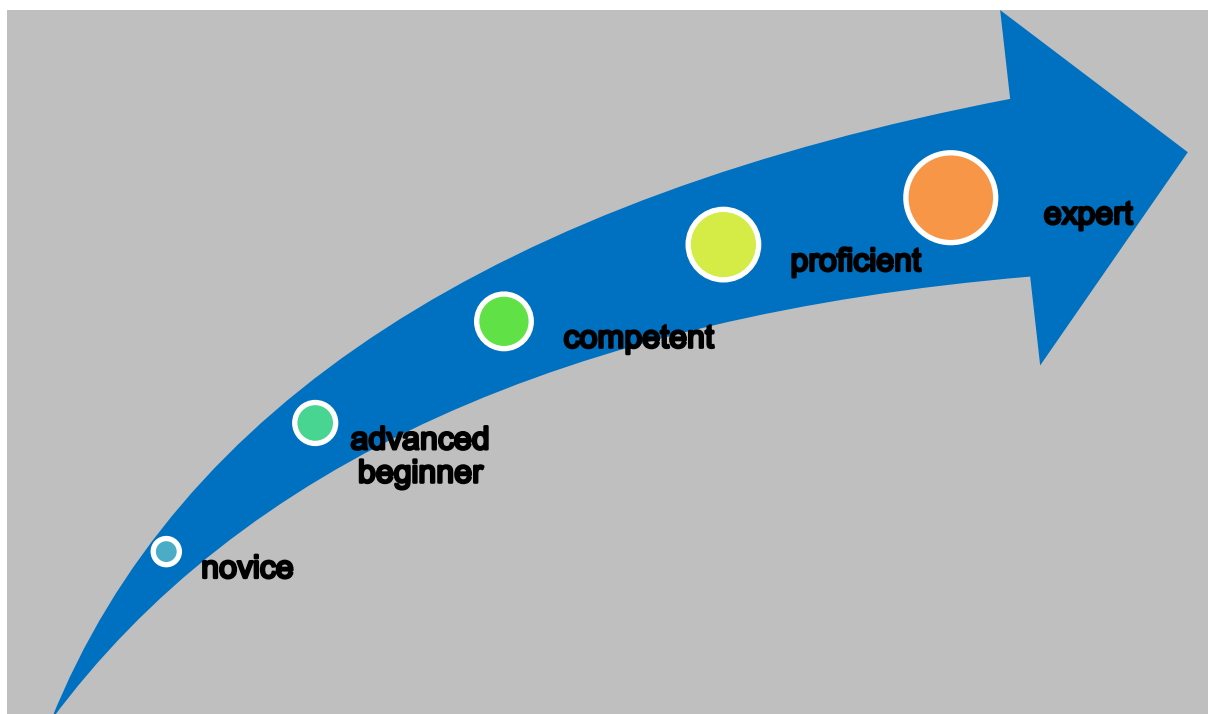
Figure 3.1: Illustration of the levels of development in
(Benner's Novice to Expert Model 1984; Benner 1984:34)

3.2.2 The newly qualified professional nurses serving the compulsory community service in South Africa

The newly qualified professional nurses in the study can be equated to the first three levels of development as follows:

3.2.2.1   Novice level

In many studies this level is applied to students of nursing, but "Benner has suggested that nurses in higher levels of skill in one area of practice could be classified at the novice level if placed in an unfamiliar area or situation" (Marriner-Tomey 1994:167). In this study, the researcher equates the novice level with the newly qualified professional nurse from a nursing education institution, starting community service up to the second month of community service. The newly qualified professional nurse starts to make meaning of the new practice area, tries to adapt to not being a student nurse and is learning a new role. He or she works under the direct supervision of an experienced professional nurse, who is either proficient or an expert (Benner 2001:20).

3.2.2.2   Advanced beginner

The researcher equates the advanced beginner level with the newly qualified professional nurse from the third month of community service to the fifth month of community service. Marriner-Tomey (1994) states that "nurses functioning at this level are rule-guided and task completion oriented and have difficulty grasping the current patient situation in terms of the larger perspective" (Marriner-Tomey 1994:167). The newly qualified professional nurse demonstrates acceptable clinical performance, and has gained enough prior experience during mentoring sessions to recognise recurring meaningful components of clinical practice. The advanced beginner uses principles to guide actions, and works under the *indirect* supervision of the experienced professional nurse (Benner 2001:22).

3.2.2.3   Competent

The competent level can be equated with the newly qualified professional nurses from six months to twelve months of community service (Lima, Newall, Jordan, Hamilton & Kinney 2016:878). The professional nurse at this level has gained experience in clinical practice, is more aware of long-term goals, and gains perspective from planning own actions based on conscious, abstract and analytical thinking (Benner 2001:22). The nurse achieves greater efficiency and organisation, can work without supervision and can be in charge of a unit. Although Benner (1984:38) states that competence is

achieved within two to three years of working in the same clinical area, in this study the researcher agrees with Garside and Nhemachena (2013:542), who state that "competence in everyday nursing practice seems to mean being slightly more than being newly qualified and is only fully achieved once the new nurse has gained the ability to be totally accountable for their professional actions". The newly qualified professional nurse in South Africa is new as a professional but has been a student in nursing education for a period of four years. In addition to the theory, the nurse has achieved 4000 clinical hours in nursing and midwifery as a requirement for registration by the SANC (SANC 1985:3).

The newly qualified professional nurses at advanced beginner stage have coped with enough real situations by themselves or with the help of a mentor (Benner 2001:22).

3.2.2.4   *Proficient level*

The professional nurses in the clinical areas perceive and understand clinical situations as whole parts. There is improved decision making. Learning is from experience; they can forecast what to expect in certain situations and can modify plans accordingly. They have experience of clinical practice and are able to supervise and mentor the newly qualified professional nurses. In their study concerning a nursing faculty mentoring programme, Snelson, Marstolf, Dieckman, Anaya, Cartechine, Miller, Roche and Shaffer (2002:655) found that new faculty members were formally mentored by experienced faculty members, guiding the novice faculty to transit to a new culture and fulfil the expectations of their new work. At this level, the competent professional nurse is able to give safe care, knows how to perform specific tasks. She gradually becomes proficient in managing healthcare situations, seeing the picture as a whole, not parts (Benner 2001:28).

3.2.2.5   *Expert level*

The professional nurse at this level can be equated with the operational nurse manager who has been in the same clinical area for a long period. Such operational nurse managers no longer rely on principles, rules or guidelines to connect situations and determine actions. They have more background experience and an intuitive grasp of clinical situations. They perform fluidly and flexibly and are highly proficient (Benner

2001:32). They are charged with the responsibility of planning and managing patient care in a specific clinical area. They can also manage supervision and mentorship of the newly qualified professional nurses allocated to the specific clinical area (Benner 2001:34).

3.2.3 Application of the Novice to Expert theoretical framework by other authors

The novice to expert framework has been used by various researchers to serve as a catalyst for staff development programmes like mentorship, with the aim of facilitating nursing excellence. It has been applied in order to gain insight into managing clinical problems, to practise skills, and to enhance clinical competence on various levels of nursing (Fero, Witsberger, Wesmiller, Zullo & Hoffman 2009:140). Nursing education bodies have used it to guide their curricula and clinical accompaniment of student nurses (Field 2004:560; Shuldham 1993:436).

3.2.3.1 Nursing education

Benner's novice to expert model was used to develop a post-basic nursing curriculum of a cardiorespiratory clinical nursing programme. Shuldham (1993:436) reported on the curriculum, stating that the curriculum was designed to promote and support the practice of professional nurses in cardiorespiratory nursing. She explains that the levels of development in the model helped to answer questions about academic and practice levels. The nurses were assessed and were found to be "novices in some respect, while some were found to be advanced beginners in cardiorespiratory nursing although competent general nurses" (Shuldham 1993:437). She agrees with Benner's (1984) view that in different situations a person may operate on one level, whereas in others that person may operate on a different level.

At Shuldham's institution, the curriculum designers used Benner's (1984) levels of practice and Bloom's (1956) academic levels to align and classify their course modules (Shuldham 1993:439). The author concluded that "underpinning curriculum development at all levels with the work of Benner (1984) and Bloom (1954) has provided a framework for further development" (Shuldham 1993:440).

Field (2004) used Benner's (1984) theoretical framework to compile a literature review on the value of learning in clinical practice. She acknowledges the five stages of development from novice to expert as the potential development of nursing expertise and identification of nursing competencies (Field 2004:560). Field is of the opinion that the key to progressing from novice to expert is through excellent mentor support, "otherwise the student would make defective assumptions based on inadequate personal reflections" (Field 2004:561).

Field (2004) goes on to discuss the fact that practical skills achievement of newly qualified nurses may be at variance with what the managers were expecting, owing to the discrepancy between classroom theory and the learning taking place in the clinical area (Field 2004:562). In reconciling theory and practice, she suggests that mentors in the clinical areas should utilise bilateral facilitation, whereby mentors will learn the current theory from the students in order to update and perfect the skills to be mastered by the students (Field 2004:563). The mentor is important in relating theory to practice, as well as coaching for excellent practice outcomes, "to coach students from novice to expert performances" (Field 2004:565).

In conclusion, Field concurs with the National Health Service (NHS) Executive's (1998) report – *Integrating theory and practice in nursing* – as well as the UKCC (1999) *The fitness for practice report*, in that it is important for nurses to develop an integrated approach to nursing knowledge because competence in nursing practice is crucial (Field 2004:564). The reviewed literature points that such competence can be achieved by sharing of the responsibility by both the health care employees and the educators in higher education.

3.2.3.2   Clinical practice

Fero et al (2009) conducted a post-hoc retrospective analysis of 2144 newly hired nurses' Performance Based Development System (PBDS) assessment data. The assessment data was collected within two weeks of employment. The assessment was to be carried out in order to customise the orientation of the new nurses at the beginning of their employment tenure.

New graduates comprised 56.5 percent (*n*=1211) of the sample. The purpose of the study was to identify critical thinking learning needs of new and experienced nurses with varying levels of nursing education preparation. The theoretical framework guiding the study was Benner's (1984) novice to expert model. The assumption was that nurses with more years of experience and the baccalaureate-prepared level of nurses would have a higher rate of meeting the expectations upon assessment using the PBDS (Fero et al 2009:140). The five levels of Benner's (1984) novice to expert model were applied by Fero et al (2009:140) as follows in their study:

Novice

The authors defined novice as a new nursing graduate with limited exposure to independently managing a critical situation, who operates in a limited and prescribed way.

Advanced beginner

An advanced beginner was described as a nurse who performs at a marginally acceptable level. Nurses at this level recognise the meaning of a critical situation but may not understand or anticipate the necessary patient care.

Competent

A competent nurse is one who is able to determine more relevant aspects of a situation. The competence level entails planning, considering, analysing and contemplating the action to be taken.

Proficient

The nurse at this level of development perceives the meaning of a situation by reflecting on previous experience and modifies plans based on the response to the clinical situation.

Expert

The nurse at this level has intuitive grasp of a critical situation and understands deeply the actions needed to resolve the clinical situation (Fero et al 2009:140).

Figure 3.2: The levels of the Benner's (1984) Novice to Expert Model in the clinical context
(Source: Fero et al 2009:143)

Fero et al (2009:139) explain that patient safety is a priority for health care systems and nurses' competence plays a large role in assuring patient safety. They also point out top factors contributing to patient care errors as inadequacies in orientation, training and competence assessment. They are of the opinion (Fero et al 2009:139) that

> new graduate nurses practice at the novice or advanced beginner level (Benner 1984). They are at the early stage of developing a skill set and applying critical thinking. Nursing shortages and budgetary issues may mean that initial orientation periods for new graduates are shortened, a potential factor prompting the increase in errors.

The results of their study were summarised as follows (Fero et al 2009:142). Approximately 25 percent of newly hired nurses had deficiencies in critical thinking ability and problem recognition, and in reporting essential clinical data, initiating

independent nursing interventions, anticipating relevant medical orders, providing relevant rationale to support decisions and differentiation of urgency.

Nurses prepared at the baccalaureate and associate level were more likely to meet expectations on the assessment as years of experience increased; a similar trend was not observed for diploma nurses. New graduates were less likely to meet assessment expectations than nurses with ten years' experience or more. Their findings supported Benner's (1984) novice to expert model. They acknowledged that nurses with more experience were, as expected, better able to identify appropriate actions when viewing the clinical vignettes during the assessment (Fero et al 2009:143).

Hogston (1993) discusses Benner's (1984) novice to expert model in the context of continuing professional development for post registration using the United Kingdom (UK) post registration and practice project (PREPP). He indicates that clinical competence extends beyond the application of knowledge and skills, and is demonstrated through inductive reasoning and critical thinking (Hogston 1993:168). He further states that the UKCC adopts Benner's initial level of novice when justifying the period of support following registration. A newly qualified professional nurse therefore operates at novice level (Hogston 1993:168).

Clinical competence incorporates values, critical thinking, clinical judgement, formulation of attitudes and integration of theory with practice. Hogston (1993:168) defines competence as "a quality indicator which assures a certain standard of service that the public can trust". Hogston suggests that there may be some similarities on the novice to expert continuum that relate directly to the UKCC's PREPP proposals.

3.2.4 Advantages of the novice to expert theoretical framework

The novice to expert model can be used to formalise promotional structures, drive work role competencies in clinical practice (Fero et al 2009:141) and for curriculum development, as well as mentorship programmes in nursing education (Field 2004:565; Shuldham 1993:440). The model has been applied in order to gain insight into management of clinical problems, practice skills and communication through innovative teaching strategies (Fero et al 2009:140).

Gardner (2013:183) states that Benner's initial stages of novice, advanced beginner and competent offer a useful framework through which operational nurse managers and experienced professional nurses can understand the transition of the newly qualified professional nurses from students to professional nurses.

3.2.5 Critics of the novice to expert theoretical framework

Higham and Arrowsmith (2013:8) point out that, although the novice to expert model is famously known through Patricia Benner (Benner 1984) and has become common in nursing curricula, the five stages of skills acquisition are not Benner's own. They point out that 'novice' and 'expert' are points at the opposite ends of a continuum of a skills acquisition model proposed by Dreyfus and Dreyfus (1980), which has the stages of advanced beginner, competent practitioner and proficient practitioner.

Gardner (2012:340) cautions that adhering fully to Benner's (1984) novice to expert model proposes a limited role for the academic lecturer, as the model suggests that formal models and theories of nursing are useful largely to novices, and should be regarded as provisional until the student acquires enough concrete experiences to enable him or her to override them.

Irrespective of some critique, the researcher is still of the opinion that Benner's (1984) model is a suitable theoretical framework for the study. The newly qualified professional nurses who are entering the nursing profession are novice professionals who need to be guided by the proficient professional nurses and expert operational nurse managers in clinical practice areas to progress to competent level. By describing and understanding the levels of competence of the newly qualified professional nurses doing community service, the experienced professional nurses and operational nurse managers, as mentors, will have a better understanding of the type of support they need to advocate on behalf of the newly qualified professional nurses (novices), when attending nursing management meetings.

3.3   THE RESEARCH METHODOLOGY

3.3.1   Research purpose

The purpose of this research was to determine the induction and professional development support given to, and that which is required by, newly qualified professional nurses to enhance their transition from novice professional nurses to competent professional nurses. The information obtained was used to develop induction and professional development support guidelines for newly qualified professional nurses during community service in SA.

3.3.2   Research objectives

i   To explore the induction and professional development support given to newly qualified professional nurses during community service in the designated public health institutions.

ii   To describe the experiences of the newly qualified professional nurses regarding their induction and professional development support during community service.

iii   To explore the experiences of the operational nurse managers in induction and professional development support of the newly qualified professional nurses during community service.

iv   To determine the role of the coordinators of community service for nurses regarding the induction and professional development support of the newly qualified professional nurses during community service.

v   To determine the support needed by newly qualified professional nurses in terms of induction and professional development.

vi   To develop guidelines for induction and professional development support of newly qualified professional nurses.

vii   To validate the guidelines through nursing experts in clinical practice and academia.

3.3.3 Research questions

Importance of questions

Research questions reflect the problem that the researcher wants to investigate, by narrowing the research objective and research purpose to specific questions that researchers attempt to address in their studies. They provide a framework for conducting the study, helping the researcher to organise the research and giving it relevance, direction, and coherence, thereby helping to keep the researcher focused during the course of the investigation. They also delimit the study, revealing its boundaries (Onwuegbuzie & Leech 2006:478).

In mixed methods studies, research questions are important because they dictate the type of the research design to be used, the sample size and sampling scheme to be employed, the type of instruments administered, and the data analysis techniques (statistical or qualitative) to be used (Onwuegbuzie & Leech 2006:475). Mixed-methods research involves the formation of both quantitative and qualitative research questions within the same enquiry.

The main research question

How are the newly qualified professional nurses supported in terms of induction and professional development during community service in South Africa?

Sub-questions

- What is the induction and professional development support given to the newly qualified professional nurses during community service to enhance their clinical competence and professional socialisation?
- What are the experiences of the newly qualified professional nurses in terms of induction and professional development support during community service?
- What are the experiences of the operational nurse managers regarding professional development support of the newly qualified professional nurses during community service?

- What role do the coordinators of community service for nurses play in the induction and professional development support of the newly qualified professional nurses during community service?

- What is the induction and professional development support needed by newly qualified professional nurses during community service?

- What guidelines could be implemented for the induction and professional development support of the newly qualified professional nurses?

3.3.4 Paradigm

A paradigm is a set of shared rules and beliefs about how a discipline functions. This includes what counts as truth (ontology) or knowledge (epistemology), as well as how it can be generated or by whom (Hennink, Hutter, & Bailey 2011:68). The paradigm for this study is pragmatism, chosen because it encourages a pluralistic view (in that both induction and deduction are important) and it is practical to study the phenomenon of induction and professional development support of the newly qualified professional nurses (Polit & Beck 2012:604). Pragmatists believe that human activity arises from our need to solve problems and that a true belief is one that is useful in solving a problem (Andrew & Hacomb 2009:17). Patton (1988), as quoted by Johnstone (2004:262), also advocates a "paradigm of choices", where paradigms are not assumed to be rigid and fixed, but ones where researchers have the latitude to use different methods found to be appropriate for different situations. The practical aspect of pragmatism is further explained by the authors Polit & Beck (2012:604), who state that "whatever works best to arrive at good evidence is appropriate". In this paradigm, researchers have freedom of choice regarding methods, techniques and procedures of research that best meet their needs and purposes (Creswell 2013:28). The freedom of choice regarding the research methods enabled the researcher in this study to employ both quantitative and qualitative research methods to answer the research question and meet the set objectives.

Onwuegbuzie and Leech (2005) see the advantages of being a pragmatic researcher as "enabling the researcher to be flexible in their investigative techniques as they attempt to address a range of research questions that arise" (Onwuegbuzie & Leech 2005:383). Reality is constantly renegotiated, debated, interpreted according to its truthfulness in new unpredictable situations.

Creswell (2013:37) describes philosophical beliefs associated with pragmatism as follows:

- **Ontological beliefs**. Reality is what is useful, practical and works. In this study, the researcher used methods that were deemed practical and worked to meet the research objectives.

- **Epistemological beliefs**. Reality is known through using many tools of research that reflect both deductive (objective) evidence and inductive (subjective) evidence. The best method is the one that solves problems, finding out new means and effecting changes where necessary. The researcher reflected on both the research findings and the literature, to objectively deduce the evidence produced by the findings.

- **Axiological beliefs**. Values are discussed because of the way that knowledge reflects both the researcher's and the participant's views. The researcher approached the participants seeking information from them as the people with the knowledge about the subject of enquiry.

- **Methodological beliefs**. The research process involves both quantitative and qualitative approaches to data collection and analysis. The research questions in this study dictated the use of both quantitative and qualitative research methods to be able to meet the research objectives, while answering the research questions. The researcher was at a liberty to choose and combine any research methods.

The researcher opted for the pragmatism paradigm because it advances multiple pluralistic approaches to knowing, using what works, focusing on the research question as important, using all types of methods to answer the question. Pragmatism rejects a forced choice between postpositivism and constructivism, and takes quantitative and qualitative methods as compatible (Molina-Azorin & Cameron 2010:97).

3.3.5 Research design

There are a number of mixed methods that researchers can use. This is best expressed by Teddlie and Tashakkori (2006:12): "mixed-methods designs are numerous to the

extent that it is impossible to create a complete taxonomy of mixed-methods designs because they are evolving in nature and can spin off numerous permutations".

This study is a mixed methods design of concurrent triangulation approach. Andrew and Halcomb (2009:143) explain concurrent triangulation as

> quantitative and qualitative data of a single study collected at the same time with the purpose of validating findings generated by each method through evidence produced by the other. The priority between the two methods is equal. Both methods play an important role in addressing the problem of the study.

The study is a fully mixed concurrent equal-status design that mixes qualitative and quantitative research within a single research study. Quantitatively a survey was used. A survey views things comprehensively and in detail in order to obtain data (Denscombe 2010:10; Fink 2009:1). Qualitatively descriptive phenomenology was used. The main methodological consideration of descriptive phenomenology is the requirement to explore, analyse and describe a phenomenon while maintaining its richness, breadth and depth, so as to obtain a 'near-real' picture of the phenomenon (Matua & Van Der Wal 2015:23; Reiners 2012:2).

In this study, the mixing occurs in the research objectives, data collection, data analysis and interpretation (Leech & Onwuegbuzie 2009:270). The quantitative part of the survey and the orientation/induction programmes were used to meet objectives i and v. Qualitatively, the open-ended questions of the survey questionnaire, the focus groups and interviews were used to meet objectives ii, iii and iv. Objective vi was met through inductive and deductive methods after the integration and synthesis of research findings in Chapter 6. The Delphi technique was used to meet objective vii.

The basic purpose of mixed-methods research is to integrate the quantitative and qualitative data to draw on the strengths of each. The researcher used mixed methods research for the following purposes:

- **Triangulation**. This is seeking convergence and corroboration of results from different methods studying the same phenomenon (Collins, Onwuegbuzie & Sutton 2006:75). The researcher specifically used data triangulation (by using

various data sources) and methodological triangulation (by using various methods). Quantitative and qualitative methods were used (Johnson, Onwuegbuzie & Turner 2007:114); in this study the researcher used documents, focus group discussions, interviews and a survey to collect data (Creswell 2013:353). The researcher reviewed and analysed the data gathered through self-administered questionnaires, copies of induction programmes, focus groups and individual interviews, using the evidence from these multiple sources in such a way that the study findings are based on the convergence of that information (Johnstone 2004:264).

- **Complementarity**. This implies using each set of methods to answer a series of related questions (Palinkas, Aarons, Horwitz, Chamberlain, Hurlburt & Landsverk 2011:46); and for seeking elaboration (Collins, Onwuegbuzie & Sutton 2006:75; Onwuegbuzie & Combs 2011:3). Complementarity was achieved in this study when information from the documents, survey, focus groups and interviews complemented each other and collaborated to answer the research questions.

- **Significance enhancement.** This involves mixing quantitative and qualitative techniques in order to maximise the researcher's interpretations of data (Onwuegbuzie & Leech 2006:479). Mixing qualitative and quantitative techniques yielded findings that enhanced the significance of the study. The findings were comprehensive and could be used to develop guidelines on induction and professional development support of newly qualified professional nurses during community service.

- **Development and evaluation of the guidelines**

The mixed methods in this study yielded information that could be used to develop the induction and professional development support guidelines (Creswell 2003:100).

3.3.6 Advantages of using mixed methods:

Gathering data about the same phenomenon from the different data sources using mixed methods adds scope and breadth; rigour and credibility to the study; thus obtaining comprehensive information.

The researcher in this study used mixed methods to obtain well-validated and well-substantiated findings (Creswell 2003:217). Multiple data sources were used to comprehensively explore the induction and professional development support of the newly qualified professional nurses during community service. Quantitatively, the data obtained through the survey and documents (induction programmes) provided a more objective understanding of the problem; whereas qualitatively the survey, interviews and focus groups explored the phenomenon in great depth (Creswell & Clark 2011:8), providing strategies for solving the identified challenges. The qualitative method allowed for more depth and multiple realities without the limits of preconceived ideas. The mixed methods provided practicality and enhanced validity (Polit & Beck 2012:604).

3.3.7 Challenges of using mixed methods

3.3.7.1 *Skills and manpower*

For this approach, the researcher has to possess the required skills. Studying a phenomenon using two separate methods requires great effort and expertise from the researcher (Creswell & Clark 2011:13). The researcher attended a pre-doctoral research methodology programme presented by Santrust to enhance her skills. In this programme, presenters were research methodology specialists from various universities in South Africa and Ireland, the sponsoring country. The researcher had an opportunity to attend mixed-methods research workshops organised by the University of South Africa, presented by Prof Anthony Onwuegbuzie (Department of Educational Leadership, Sam Houston State University), who is a mixed-methods research specialist. The researcher also received constant supervision from the study promoter, who is an expert researcher.

3.3.7.2 *Time and resources*

Implementation of mixed methods research is tedious and time consuming. The complexity of the process and logistics involved in identifying and collecting data from diverse sources can be daunting (Scammon, Tomoaia-Cotisel, Day, Day, Kim, Waitzman, Farrell & Magill 2013:2203). A lot of time was needed to collect and analyse different types of data. The researcher had to employ sufficient manpower and other

resources, and sample many sources from which to collect data (Creswell & Clark 2011:14).

The researcher was granted study leave by the employing university, through a grant from the Academic Qualification Improvement Programme (AQIP). The grant provided for a replacement lecturer, allowing the researcher to focus on her study and finances for other resources needed to conduct the study. Additional funds were obtained through a grant awarded by the National Research Foundation of South Africa (NRF).

The researcher did not struggle with data sources. South Africa (SA) has nine provinces which are either urban or rural, with many public health institutions designated for community service, thus providing rich data sources. All the newly qualified professional nurses in South Africa serve compulsory community service in public health establishments designated for community service (SANC 2007:2), thus providing the researcher with the population from which to sample.

3.3.7.3 *Convincing others*

The researcher must be able to convince people involved in the study and other academics to understand the value of the mixed methods in the study (Creswell & Clark 2011:15). This study's research proposal was presented to a panel of researchers and live audience upon conclusion of the Santrust programme, where the researcher defended the methodology. The proposal also went through a review process by the Higher Degrees Committee of the Health Studies Department at the University of South Africa (Unisa) (Ethics Committee), before the approval. The board of the South African Nursing Council (SANC), and the Provincial Department of Health Ethics Committees of Eastern Cape, Gauteng, Mpumalanga and Western Cape reviewed the proposal when the researcher applied for permission to conduct the study. The proposal was also submitted to the public health institutions when applying for institutional permission. The researcher developed an orientation programme to guide and train the research assistants who were used in the study. Two assistant researchers helped with the physical distribution of the survey questionnaires, while two research assistants helped with the data collection through focus groups and interviews (the researcher using one of the two at a time).

3.3.8 Population

A population is all individuals or objects with similar defined characteristic (Polit & Beck 2012:519). Public health institutions in all provinces of SA were the population sites for the survey and focus groups. Provincial department of health offices in all the provinces of SA were the population sites for the individual interviews. Newly qualified professional nurses who completed community service 2013/2014, 2014/2015; operational nurse managers working at public health institutions designated for community service and coordinators of community service for nurses were the population for data source.

3.3.9 Sampling

Sampling is a process of choosing a part of the population to represent the whole population (Polit & Beck 2012:519). Multi-method sampling was used owing to the different research methods employed. The study is a mixed method of concurrent design using multilevel samples for the qualitative and quantitative components of the study (Onwuegbuzie & Collins 2007:295). Both probability and non probability sampling were used.

Site sampling and data source sampling are described for the survey, focus groups and interviews. The documents were requested from the public health institutions where focus groups were conducted. The operational nurse managers brought the induction/orientation programmes to the focus groups as requested by the researcher during the application for institutional permission.

3.3.9.1 Sampling for the survey

The sampling for the survey was systematic probability sampling using the RaoSoft Survey Tools sample size calculator, which is a computer program. Systematic sampling means choosing individuals from a list by selecting every *n*th sampling frame member, where *n* typifies the population divided by the preferred sample size (Onwuegbuzie & Collins 2007:285). In this study, every 7th name was chosen from the list of newly qualified professional nurses who had recently completed community service from each province in South Africa. Every 7th newly qualified professional nurse

was selected from the sample frame of 2503, as provided by SANC, to meet the pre-calculated sample size of 350. This sampling ensured greater representativeness of participants (Gray 2009:155).

The criteria used included homogeneity in that the sample had to consist of newly qualified professional nurses who had recently completed community service in public health institutions and were on the list from the South African Nursing Council (SANC). Homogeneity means that the individuals were chosen on the basis of similar or specific characteristics (Onwuegbuzie & Collins 2007: 285).

The researcher used a predetermined percentage of addresses of newly qualified professional nurses who had recently completed community service in SA, using the RaoSoft Survey Tools sample size calculator. The total addresses on the list were 2503. The sample size after calculation became 350 addresses.

The number of newly qualified professional nurses on the list obtained from the SANC for January 2013–March 2015 was 2503. The following formula was used:

$$x = Z(^c/_{100})^2 r(100\text{-}r)$$
$$n = {}^{Nx}/_{((N\text{-}1)E^2 + x)}$$
$$E = \text{Sqrt}[^{(N\text{-}n)x}/_{n(N\text{-}1)}]$$

(Formula obtained from: www.raosoft.com/samplesizecalculator).

The margin of error accepted was 5 percent; confidence level needed was 95 percent; population size was 2503; and the response distribution of 50 percent. The minimum recommended size of the survey became 350 newly qualified professional nurses.

3.3.9.2 *Sampling for focus groups and individual interviews*

The sampling method used for focus groups and individual interviews was non-probability, purposive, criterion based and homogeneous. Purposeful sampling strategy is used when the enquirer selects individuals and sites for study because they can inform an understanding of the research problem and central phenomenon of the study

(Creswell 2013:156). Purposeful selection of participants was also done to obtain insights into the phenomenon being studied (Onwuegbuzie & Collins 2007:287). Participants that could give the relevant information regarding the induction and professional development support of the newly qualified professional nurses were selected.

This approach was used when sampling operational nurse managers from the various public health institutions. The operational nurse managers were homogeneous in the sense that they all supervised the newly qualified professional nurses during community service. They were also responsible for the professional development support of the newly qualified professional nurses in the various public health institutions. They were able to provide detailed descriptions of their experiences of the induction and professional development support that they provided to the newly qualified professional nurses during community service.

The individual interviews with the provincial coordinators of community service were purposive and criterion-based because they met a predetermined criterion of importance and had experiential information on the phenomenon of interest, being coordinators of community service for nurses (Polit & Beck 2012:519). They had allocated the newly qualified professional nurses to serve community service in the various categories of designated public health institutions in the sampled provinces of SA. They were also responsible for the completion of community service forms which they had to send to the SANC for the final registration as a professional nurse, once the newly qualified professional nurses had completed the compulsory remunerated community service.

Sampling of provinces

Four provinces from the nine were purposively selected by the researcher as sites for focus groups and individual interviews. The Eastern Cape and Mpumalanga are predominantly rural provinces, while Gauteng and Western Cape are predominantly urban. (Further on in the study they are referred to as largely rural and largely urban.) The variety in sampling of provinces was necessary to provide representation of all the types of provinces in South Africa. The variety allowed the researcher to discern whether there were differences in the induction and professional development support

of newly qualified professional nurses between the rural and urban provinces of South Africa.

Sampling of public health institutions

The researcher obtained the list of designated public health institutions for the sampled provinces from the Regulations relating to categories of hospitals (South Africa Department of Health 2011:8). The names of the health institutions provincially were categorised according to tertiary hospitals, regional hospitals, district hospitals, 24-hour community health centres and 8-hour clinics. Central hospitals and specialised hospitals are not available in some provinces. Where these institutions are available and have community service nurses allocated, their names were included in the tertiary hospitals of that province. A name of one designated public health institution was randomly selected from each category per sampled province. Five health institutions were sampled from each province, leading to a total of 20 health institutions. They comprised four 8-hour clinics, four 24-hour community health centres, four district hospitals, four regional hospitals and four tertiary hospitals.

Sampling of community service coordinator's offices

There is one community service coordinator's office per province. Each provincial community service coordinator's office in the sampled provinces formed part of the sample. The total offices were four.

3.3.9.3   Population and sampling for documents

The population for documents was the orientation/induction programmes of public health institutions in all nine provinces of South Africa. The sampling was purposive. Operational nurse mangers were requested to bring along the orientation/induction programmes as they come to the focus groups. The documents were found to be the same in institutions. The researcher ended up collecting documents per institution where the documents were the same in all the disciplines. Fourteen documents were collected.

3.3.10   Data collection

Data collection was concurrent, and integration of the results occurred during the interpretation phase (Gray 2010:204), when the researcher explained the convergence of the results. "In concurrently gathering both forms of data at the same time, the researcher seeks to compare both forms of data to search for congruent findings (e.g. how the themes identified in the qualitative data collection compare with the statistical results in the quantitative analysis)" (Creswell 2003:217).

In this study the newly qualified professional nurses who had recently completed community service described their experiences through the open-ended questions of the survey questionnaire. The coordinators of community service for nurses described in individual interviews the role that they played in the induction and professional development support of the newly qualified professional nurses. The operational nurse managers described their experiences of the induction and professional development support of the newly qualified professional nurses in focus groups.

Orientation/induction programmes were collected from various public health institutions for quantitative data analysis, using a checklist developed by the researcher from the literature.

Data collection was concurrent and not depending on the completion of one to proceed with data collection for the next. The researcher collected the orientation/induction documents and the focus groups data as and when the permission from the institution was given. Data was collected between February 2014 and May 2015. (See Annexure O for a sample of focus group transcript.) Obtaining provincial and institutional permission was a challenge in three of the four provinces. There were delays in the communication and response periods between the researcher and ethical committees of public health institutions. The challenges were surmounted through the proper use of gatekeepers and patience on the part of the researcher. See Annexures B, C, D, and E for provincial and institutional permission letters.

The eventual number of focus groups was determined by data saturation per province category (rural province or urban province). More focus groups could be added per province category until data saturation was reached.

3.3.10.1　Quantitative data collection and instruments

Quantitative data collection activities in this study could be summarised as: parallel collection of induction/orientation programmes, posting of survey questionnaires, getting poor response, re-planning; hand-delivering survey questionnaires to increase number of responses; and obtaining a response rate that could be used for descriptive and inferential statistics and data analysis (see Figure 3.3).
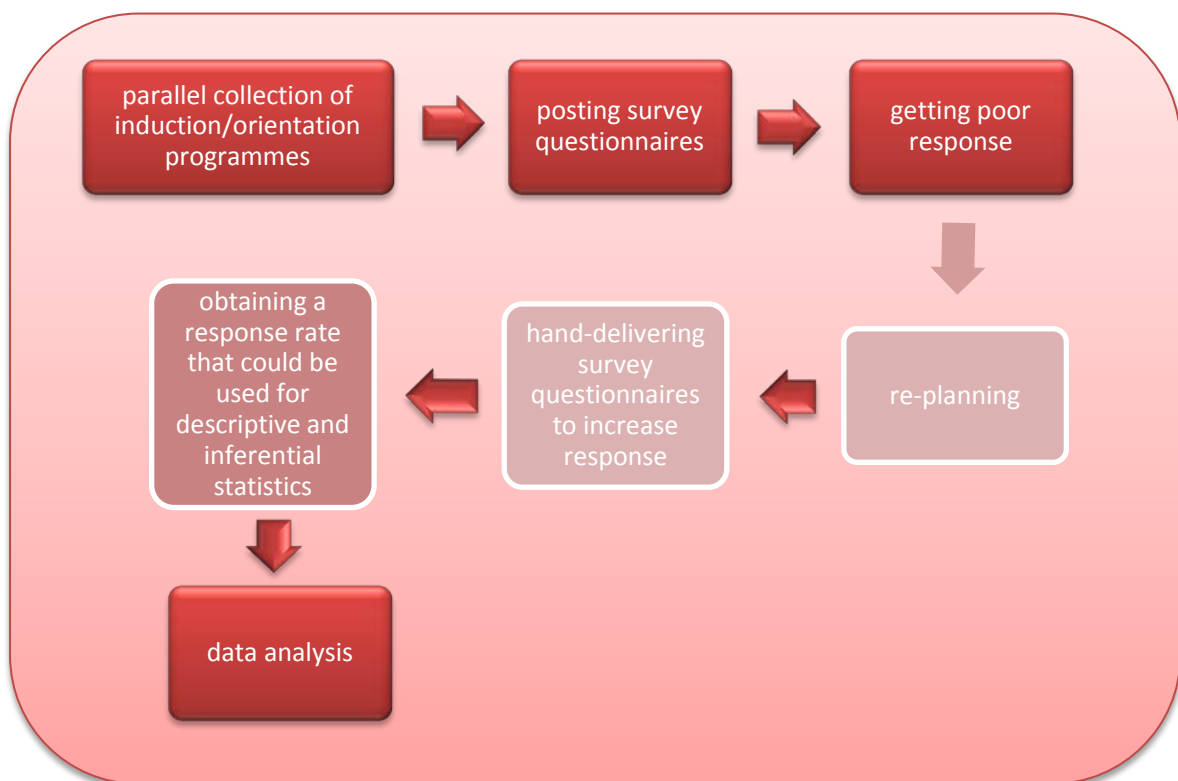
Figure 3.3:　Quantitative data collection activities

The survey

"A survey is an information-collection method used to describe, compare or explain individual and societal knowledge, feelings, values, preferences, and behaviour" (Fink 2009:1). A survey views things comprehensively and in detail in order to obtain data (Denscombe 2010:10; Fink 2009:1). One of the characteristics of a survey is that it has a wide and inclusive coverage, making large samples feasible. It is also used to describe the characteristics of a large group. The survey was essential for the study because of the large number of newly qualified professional nurses who had completed

community service, forming the population from which a sample was chosen to be included in the study. Surveys are flexible, in that many questions can be asked on a given topic (Babbie 2010:287).

The challenges of using a survey are that:

- They are not individualistic, but work on what the group says on a particular aspect.
- Sometimes people's views cannot be expressed within the limits of the options provided in a questionnaire (Babbie 2010:287).

The benefits that prompted the researcher to use the survey are that:

- The researcher could reach a large number of respondents from all the provinces of South Africa.
- The responses could be generalised over a large population of newly qualified professional nurses who completed community service from January 2013 to March 2015.
- Both quantitative and qualitative questions could be included in the questionnaire.
- The number of responses was large enough to allow performing of statistical analysis (Denscombe 2010:11).

A self-administered questionnaire was used to obtain data from the newly qualified professional nurses who had recently completed the compulsory community service. LoBiondo-Wood and Haber (2010:275) state that "a questionnaire is a paper-and-pencil instrument designed to gather data from individuals about knowledge, attitudes, beliefs and feelings". The researcher constructed a new questionnaire as there was no existing instrument to measure the concepts of this study. The researcher followed these steps of construction of a new instrument, according to LoBiondo-Wood and Haber (2010:280):

- Defining the concepts to be measured
- Clarifying the target population

- Developing the items
- Assessing the items for content validity
- Developing instructions for respondents and users
- Pretesting and pilot testing the items
- Estimating reliability and validity

The questionnaire comprised various sections collecting related data about different aspects of the phenomenon. The first section collected demographic data (age, gender, race, date of community service completion, category of community service institution, province of community service). The other sections collected descriptive data about the variables of the study. Open-ended questions yielding narrative responses and closed questions yielding fixed alternatives were asked. (See Annexure I for the survey questionnaire.)

Administering the SAQ

The questionnaire, information leaflet and consent form were posted to 350 respondents.

Two self-addressed and self-stamped envelopes were included in the package, for respondents to return the completed questionnaires and consent forms separately.

A follow up process of resending the questionnaires was put in place when there was a poor response. There was an extended post office strike and thus a poor response rate from the posted questionnaires. The researcher had to employ two research assistants, after the post office strike, to hand-deliver the questionnaires to newly qualified professional nurses meeting the criteria in order to increase the response rate. The sample size did not change.

A survey monkey is another option whereby the questionnaire could be sent to respondents as an internet link via email. Respondents click on the link to participate anonymously in the survey. The advantage of an email survey is that it is fast, economical and yields fast results (Denscombe 2010:14). The disadvantage is that respondents have to be linked to the internet to respond; not all respondents in this

study had access to both email and internet. Some had personal email access only from their work computer, where internet access was restricted to them.

The checklist used on collected documents

A checklist was used to obtain confirmatory data about the content of the induction programmes that the nurse managers brought to the focus groups. The checklist was developed from the literature about induction and professional development support of newly qualified professional nurses. (See Annexure T for the checklist.)

Pilot testing of the questionnaire

The questionnaire was pilot tested with 11 newly qualified professional nurses who had completed community service in 2012. The pilot testing was done to test how understandable the questionnaire was; to detect typing errors; to test the applicability of the time frame suggested and to test the questions for reliability using the Cronbach test. There were no corrections to be effected and all 33 questions passed the reliability test, with the Cronbach result being at 0.756, which is an acceptable level statistically, as it is higher than 0.7. The other 10 questions related to demographic data. (See Annexure J for the Cronbach test results.)

3.3.10.2 *Qualitative data collection and instruments*

Qualitatively, a descriptive phenomenology approach was used for the focus groups and interviews. Qualitative design focuses on participants' perspectives, their meanings and their multiple subjective views within their context or setting (Creswell 2013:46), presenting a complex holistic picture. The descriptive phenomenology approach stresses the description of human experiences (Polit & Beck 2012:496; Streubert-Speziale & Carpenter 2011:84). (See Annexures H and L for the focus group and interview guides.)

Phenomenology emphasises a phenomenon to be explored with a group of individuals who have all experienced the phenomenon (Creswell 2013:78). All the groups of participants in the study had experienced the induction and professional development support of newly qualified professional nurses, according to their different roles. The

newly qualified professional nurses were allocated to the public health institutions to serve the compulsory remunerated community service; they were supposed to be supported through induction and professional development to enhance their clinical competence, as well as to enhance their transition from student to professional nurse. All the sampled coordinators of community service for nurses had allocated the newly qualified professional nurses to the public health institutions, and had a strategic role to play in their induction and professional development support. The operational nurse managers were implementing the induction and professional development support to the newly qualified professional nurses serving community service in the public health institutions.

The researcher used the field notes she wrote immediately after the focus group discussions and interviews, together with those written by the research assistants, as supplementary texts to the audiotapes (Polit & Beck 2012:496).

Phenomenology is a valuable method for the study of phenomena relevant to nursing education, research and practice (Streubert-Speziale & Carpenter 2011:87). Streubert-Speziale and Carpenter (2011:87) also caution that a phenomenological researcher must have the ability to communicate clearly and to help participants feel comfortable while expressing their experiences. The qualities needed by the researcher are those that will permit access to data that is in the possession of the participants (Streubert-Speziale & Carpenter 2011:89).

Phenomenological method is a process of learning and constructing the meaning of human experiences through dialogue with persons who are living the experience (Creswell 2013:102). The interview and focus group guides were semi-structured but the researcher used probing to elicit more information from the participants. The researcher's own perspective should be bracketed (set aside) when using phenomenology as a method. These are the personal biases about the phenomenon. Bracketing researcher's biases enables the researcher to pursue issues of importance as introduced by participants, not leading the participants to issues the researcher deems important (Creswell 2013:104).

The researcher had previously worked at the SANC as a professional officer in the registration section of the provider affairs. At some stage, she was responsible for the

registration of the newly qualified professional nurses when they commenced and completed community service. She received a lot of enquiries from them regarding their induction and professional development support. She had to bracket that information during the interviews with the coordinators of community service and focus groups with the operational nurse managers. She did not interview the newly qualified professional nurses and rather asked them to air their views in the survey, without the researcher's probing, to prevent personal biases related to this previous work experience.

Semi-structured focus groups and interviews were used to collect part of the qualitative data, while the other data was collected through the survey. The researcher memorised the questions to minimise losing eye contact with the participants (Lobiondo-Wood & Haber 2010:168).

Focus groups

A focus group is a form of group interviewing in which there is interaction between participants (Onwuegbuzie, Leech & Collins 2010:711). This form of group interview is intended to exploit group dynamics. "This data collection strategy provides a forum for members of the focus group to explore a topic with each other. In nursing, focus groups have been used to explore a range of topics in clinical, education and management areas" (Streubert-Speziale & Carpenter 2011:38).

Focus groups have the ability to expose attitudes, feelings and beliefs that participants have about a given topic during their interaction. The researcher has to be focused, use the interview schedule effectively and control the group dynamics that might hinder the process. These might be dominant behaviour, silence on the part of some participants or when the group moves out of the topic (Dyson & Norrie 2010:32).

Focus groups are economical, because participants are interviewed in a group setting. The data can be collected faster at a lower economic cost to the researcher. Focus groups increase the number of participants in the study. They are a means to collect social data in a social environment. The interaction among participants can be identified through focus groups. They create an atmosphere where more responses can take place. Participants are likely to tell the truth in a group of people who have experienced the same phenomenon (Onwuegbuzie et al 2010:711).

Focus groups are usually conducted for one to two hours. The recommended size is six to twelve participants, so that the group is small enough for all members to talk and share their thoughts, and yet large enough to create a diverse group. Three to six focus group meetings should be held (Onwuegbuzie et al 2010:712).

To ascertain validity of information given during focus groups, the researcher has to pay careful attention to the composition of the group (using selection criteria) and interview across groups with similar experiences (Streubert-Speziale & Carpenter 2011:40). In this study the researcher adhered to the sampling criteria and politely excused nurse managers who did not meet the criteria from participating in the focus groups. The focus groups were conducted at various levels of the public health institutions in four provinces until data saturation was reached per province. Saturation refers to the repetition of discovered information and confirmation of previously collected data (Streubert-Speziale & Carpenter 2011:30). The researcher reached information saturation after three focus groups per province.

A semi-structured focus group guide was used to collect data during the focus group discussions. Probing was done to clarify and validate information. Focus groups of at the most eight members per group were conducted with the operational nurse managers of the sampled public health institutions at an agreed-upon venue, to elicit textual and structural descriptions of their experiences as well as to provide an understanding of their common experiences (Creswell 2013:81). The researcher asked questions, observed the participants and took notes immediately after the interviews and focus group discussions. The assistant handled the audio recording and additional note-taking for comparison at a later stage. Data regarding those who did not agree (argumentative interactions) was included to increase the chances of obtaining rich data.

The focus groups were conducted in English, lasting on average for an hour. Streubert-Speziale and Carpenter (2011:38) support the focus group as an ideal data collection strategy in nursing management when the topic of enquiry is sensitive. In this study the focus group was used to elicit the experiences of the operational nurse managers on giving induction and professional development support to newly qualified professional nurses serving compulsory community service.

Individual interviews

A qualitative interview is a method of data collection in which the researcher asks the participants to answer open-ended questions (LoBiondo-Wood & Haber 2010:275). The authors explain that interviews are used to clarify the task for the respondent or to obtain more personal data from the respondent. In this study the interviews were used to obtain more personal data from coordinators of community service for nurses regarding their role in the provision of induction and professional development support to the newly qualified professional nurses that they placed at public health institutions to serve the compulsory remunerated community service.

The interviews conducted were semi-structured. A semi-structured interview is more flexible. Accessing of closely held information will only occur if there is mutual trust and respect between researcher and informant. Otherwise, interviewees may choose to disclose only what they think is socially acceptable (Streubert-Speziale & Carpenter 2011:34). Streubert-Speziale and Carpenter (2011) add that some of the ways to reduce the risk of obtaining socially acceptable answers are building trusting relationships, triangulating and saturating data (Streubert-Speziale & Carpenter 2011:35). The researcher respected the participants at all times. She kept appointments and respected time schedules. She allowed the participants to ask questions and answered their questions after explaining the purpose of the study and other logistics even though they had been given information leaflets about the study. This was done to build trusting relationship between the researcher and the participants. Consent was obtained in writing without any coercion. Those who declined to participate were treated as politely as other participants. Their questions were answered with a positive attitude although they were not participating in the research.

The individual interviews with the provincial coordinators of community service for nurses were conducted at each coordinator's office or an agreed-upon venue. A semi-structured interview schedule was used. Questions were descriptive and exploratory. According to Dyson and Norrie (2010:30), an interview schedule is a necessary forward-planning method to ensure the effective use of time and that the collected data is meaningful as well as appropriate for the study (Dyson & Norrie 2010:31). The interviews were conducted in English and lasted on average for thirty minutes.

The researcher used high-quality digital recorders for audio-recording information during focus groups and interviews. The two digital recorders served as backup to each other in the field to ensure that the researcher would have a properly recorded focus group/interview. At the end of the focus group/interview, the researcher saved the best recording (in terms of audibility) onto the computer file in addition to the audiotapes. She developed backup copies of computer files and kept a list of types of information gathered during data collection. For storing data, documents were stored in folders which were named appropriately (Lobiondo-Wood & Haber 2010:175). Focus groups and interviews were later transcribed verbatim. There was no need for translation of the original narratives as the data was collected in English.

Two field workers were employed as research assistants. One field worker was used at a time to set up the audiotapes and ensure that they were recording. He assisted participants to fill in the consent forms after information was given, took field notes and observed the participants during the focus groups and interviews. Field notes are explained as a short summary of observations made during data collection, representing a narrative set of written notes intended to paint a picture of a social situation in a more general way (LoBiondo-Wood & Haber 2010:272).

The field worker assisted in obtaining consent from participants. He was also responsible for avoiding distractions such as noise and redirection of unintentional intruders during the focus group and interviews. The venues for the focus groups and interviews were either a boardroom or an empty office at the public health institution, depending on what was available upon request. The researcher had planned for a conducive environment by specifying what would be needed from the public health institution during institutional permission requests; but disruptions were inevitable in some cases; thus the two audiotapes and the field worker rescued such situations.

Data saturation is the situation of obtaining the full range of themes from the participants, to the extent that no new data will emerge when interviewing additional participants (Creswell 2013:105). In this study data saturation was reached after three focus groups per province in three of the provinces; in one of the largely urban provinces data saturation was reached after three focus groups and an interview with one operational nurse manager (12 focus groups + 1 interview). Regarding the interviews, data saturation was reached after four individual interviews.

Qualitative data collection activities in this study can be summarised as follows:

- Purposefully sampling sites and participants
- Gaining access and establishing rapport
- Obtaining institutional consent and resolving field issues
- Obtaining individuals' consent
- Collecting data (recording and writing notes)
- Creating computer files to store data
- Doing provisional data analysis by listening to the tapes to determine data saturation or the need to continue with data collection (Creswell 2013:146). (See Figure 3.4 for the qualitative data collection activities.)
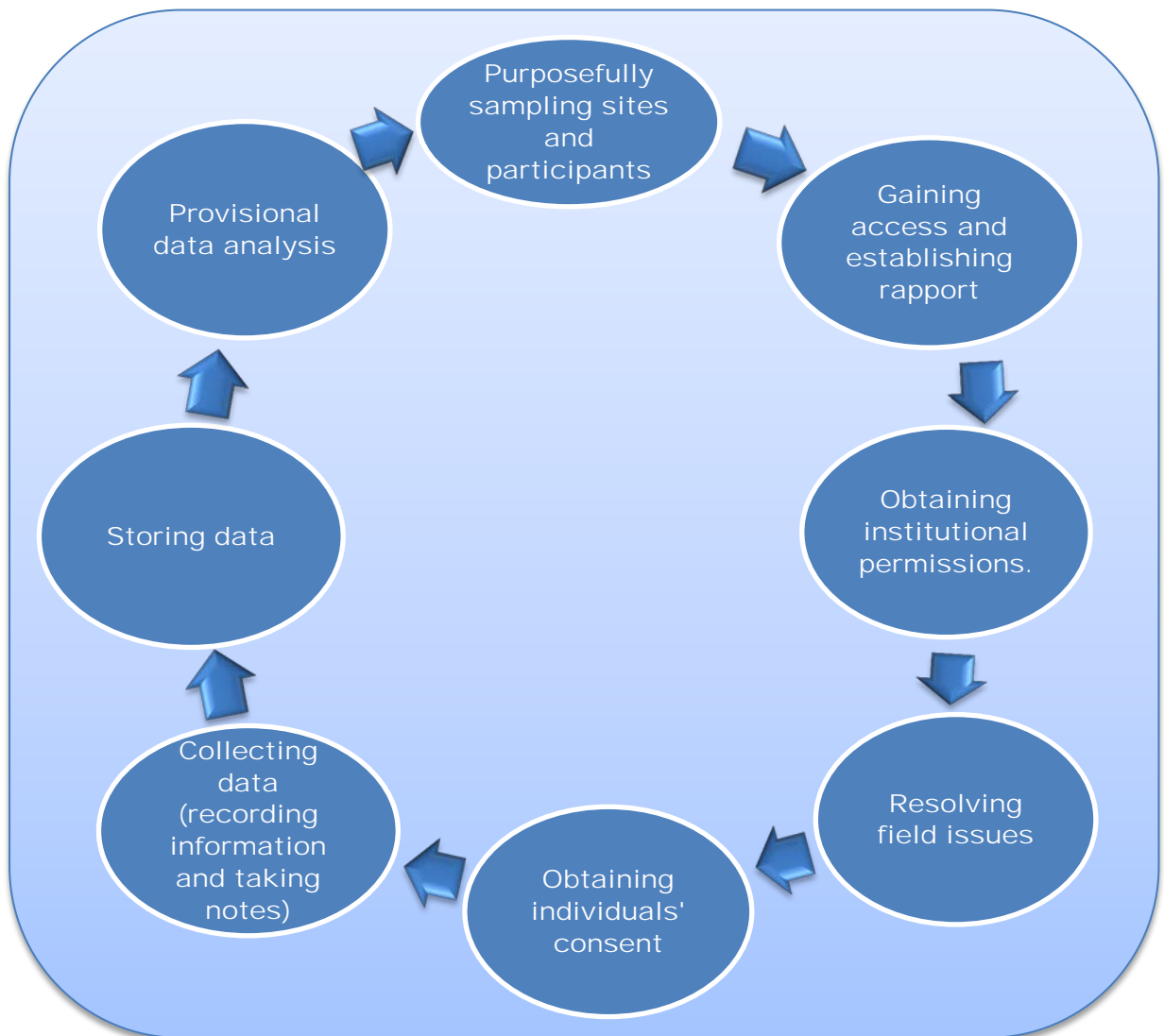
Figure 3.4: Qualitative data collection activities

(Source: Modified from Creswell 2013:146)

Pilot testing of interview and focus group guides

Pilot testing was done to refine the interview and focus group questions and the procedures. Two interviews and two focus groups were held with operational nurse managers to test the guides. The focus group guide had to be refined to accommodate the time frame. The researcher learned to control group dynamics and to probe effectively where information needed to be clarified. There were no changes necessary for the interview guide.

3.3.11   Data management and analysis procedures

"Data analysis is a systematic search for meaning" (Leech & Onwuegbuzie 2007:564). The researcher used the equal-status concurrent multiple mixed analysis: QUAN+QUAL (Onwuegbuzie, Slate, Leech & Collins 2007:8). Mixed analysis is the term used for analysing data in mixed research (Onwuegbuzie & Combs 2011:2). When quantitative and qualitative analytical techniques are utilised concurrently (concurrent mixed analysis), results stemming from one data analysis phase (e.g. quantitative analysis) do not inform the results stemming from the other phase (e.g. qualitative) (Onwuegbuzie et al 2007:5).

The survey consisted of closed and open-ended questions to collect both quantitative and qualitative data. This is permissible in concurrent mixed methods research design (Onwuegbuzie et al 2007:5). Some of the quantitative data were collected from documents (induction and orientation programmes). Focus groups and interviews were conducted to collect more of the qualitative data.

Onwuegbuzie et al (2007) describe the following steps for mixed analysis (Onwuegbuzie et al 2007:12):

- **Data reduction:** quantitatively through descriptive and inferential statistics, with data display through visual data description in tables and graphs; qualitatively via interim analysis, thematic analysis and memoing with data display through visual data description in tables, graphs, charts, matrices and networks.
- **Data transformation**: qualifying quantitative data or quantifying qualitative data (This was not significant for this study).

- **Data correlation:** (not applicable to this study because there was no transformation of data in this study).

- **Data consolidation:** combining of both data sets (not applicable to this study as separate analysis was done per data set).

- **Data comparison:** comparing findings from both quantitative and qualitative data analyses.

- **Data integration:** integrating both qualitative and quantitative findings to make a coherent whole.

In convergent designs (also referred to as concurrent design), qualitative and quantitative data are analysed separately and then merged at interpretation (Fetters, Curry & Creswell 2013:2137). The purpose of the mixed analysis in this study was to achieve complementarity and triangulation. The applicable steps in the mixed analysis were data reduction, data comparison and data integration.

The triangulation process leads to researchers

- Developing creative ways of collecting data
- Obtaining thicker, richer data
- Being more confident of the interpretation of the results
- Obtaining convergence of findings
- Elaborating analysis to provide richer data (Streubert-Speziale & Carpenter 2011:74)
- Being more certain of their findings
- Developing enterprising ways of collecting data
- Unravelling contradictions

The more sources one examines, the more likely one is to gain an adequate representation of the underlying phenomenon (LoBiondo-Wood & Haber 2010:272). The researcher conducted separate analyses of the qualitative and quantitative data. For the quantitative analysis, the researcher used a checklist for content analysis of the documents, calculated descriptive statistics, mean scores and standard deviations across the groups; these are described in Chapter 4. The qualitative data was analysed using procedures of theme development specific to phenomenology (Creswell 2013:79).

Themes, sub-themes and codes were obtained. Qualitative analyses are described in Chapter 5. Triangulation of results occurred in Chapter 6, where the themes and concepts of the research findings from the quantitative and qualitative methods were compared, contrasted and supported with literature.

3.3.11.1   Quantitative data management and analysis procedures

Data management

Quantitatively, a checklist was used to obtain confirmatory data about the content of the induction programmes that the nurse managers brought to the focus groups. A self-administered questionnaire was used in the survey to collect data from the newly qualified professional nurses who had recently completed community service.

Data handling and storage

The hard copies of induction and orientation programmes were filed in an arch lever file as they were received from the public health institutions. The returned questionnaires were put in a box with a lid for safekeeping in the researcher's office and the box was locked in a cupboard.

Data analysis

A document analysis checklist was used for content analysis of the induction programmes. Data analysis of the survey was done using the statistical package for social sciences (SPSS) version 23. The following descriptive statistics were used to describe and synthesise data (Polit & Beck 2012:379):

Frequency distributions

These arranged the values from lowest to highest and were used to develop pie charts, bar diagrams and frequency columns as directed by the obtained values. The demographic data of the newly qualified professional nurses was analysed into frequencies and displayed in pie charts, bar diagrams and frequency columns.

Central tendency

This was used to obtain the mode, the median and the mean values for comparison of scores where possible. Inferential statistics obtained when groups of newly qualified professional nurses were clustered were displayed in tables.

Variability

This was used to obtain the range, standard deviation, contingency (crosstabs) tables, as well as correlation, to contrast and describe the relationships between variables. Inferential statistics were used to provide a means for drawing conclusions with the given data from the sample (Gray 2009:485; Polit & Beck 2012:404).

Correlations

Correlations were tested and results were displayed using tables.

3.3.11.2 *Qualitative data management and analysis procedures*

Data analysis during data collection

Ezzy (2002) states that if you have been collecting your data carefully, you have already begun to analyse the data, establishing what you are interested in and what issues those data have raised (Ezzy 2002:60). The author argues that if data analysis can begin only after all data have been collected, the researcher will have missed many valuable opportunities that can be taken only at the same time as data collection. Integrating data collection and data analysis builds on the strengths of the qualitative method as an inductive method for building theory and interpretation from the perspective of the people being studied. It allows the analysis to be shaped by the participants in a more fundamental way than if analysis is left until after the data collection has been finished (Ezzy 2002:61).

The researcher and the research assistants listened to the audio tapes after each focus group or individual interview to assess for audibility and to start with the preliminary analysis. This was done to immerse themselves in the data, to discern if the participants

were giving relevant information and to assess for saturation of preliminary concepts, codes and themes.

Data handling and storage

Focus groups and the interviews were audio recorded, field notes were filed and kept in a locker at the researcher's office. A backup of the recorded interviews was done immediately after recording by using an external hard drive with coded file access. This was done to prevent unpredicted loss of recorded interviews and to ensure confidentiality through controlled access to data.

Data analysis procedures

Streubert-Speziale and Carpenter (2011) advocate that "researchers must become deeply immersed in the data. They have to commit fully to a structured analytic process to gain an understanding of what the data convey. This requires a significant degree of dedication to reading, intuiting, analysing, synthesising and reporting the discoveries" (Streubert-Speziale & Carpenter 2011:45). They also state that, "as a neophyte qualitative researcher, interaction with an experienced researcher is the best way to become comfortable with data analysis" (Streubert-Speziale & Carpenter 2011:45). The researcher consulted with the promoter at all the levels of the analysis for guidance and support.

Phenomenological analysing involves identifying the essence of the phenomenon under investigation based on data obtained and how the data is presented (Streubert-Speziale & Carpenter 2011:81). In phenomenology there are specific structured methods of analysis. In this study the Stevick-Colaizzi-Keen method was used. This method was also advanced by Moustakas (1994) and later by Creswell. The method provides a most practical and useful approach to data analysis (Creswell 2013:193). The method comprises the following steps:

Data organisation: Creation and organisation of data files. The researcher made verbatim transcriptions of audio recordings, creating computer files for analysis using tables in a Word document which is part of the Office computer program.

Reading/memoing: Reading through text, making margin notes and forming initial codes.

Describing the data into codes and themes: Describing the essence of the phenomenon. The researcher described, classified and interpreted data into codes and themes. Coding involves aggregating the text into small categories of information (Saldana 2009:184); whereas themes are broad units of information that consist of several codes aggregated to form a common idea (Saldana 2009:186). (See Annexure N for the sample of the coded data.)

Classifying the data into codes and themes: Developing significant statements and group statements into meaningful units. The researcher kept a code list to comply with this step. Saldana (2009) states that the researcher should keep a record of the emergent codes in a separate file as a code book comprising the compiled codes, their content descriptions and a brief data example for reference (Saldana 2009:21).

Interpreting the data: Developing a textural description of "what happened". The researcher developed a structural description of how the phenomenon was experienced; for example how the newly qualified professional nurses were supported/not supported during community service. Interpretation involves abstracting beyond the codes and themes to get to the larger meaning of the data (Saldana 2009:187). The researcher created a visual image of what was found in the text, using figures (pie charts, bar diagrams and descriptive columns) and tables, in Chapter 4; and tables (displaying themes and codes) in Chapter 5. Bazeley (2009) states that qualitative researchers should not rely only on the presentation of key themes supported by quotes from participants' text as the primary form of analysis and reporting of their data. They should also include strategies such as: improving interpretation and naming of categories or themes; using divergent views and negative cases to challenge generalisations; returning to substantive, theoretical or methodological literature; creating displays using matrices, graphs, flow charts and models, and using writing itself to prompt deeper thinking (Bazeley 2009:6). Findings were compared, contrasted and supported with literature in Chapter 6.

Developing the "essence": Giving the overall picture of the outcomes/findings. Integration was achieved through interpretation and reporting procedures. The

researcher used the weaving approach when integrating the findings at interpretation and reporting level. "The weaving approach involves writing both qualitative and quantitative findings together on a theme-by-theme or concept-by-concept basis". (Creswell 2013:2142). The researcher integrated and described the research findings from chapters 4 and 5, writing them down in concepts and themes to accommodate both quantitative concepts and qualitative themes in Chapter 6.

Representing/visualising the data: Presenting the narration of the findings in tables, figures or discussion. Chapter 6 provided the narration of the integrated research findings.

3.3.12   *Approaches to integration*

The quantitative and qualitative data results were mixed during interpretation of the findings, after both sets of data had been collected and analysed (Creswell & Clark 2011: 67). The results from the qualitative and quantitative data were integrated using a joint display. The researcher followed with a narrative approach that described the qualitative and quantitative results thematically (weaving) (Creswell 2013:2150). The researcher interpreted to what extent and in what ways the two sets of results converged, diverged from one another, related to one another and/or combined to create a better understanding in response to the study's overall purpose (Creswell 2013:78).

Methodological triangulation

This is when two or more research methods are incorporated into one investigation, at the level of either design or data collection. This research study employed methodological triangulation at the design level, with concurrent data collection (Streubert-Speziale & Carpenter 2011:354).

Data triangulation

This is when researchers include more than one source of data in a single investigation. The types of data triangulation are: time, space and person. In this study person triangulation was used. This entails collecting data from more than one level of person,

a set of individuals, groups or collectives. Various levels of persons relevant to the study were used to validate data between the levels (Streubert-Speziale & Carpenter 2011:353). Levels of persons used were: newly qualified professional nurses, operational nurse managers and coordinators of community service for nurses. Explicitly looking for disagreements between findings from different methods is an important part of the triangulation process (O'Cathain, Murphy & Nicholl 2010:1147).

The integration is illustrated in Figure 3.5, adapted from Creswell and Clark (2011:69).
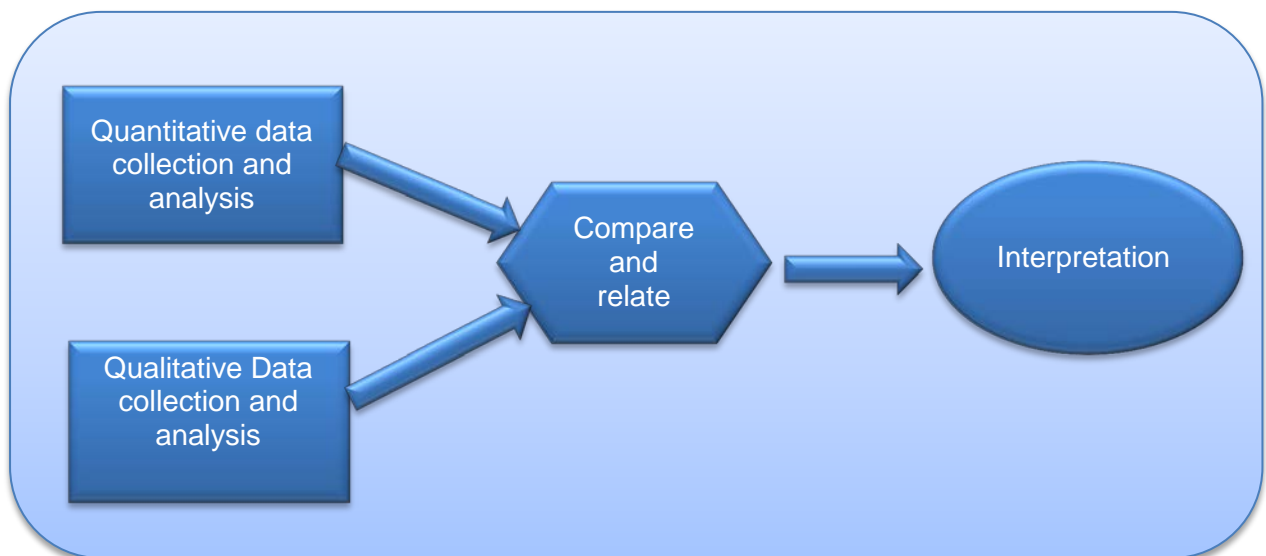
Figure 3.5: Illustration of the convergent design

(Source: adapted from Creswell & Clark 2011:69)

3.4   DATA AND DESIGN QUALITY

3.4.1 Quantitative research

Validity

This refers to testing whether the methods really measure the concepts that they are said to be measuring (soundness of the study's evidence). The pilot testing of the questionnaire enhanced its validity. The researcher was able to get information about the time needed for taking the questionnaire, concepts were clarified to give meaning and the structure of the questionnaire was modified according to the report. There were no typology errors found.

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Internal validity

The sampling methods were comprehensive to prevent selection bias. Site and people data sources have been discussed in detail under the sampling topic.

External validity

The research methodology has been explained and recorded accurately to allow other researchers to follow it if needed for other similar research in future.

Data gathering instrument

Instrument fidelity

This is the instrument's consistency in measuring the target attribute (Polit & Beck 2012:331). The researcher conducted a pilot test to assess the appropriateness of the created instrument (Collins et al 2006:77).

The survey questionnaire was pilot tested with a group of 11 newly qualified professional nurses who ultimately did not form part of the study because they had completed community service in 2012, and were relevant to participate in 2013 when the questionnaire was formulated. The pilot testing was done to assess the ease of taking the survey and for detection of wording errors or other structural problems. The Cronbach Alpha test was also done to increase the validity of the questions asked. The questionnaire was sent as part of an email to five participants with email addresses and sent by post to the ten who did not have access to emails.

Reliability

Strategies to enhance reliability

Reliability was enhanced by employing assistant researchers to hand deliver the survey questionnaires in order to increase the response rate from the initial 10 percent from the postal delivery to the 35 percent achieved after hand delivery and collection of questionnaires.

Triangulation involves the use of multiple and different methods, investigators and sources to obtain corroborating evidence (Creswell 2013:239). The researcher used multiple sampling methods for the sites and participants, employed assistant researchers, and used quantitative and qualitative methods of data collection and analysis. These provided corroborating evidence and prevented systematic biases that can occur when utilising a specific method. Triangulation also provided the researcher with ways of providing credibility of findings by collecting rich and thick data (Creswell 2013:244).

As regards leaving an audit trail: the researcher maintained an extensive documentation of records and data obtained during the study as follows:.

Availability of raw data (filled questionnaires and induction/orientation documents): questionnaires from the survey respondents were filed and kept safe.

Data reduction and analysis products (statistical information): the researcher kept the files on statistical data analysis from the induction/orientation programmes, including those from the statistician.

Data reconstruction and synthesis products: data analysis files, descriptions of results, interpretations and final reports have been stored as coded computer files with backup files.

Materials related to intentions and dispositions: research proposal, ethical clearance certificate, permission requests, permission from the SANC, provincial departments of health, public health institutions and district health offices are available and some documents are included in the report as annexures.

Instrument development information: pilot forms and preliminary schedules have been filed safely for ease of reference when applicable (Creswell 2013:240).

Representativeness relates to both internal and external generalisability, which can be lacking when the number of respondents is inadequate (meaning there is too little data to run inferential statistics) or when non-representative respondents are sampled

(Creswell 2013:241). Representativeness in this study was improved by the researcher's increasing the number of responses when the filled posted questionnaires received were very minimal (38 received out of 350 posted). The researcher than hand delivered 312 questionnaires to the newly qualified professional nurses who had recently completed community service in various public health institutions. The response improved; 86 responses were received, raising the responses to 124. The number of participants ended up being 112 because 12 responses were from participants who did not meet the criteria. They were either still on community service or had completed community service too long before.

Peer debriefing provides an external evaluation of the research process and also serves as an inter-rater of reliability, though logically based (Creswell 2013:244). The promoter and critical readers appointed by the researcher played the "devil's advocate" on separate instances. The critical readers were asked by the researcher to critique the work done, evaluate the progress made and suggest the way forward. The promoter provided such feedback formally during her supervision of the study. The promoter strove to keep the researcher "honest", posing difficult questions about the procedures, meanings, interpretations and conclusions. The critical readers also provided the researcher with the opportunity for "catharsis" by being empathetic with the researcher (Creswell 2013:244).

3.4.2 Qualitative research

Trustworthiness indicates the reliability and validity of the qualitative research method.

Methodological rigour in qualitative research needs to answer questions about the following: truth value (credibility), applicability, consistency and confirmability.

Credibility

This represents the truth of the data and the researcher's interpretations (Streubert-Speziale & Carpenter 2011:406):

Truth value (credibility), addresses the authenticity of the data and is equivalent to internal validity. The question to be asked is do the findings of the study 'make sense' to the people being studied? Actions to be taken to support truth value include: the iterative process of data collection being guided by simultaneous data analysis, validation of key points at the end of each interview and presentation back to the original participants to insure accurate depictions of their experiences.

Credibility is enhanced when the readers can identify with the experience (Mooney 2007:76). In this study there was prolonged engagement with the participants during the focus groups and interviews to elicit adequate data. Constant respondent validation to solicit their views about the credibility of the data and the researcher's interpretations was done during data collection (Creswell 2013:252). Member checking could be done to some extent. The researcher verified the correctness of the information with the participants during the interview, at the end of the interview and after the researcher had listened to the audio tape, performing preliminary analysis in the evening. The researcher called one or two members of the focus group telephonically the following morning, to verify and expand her field notes. This was done to clarify information and to validate the correctness of the information. The researcher ensured that she was in context at all times during the focus groups and interviews, by allowing only discussions about the phenomena being studied. Focus groups and interviews were recorded to maximise credibility. Field notes were taken to reduce the loss of important information. The participants' body language was observed for nonverbal cues during the focus groups and interviews.

The recorded focus groups and interviews were transcribed verbatim to ensure that correct data analysis was done, as well as to ensure no information was missed during the analysis. The findings of the study were reported accurately to enhance accurate interpretation of the research report by readers. The study promoter acted as an auditor, providing expert critique concerning decisions made throughout the study, as advised by Andrew and Halcomb (2009:127).

Peer review: the promoter kept on asking hard questions about the methods, meanings and interpretations to keep the researcher honest. She did not simply accept any information provided by the researcher during consultations. The researcher had to read extensively to be able to defend the methods employed in the study. The researcher

had to consult with the promoter before and after every data collection session, from one province to the other and when collecting different forms of data. The consultations served as debriefing sessions, as the promoter allowed the researcher to talk about her feelings and frustrations encountered at the field, while also providing an external check of the research process (Creswell 2013:251).

It was not feasible for the researcher to go back to the original participants to do actual member checking over and above the one done during preliminary analysis telephonically a day after data collection. However, the researcher explained the process of sampling, data collection and analysis to the participants during data collection. The researcher also presented the sampling, data collection methods, analyses, interpretations, findings and conclusions to an audience of newly qualified professional nurses, experienced professional nurses, operational nurse managers and other researchers, at a national nurses' research day as well as at two international conferences to elicit the views of the delegates on the process before the study was finalised. This process provided the researcher with information on whether the research process was on track, and whether they concurred with the information presented or could point out what was missing (Creswell 2013:252).

Credibility may be internal or external. Internal credibility can be defined as the truth value, applicability, consistency, neutrality, dependability and/or credibility of interpretations and conclusions within the underlying setting or group (Onwuegbuzie & Leech 2007:234).

Factors affecting internal credibility in qualitative research

Theoretical validity, which "represents the degree to which a theoretical explanation obtained/developed from research findings fits the data, is thus credible, trustworthy and defensible" (Onwuegbuzie & Leech 2007:235). Theoretical validity was not applicable to this study.

Observation bias, which "arises at the research design/data collection stage when the data collectors have obtained insufficient sampling of behaviors or words from the study participants" (Onwuegbuzie & Leech 2007:235). In this study there was extensive sampling (four provinces for qualitative data and a sample of 350 newly qualified

professional nurses for the survey from all provinces) to prevent observational bias. Prolonged engagement was also done. The researcher collected all the qualitative data by herself, assisted in note taking and audio recording by the assistant researcher. There was no time where the researcher spent time away from the data collection sites during data collection (going native) (Onwuegbuzie & Leech 2007:242).

Ability of the researcher to travel and collect data from all the sites in the various provinces was possible because the researcher had obtained study leave and finances to get a replacement lecturer at her place of work for the duration of the study period, as well as for other research-related expenses. Financial aid was provided through a grant from the institution's Qualifications Improvement Programme (AQIP) and the National Research Foundation of South Africa (NRF).

Researcher bias. Clarifying researcher bias from the outset of the study is important, so that the reader understands the researcher's position and any biases or assumptions that might influence the inquiry. In this clarification, the researcher comments on past experiences, biases, prejudices and orientations that have possibly shaped the interpretation and approach to the study (Creswell 2013:251).

"Researcher bias occurs when the researcher has personal biases or *a priori* assumptions that he/she is unable to bracket" (Onwuegbuzie & Leech 2007:236). The bias can be transferred to the participants such that their behaviour, attitudes or experiences are affected. The researcher had never supervised newly qualified professional nurses on community service during her previous employment as a professional nurse. Community service was promulgated by the Government of South Africa in 2008, long after the researcher had left nursing practice for nursing education in 1997 (SANC 2007:1). During data collection, the researcher avoided mannerisms or statements that could influence the participants' behaviour. She listened intently and probed where necessary to clarify provided information. All data were recorded and transcribed, irrespective of whether the focus group or interview would yield valuable concepts, codes or themes. The researcher and the assistant did not know the participants prior to data collection.

Researcher bias was also prevented by making contrasts/comparisons through the multisite data collection (Onwuegbuzie & Leech 2007:242). Data was collected from

public health institutions with all levels represented, in largely rural and largely urban provinces.

Reactivity. This refers to "changes in a person's responses that result from being cognisant of the fact that one is participating in a research investigation and is being observed" (Onwuegbuzie & Leech 2007:236). The researcher managed to prevent reactivity by using focus groups and a self-reporting questionnaire. The operational nurse managers gave information as part of a group. The researcher facilitated the focus groups while the assistant recorded the conversations and took notes. The debates were very active and the participants sometimes mentioned that they had forgotten that she was conducting research. Most were very eager to voice their experiences, looking forward to an improvement in the professional development support offered to newly qualified professional nurses.

The other group members would also realise if someone was not being themselves as they had all experienced the support of the newly qualified professional nurses in the public health institutions. To prevent reactivity further, the researcher did not allow participation by other members who did not meet the inclusion criteria: other nursing managers or those who refused to participate were not allowed to sit in during the focus groups. The researcher promised the participants anonymity and confidentiality, and also requested members to keep information confidential outside the group. The newly qualified professional nurses wrote their responses to the open-ended questions at their leisure, not being observed by the researcher and or assistant.

Factors affecting external credibility in qualitative research

Investigation validity, which refers to quality of craftsmanship, regarding which validity is the researcher's quality control. "Accordingly validity is not only about the methods used, but also of the researcher's personality traits, including her or his ethicalness" (Onwuegbuzie & Leech 2007:238).

The researcher acted ethically in all aspects and also observed all ethical principles. An audit trail of all the research methods can be provided; some are included as annexures to the thesis. For example, institutional permission letters are provided as annexures, while individual consent forms are being kept in a locked cupboard, to be disposed of

accordingly after five years of the study. The signed consent forms were scanned and translated into pdf documents. Verbatim transcriptions, transcriptions with codes and preliminary themes, as well as tables of codes and themes, are kept as computer files and saved in the researcher's computer and backup systems (emails to the researcher and friend, external hard drive).

Interpretive validity, which "refers to the extent to which a researcher's interpretation of an account represents an understanding of the perspectives of the group under study and the meanings attached to their words and actions" (Onwuegbuzie & Leech 2007:238). The researcher summarised what the participants had said and confirmed with them during the focus groups and interviews, to ensure that the participants' perspectives were captured and interpreted correctly. Probing was also done during the focus groups and interviews to clarify information or to expand on a perspective. Member checking was done to some extent, when the researcher called some of the participants to verify the information after the preliminary analysis. This happened the following day after the interview or focus group, while the information was still fresh in the participant's mind.

Increasing legitimacy

Prolonged engagement involves "conducting a study for a sufficient period of time to obtain an adequate representation of the 'voice' under study" (Onwuegbuzie & Leech 2007:239). The qualitative data was collected over a period of 15 months (February 2014 to May 2015). This period allowed the researcher to engage with the study, build trust with gatekeepers, understand the health institutions' policies and comply with the requirements as set out in the given permission. The researcher engaged with the participants earlier than the interview or focus group hour, to greet them, build rapport and briefly explain the study to them. This period allowed members to agree or refuse to participate in the study but still have information about the study. The researcher was also able to ascertain that the participants met the set criteria. The focus groups and interviews were conducted over four provinces, two largely rural and two largely urban provinces. Participants were from all the levels of public health institutions in each of the four provinces. This provided enough scope for the study.

Persistent observation

This was done to identify characteristics, attributes and traits relevant to obtaining information about the professional development support given to newly qualified professional nurses in each public health institution. The researcher observed the environment, organisational culture, the mode of communication between relevant stakeholders, observation of timeframes by gatekeepers and actual traits of participants during the data collection. Creswell (2013) states that "Prolonged engagement and persistent observation in the field include building trust with participants, learning the culture and checking for misinformation that stems from distortions introduced by the researcher or informants" (Creswell 2013:250). In the field, the researcher makes decisions about what is salient to the study, relevant to the purpose of the study and of interest for focus.

The observations before and during the interaction with the participants provided depth, so that the researcher could distinguish between relevant and irrelevant observations (Onwuegbuzie & Leech 2007:239). For example, the interactions between members of a particular public health institution differed from those of another according to the organisational culture of each. Some organisations were calm and quiet; the same mood would translate to the focus group. Others were loud and cheerful; then the interactions within the group would take on the same tone. In instances where the mood in the focus group did not correspond to the one observed while waiting or passing through the passages to get to the venue, the researcher could observe the uneasiness of the group members and had to remind them of the ground rules: confidentiality of information and the right to withdraw from the group without incurring any penalty. In one such instance the researcher discovered that a senior manager was among the group and participants did not feel free to participate. After that observation the senior manager was reminded of the inclusion criteria and was politely requested to leave the group. The group dynamics changed to those of the observed culture of the organisation.

Significance enhancement

Significance enhancement represents mixing quantitative and qualitative techniques to enhance the researcher's interpretation of data (Collins et al 2006:83). This was done

by comparing results from the quantitative data with the qualitative findings (triangulation). According to Polit and Beck (2012), "triangulation of results is done to support or refute results of either quantitative or qualitative method. This is also done to enhance the validity of the conclusions" (Polit & Beck 2012:175). The researcher used multiple, different sources and methods to produce corroborating evidence and to shed light on the induction and professional development support of the newly qualified professional nurses as a phenomenon being studied.

Dependability

Consistency (fit) means that the process of the study has been reasonably stable over time and across researchers and methods (Polit & Beck 2012:175). "Consistency can be achieved through close adherence to the methods, sampling, reviewing transcriptions to refine probes, and reviewing audio tapes to insure interview technique consistency" (Streubert-Speziale & Carpenter 2011:406).

The researcher developed a semi-structured interview guide whose questions had been checked for reliability by the study promoter, peers and field experts. Mock interviews were conducted with peers to enhance dependability. The focus groups and interviews were audio-recorded, field notes kept and a backup of the recordings was made using an external hard drive with coded file access. This was done to prevent unpredicted loss of recordings and to ensure confidentiality through controlled access to data. The researcher recorded clearly and explicitly during the study to offer readers an audit trail that can be examined.

Confirmability

Confirmability (applicability) "is the degree to which study results are derived from characteristics of participants and the study context, not from the researcher's biases" (Polit & Beck 2012:175). It refers to neutrality and replicability of the study demonstrated through memos, detailed records of the study's methods, documentation and tracking of meeting minutes by the principal investigator and research team. These sources will provide an audit trail for identification of potential biases and tracking of coding decisions.

The focus groups and interviews were audio recorded and transcription was verbatim. Field notes were kept and member checking was done after the preliminary analysis to confirm information.

External audits take place when the researcher allows an external consultant, or the auditor, to examine both the process (methods) and the product of the account for accuracy. The auditor should have no connection with the study. In assessing the product, the auditor examines whether or not the findings, interpretations and conclusions are supported by the data (Creswell 2013:252). The researcher consulted with experts in mixed methods research to act as critical readers of the report, to enhance confirmability. Neither expert was part of the research study.

Transferability

Transferability (generalisability) is the extent to which qualitative findings can be transferred to other settings as an aspect of a study's trustworthiness (Polit & Beck 2012:180). It "refers to whether the conclusions of the study have any further import or generalisability to other contexts or groups" (Streubert-Speziale & Carpenter 2011:406).

Rich, thick descriptions mean that "the researcher provides details when describing a case or when writing about a theme (Creswell 2013:253). Thick description allows the readers to make decisions regarding transferability because the writer describes in detail the participants or setting under study. With such detailed description, the researcher enables readers to transfer information to other settings and to determine whether the findings can be transferred "because of shared characteristics".

In this study, it was envisaged that findings would be applicable to newly qualified professional nurses other than those studied. The researcher provided detailed information in the introduction, background and problem statement to provide the reader with discernible information. The descriptive data collected were described in rich, thick descriptions to allow the reader to evaluate the applicability of the data to other contexts.

3.5   ETHICAL CONSIDERATIONS

3.5.1 Participants

The participants of the study were all over 18 years of age and had tertiary qualifications. They could all speak, read and write English proficiently.

The study aims and objectives were explained to the participants in writing and orally where applicable. Participation in the study was voluntary. Participants gave their written consent to participate. They could withdraw from the study at any time without penalty. Ethical clearance was obtained from the university's Higher Degrees Committee, where the proposal was evaluated for compliance with set standards (Thomas, McIntosh & Mensik 2016:59).

A letter was written to provincial departments of health and relevant public health institutions requesting permission to conduct the study. All information obtained during data collection was kept confidential and data management principles were adhered to by the researcher and the assistants (field workers). Full disclosure of information was made so that participants could take an informed decision on whether to give consent for participation or not.

There was no harm or injury expected as there was no physical examination or treatment given to participants. Participants answered the survey questionnaires in the comfort of their own venues. Focus groups and interviews were conducted at a mutually agreed-upon venue. No harm was anticipated from self-reporting when filling in the questionnaires and talking during interviews (Thomas et al 2016:68).

Induction programmes from the sampled health institutions were requested in writing during institutional permission requests. The documents were filed and kept under lock and key to maintain confidentiality. Reporting would be by group, not individual or institution.

3.5.2 Scientific integrity of the research

The ultimate reflection of the researcher's integrity was the accuracy of the recording and reporting of the research results. The participants were not given any form of compensation or incentives for participation. Great care was taken by the researcher to ensure that the participants did not travel to the venues at their own cost. Venues were at employing health institutions and 8-hour clinic operational nurse managers travelled with the researcher to the District Health Offices to prevent them from incurring costs.

3.5.3 Domain-specific ethical issues

Avoiding harm to participants

Harm during research can be physical, mental or emotional (Gray 2009:74). In this study there was no harm anticipated. Confidentiality of all information obtained was maintained. Group reporting of information was done to prevent identification of individuals or institutions and to preserve anonymity. The questionnaires were self-reporting and were completed in the comfort of the participant's chosen venue. The focus groups and interviews were scheduled and conducted at a mutually agreed-upon venue and time to avoid disruptions to the participants' schedules. Focus-group participants were requested to maintain confidentiality, not to talk about the discussed information after the meeting. Participants used pseudonyms to protect their identities.

Ensuring informed consent

Consent forms and information leaflets were put together with the questionnaire and those who were willing to participate responded.

Participants were provided with information leaflets and written consent forms and oral explanation about the study was also given to the interviewees. Information given was about the aim of the study, approval, participation, duration of interviews, time taken to complete the questionnaire, the researcher and expectations when participating. This was done to allow participants to take an informed decision on their participation. Further ongoing consent was sought verbally prior to and during the interviews.

Participants were told that participation was voluntary and that they could withdraw from the study at any time without penalty.

Respecting privacy of participants and ensuring anonymity

The participants' right to privacy was respected by the researcher and assistants. Personal identifiable information was not asked for. The responses to the questionnaires were given to the researcher without identifying information to ensure anonymity of respondents. Data protection principles were used to protect obtained data on site and off site from being accessed by unauthorised people. Information was used for the purpose of the study, recording and reporting the research findings. Research assistants signed non-disclosure confidentiality forms.

Avoiding deception

The researcher did not present false information to participants about the research. Agreed-upon time frames were adhered to during the focus groups and interviews. Prior arrangements were made and participants informed timeously when there were unplanned changes to the agreed-upon time frames. Pilot testing of the questionnaire assisted in the estimation of the time that it would take to complete the questionnaire, so that the researcher could inform the respondents of how long the questionnaire would take.

3.6   APPROACH FOLLOWED IN GUIDELINE DEVELOPMENT

This section discusses the last objective, namely *to develop and validate guidelines for the induction and professional development support of newly qualified professional nurses.* Guidelines in this context can be described as a systematic development of statements to assist health facilities and nursing management in the decision-making process about the best professional development support that can be given to new nurses (Newell & Burnard 2006:236; Scottish Intercollegiate Guideline Network 2008:2). Various strategies such as systematic reviews, case studies, expert opinions and meta-analyses may be used to develop guidelines (Leech, Van Wyk & Uys 2007:104; Miller & Kearney 2004:815; Polit & Beck 2008:32).

The AGREE II instrument has been widely used by the World Health Organization (WHO) and other clinical practice guideline developers, with the goals to provide a methodologic strategy for the development of practice guidelines, to recommend how and what information should be reported in guidelines, and to assess the quality of clinical practice guidelines (CPGs) (Brouwers, Kho, Browman, Burgers, Cluzeau, Feder, Fervers, Graham, Grimshaw, Hanna, Littlejohns, Makarski, Zitzelsberger and AGREE Next Steps Consortium 2012:526). The most feasible goal of the AGREE II applied to the developed guidelines in this study, was the one of assessing guideline quality. The researcher had to be confident that the potential biases of guideline development have been addressed, the recommendations are valid and are feasible for practice (Dans 2010:1281).

Whichever method is used to develop guidelines, it must be founded on research evidence (Leech et al 2007:106; Miller & Kearney 2004:815. This study's guidelines were developed from the evidence of the quantitative and qualitative research findings, using logical reasoning processes of induction and deduction.

Validation of the guidelines was done through the Delphi Technique. The Delphi technique is a forecasting method based on the results of questionnaires sent to a panel of experts. Responses are anonymous. Several rounds of questionnaires can be sent out until consensus is reached (Hsu & Sandford 2007:5). In this study, consensus was reached within the first round. The researcher and the promoter, who served as the facilitators, agreed that the results were ready for publishing (Yousuf 2007:7).

Advantages of using the Delphi technique are that it aggregates opinions from a diverse set of experts, without having to bring them together for a physical meeting. Participants are anonymous, individual panellists are assured of confidentiality of information (Hsu & Sandford 2007:1). The disadvantages experienced by the researcher in this study are that response times were long even if given a due date for responses. Some experts did not return their responses, unlike in a live discussion where silent participants could be probed (Imran 2007:2).

3.6.1 The reasoning processes followed during guideline development

According to Polit and Beck (2008:13) and Schmidt and Brown (2009:14), experience, intellectual ability and thought processes are utilised in the process of logical reasoning: inductive and deductive reasoning. Inductive reasoning proceeds from a particular point of departure to a general conclusion, while deductive reasoning moves from general or various findings to a particular conclusion. Deductive reasoning was applied during the formulation process of the guidelines by using evidence from quantitative and qualitative findings of the study and the literature. Each theme included a summary of related concluding statements. Guidelines were formulated from the concluding statements of each theme. Inductive reasoning was applied when recommendations for implementation were drawn up.

3.6.2 Validation of the guidelines

There are various validation strategies for guidelines. In this study nursing experts in nursing management and academia were invited to evaluate the proposed guidelines (Coetzee 2006:101; Mkhonta 2008:151).

Credibility, applicability, clarity, completeness, reliability, comprehensiveness and cost effectiveness are some of the attributes used to validate guidelines (Adams & McCarthy 2007:132). A combination of the attributes was used as criteria for guideline validation. The nursing experts were invited to validate the guidelines (Annexure Q), provided with a copy of the proposed guidelines for validation, a validation form (Annexure R) and a summary of the research findings. The agreed-upon time for returning the guideline feedback was two weeks. Necessary changes were effected to the guidelines after receiving feedback. The guidelines were then disseminated through describing the research findings in a thesis. Further dissemination of these guidelines by means of an article, adoption and implementation thereof by policy makers and public health institutions is envisaged.

3.7   CONCLUSION

In this chapter the researcher described the theoretical framework guiding the study and the methodology followed to conduct the study. Chapter 4 will describe the data collected and its analysis for the quantitative part of the mixed-methods research design.

CHAPTER 4

DESCRIPTION OF THE QUANTITATIVE DATA RESULTS: ORIENTATION PROGRAMMES AND THE SURVEY

4.1   INTRODUCTION

Chapter 3 discussed the research methodology in detail. This chapter will discuss the quantitative data analysis. The quantitative data consisted of questionnaires from the newly qualified professional nurses and orientation programmes of the public health institution. The researcher asked for permission to conduct the research from the provincial departments of health, the district health offices and public health institutions in four provinces. The largely rural provinces were represented by Eastern Cape and Mpumalanga, whereas the largely urban provinces were represented by Gauteng and the Western Cape. Chapter 4 describes the compliance rate and presentation of findings.

4.2   ANALYSIS OF ORIENTATION/INDUCTION PROGRAMMES (QUANTITATIVE)

Orientation and induction programmes were formally requested from sampled public health institutions in the four provinces. The operational nurse managers were asked to bring the requested programmes to the researcher during the focus group discussions. In some public health institutions, the researcher had to go to the nursing management to get the documents herself. The operational nurse managers would say either that they had forgotten or would prefer the document to be given out to the researcher by the nursing manager as per institutional protocol. The researcher took one orientation programme per public health institution, as the units, wards or clinical departments added their area-specific items to the generic institutional programme. Eventually the orientation programme was institutional, not unit-, ward- or clinical department-based.

Orientation programmes received from the public health institutions of the largely urban provinces were six in number, from six public health institutions. The number from the largely rural provinces was eight programmes, from nine public health institutions. One public health institution did not submit the orientation programme even after numerous

reminders. The total orientation programmes came to 14 (*N*=14*).* In one of the largely rural provinces, four of the orientation programmes were generic, with specifications according to 8-hour clinic or community health centre. The researcher was informed that the operational nurse managers from the clinics and community health centres converged at the district health office to formulate the original orientation programme under the guidance of the district health manager, and they continue to converge yearly to review the generic orientation programme.

A checklist derived from the literature was developed by the researcher and was used to analyse the orientation/induction programmes. The checklist is divided into phase one, which is the core induction for the duration of a week to two months, and phase two, which comprises the role-specific aspects, from two to six months.

Table 4.1   Phases and the orientation aspects evaluated

Phases of checklist programme	Orientation aspects evaluated
4.2.1 General aspects of the orientation/induction programme	4.2.1.1 Name of programme and the health institution 4.2.1.2 Name of orientee or inductee 4.2.1.3 The goal of the programme 4.2.1.4 Contact details of person responsible for the orientation/induction programme
4.2.2 Phase 1 – core induction phase (1st week–2 months)	4.2.2.1 Practice orientation 4.2.2.2 Legal framework 4.2.2.3 Occupational health aspects 4.2.2.4 Human resources aspects 4.2.2.5 Learning and personal development
4.2.3 Phase 2 – role-specific phase (2–6 months)	4.2.3.1 Clinical practice 4.2.3.2 Consolidated competencies necessary to be effective in role 4.2.3.3 Professional development support 4.2.3.4 Supervision of subordinates 4.2.3.5 Mentorship/preceptorship 4.2.3.6 Review of the programme

4.2.1 General aspects of the orientation/induction programme

The checklist requires that the orientation/induction programme should have a name by which it is referred to, as well as that of the public health institution. All the programmes were labelled (*N*=14, 100%). The programme should be personalised with the name of the orientee or inductee. The orientation/induction programmes that had a space for the name of the orientee or inductee were 21 percent (*n*=3). The goal of the programme should also be indicated. There were 29 percent (*n*=4) programmes that indicated the goal of the orientation/induction. The person responsible for the orientation/induction programme should be indicated, with the contact person's contact details.

Of the programmes, 50 percent (*n*=7) omitted the name and details of the contact person.

4.2.2 Phase 1 – Core induction phase (1st week−2 months)

The core induction phase of the checklist should have consisted of practice orientation, legal framework, occupational health aspects, human resource aspects and learning and personal development. None of the orientation programmes addressed all the aspects.

4.2.2.1 Practice orientation

The induction programmes scored very well on the following aspects: physical orientation to the practice structure (building and equipment), reporting times for duty, human resource issues, introduction to colleagues, communication channels/ hierarchical structure of the public health institution, arrangements for reporting absence, and orientation to the job description. The majority of the public health institutions (n=8) scored 70 percent on practice orientation, while the remaining programmes *(n=*6) scored 100 percent.

4.2.2.2 Legal framework

The aspects to be checked under this topic were as follows: relevant acts, regulations, policies, guidelines and protocols applicable to the post at all levels of governance (e.g.

SANC, DoH, etc.); emphasis on accountability, handling of client complaints, incidents and client feedback. Fifty percent of the induction programmes did not address the issue of accountability, handling of client complaints, incidents and patient feedback *(n=7)*.

4.2.2.3   Occupational health aspects

This topic should have addressed the applicable health policies as well as the professional nurse's responsibilities in relation to occupational health and safety within the public health institution. Most of the programmes mentioned the occupational health policies but said nothing about the professional nurse's responsibility in relation to these policies or occupational health and safety within the public health institution *(n=7; 50%)*. Only 14 percent mentioned both policies and the professional nurse's responsibility.

4.2.2.4   Human resources aspects

The topic concerned the remuneration and benefits, grievance procedures and the appointment letter. Only 21 percent *(n=3)* of the orientation programmes addressed these aspects. These were orientation programmes from institutions that had an orientation or induction programme that was done at the staff development department (14%; n=2) and those that had a district health orientation (7%; *n=1*) in addition to the ward or clinic programme.

4.2.2.5   Learning and personal development

Aspects to be addressed under this topic were: the appraisal system, opportunities for learning and clinical supervision. Seventy-one percent of the orientation programmes addressed the appraisal system *(n=10)*, while 36 percent *(n=5)* addressed the opportunities for learning and only 21 percent *(n=3)* addressed the appraisal system, opportunities for learning and clinical supervision.

4.2.3   Phase 2 – Role-specific phase (2–6 months)

The role-specific phase of the checklist should have addressed the following topics: clinical practice, consolidated competencies necessary to be effective in role,

professional support, supervision of subordinates, mentorship/preceptorship and review of the programme. Only one orientation programme *(n=1)* mentioned all role-specific aspects.

4.2.3.1   Clinical practice

This aspect was largely addressed in the orientation programmes *(n=14; 100%)*. Programmes included routine tasks, procedures, delegation and health care services specific to the ward or clinic.

4.2.3.2   Consolidated competencies necessary to be effective in role

The orientation programmes that addressed this aspect were 64 percent *(n=9)*. Some orientation programmes, 14 percent *(n=2)*, even specified the clinical competencies required from the newly qualified professional nurse to be effectively incorporated as a team member.

4.2.3.3   Professional development support

This aspect was poorly addressed in the orientation programmes: 21 percent *(n=3)*. Most programmes did not mention the professional development support to be offered to the newly qualified professional nurses: 79 percent *(n=11)*. The professional development support mentioned in the 21 percent *(n=3)* orientation programmes was said to be given by operational nurse managers and experienced professional nurses of the unit or clinic. The professional development support was said to be in the form of in-service training attended by the newly qualified professional nurses, and departmental case meetings where specific incidents or cases were presented.

4.2.3.4   Supervision of subordinates

This aspect was also poorly addressed in the orientation programmes. A few addressed the issue: 21 percent *(n=3)*. Those that mentioned it indicated that the newly qualified professional nurses should supervise student nurses allocated to the ward or clinic.

4.2.3.5 Mentorship/preceptorship

A few orientation programmes addressed this aspect: 14 percent *(n=2)*. They mentioned that mentorship/preceptorship would be offered to the newly qualified professional nurses but did not specify whether it would be formal or informal. The period specified in some programmes for the mentorship/preceptorship ranged between two and six months and one year, or for the duration of the compulsory community service.

4.2.3.6 Review of the programme

Most orientation programmes did not cover this aspect: 86 percent *(n=12)*. The orientation programmes did not have goals, therefore did not consider whether the orientation programme was effective or not. Only 7 percent *(n=1)* mentioned personal development plans for the newly qualified professional nurses; 14 percent *(n=2)* mentioned that the developmental needs of the newly qualified professional nurses should be determined.

4.3   EVALUATION OF THE PROVINCES' ORIENTATION PROGRAMMES

The checklist was used to evaluate the orientation programmes according to public health institutions within a province, provincial classification, and national, where all four provinces were combined. The largely urban provinces had provincial guidelines in addition to the institutional orientation programmes, whereas the largely rural provinces depended only on the institutional orientation programmes for the orientation and induction of the newly qualified professional nurses. There were 28 checklist items. An orientation programme was marked against the checklist items to obtain a percentage.

4.3.1 Largely rural provinces

Performance of orientation programmes from health institutions of Rural Province 1

Percentages scored by programmes of Rural Province 1

79%
50%
50%

District Health
Hospital 1
Hospital 2
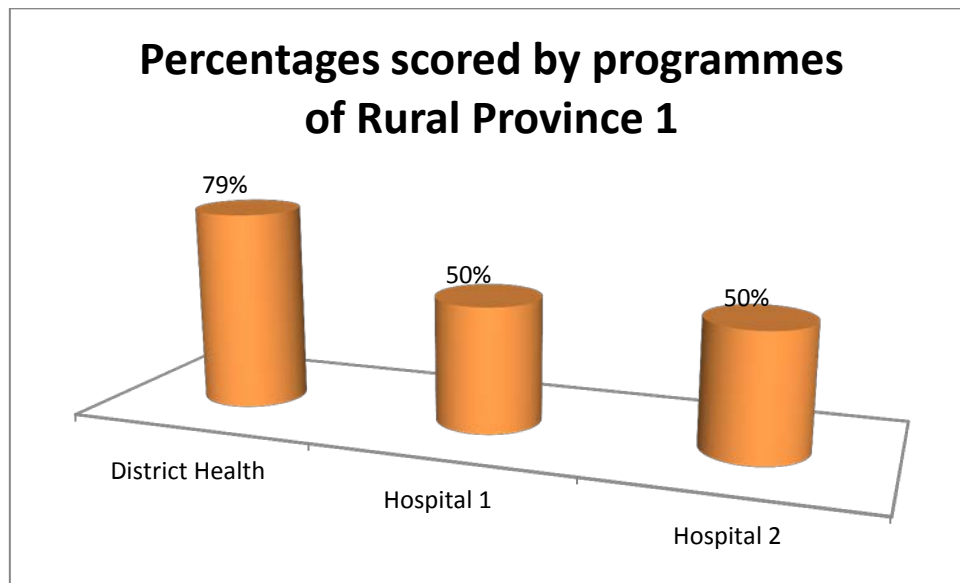
Figure 4.1: Percentages scored by programmes of Rural Province 1

The district health orientation programmes obtained 22 points out of the 28 points on the checklist, the outcome being 79 percent. This was the highest score obtained of all the orientation programmes evaluated from all four provinces. The programmes were comprehensive, especially in the core induction phase, though they lacked some aspects of the role-specific phase.

The hospitals' orientation programmes obtained 14 points out of the 28 points of the checklist, giving a percentage of 50 percent. The programmes lacked a few aspects in the core induction phase and many on the aspects of the role-specific phase. The overall percentage for this province was 65 percent.

Performance (outcome) of orientation programmes from health institutions of Rural Province 2
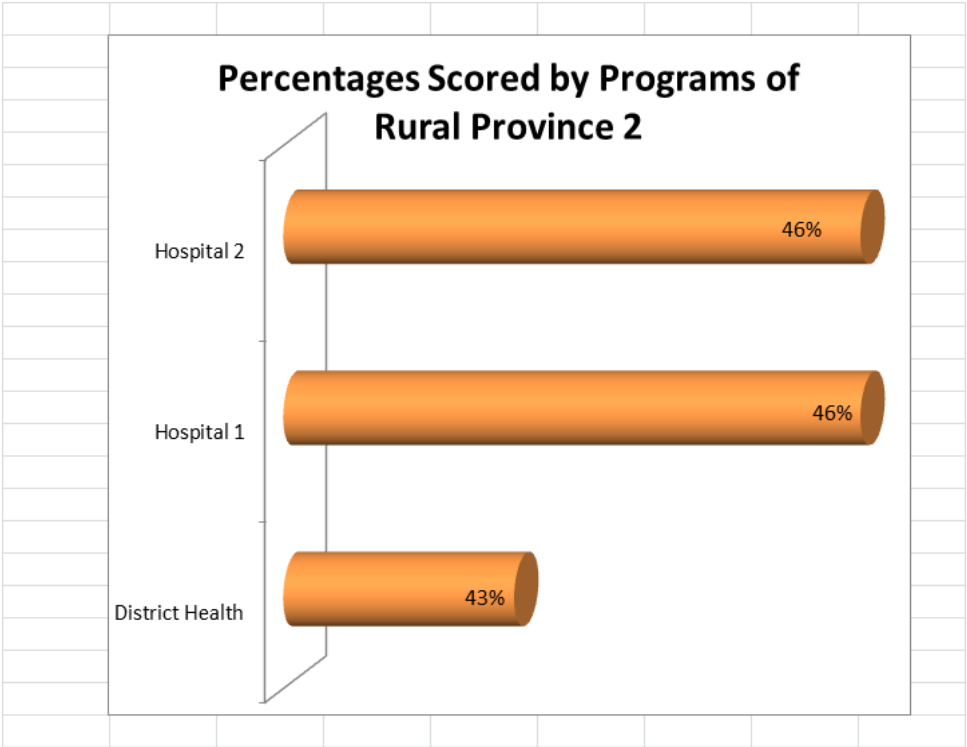
Figure 4.2: Percentages scored by programmes of Rural Province 2

The district health orientation programmes obtained 12 points out of the 28 points of the checklist, thus obtaining 43 percent. The hospitals' orientation programmes obtained 13 points each out of 28 points of the checklist, giving a percentage of 46. The overall percentage for the province was 45. The orientation programmes of the public health institutions lacked a lot of aspects in both core induction and role-specific phases.

The average of both largely rural provinces was 55 percent.

4.3.2 Largely urban provinces

The largely urban provinces both had guidelines for the orientation of the newly qualified professional nurses during community service. The guidelines were formulated in 2007 in preparation for the commencement of community service for the nurses in 2008. They had not been revised by the period of data collection, which was September 2014 and January and February 2015. The coordinators of community service communicated the guidelines to the public health institutions designated for community service within

the province. One of the provinces also circulated the guidelines in the form of a circular to relevant institutions, including nursing education institutions. The circular was also available on the province's Department of Health web page.

Performance (outcome) of orientation programmes from public health institutions of Urban Province 1
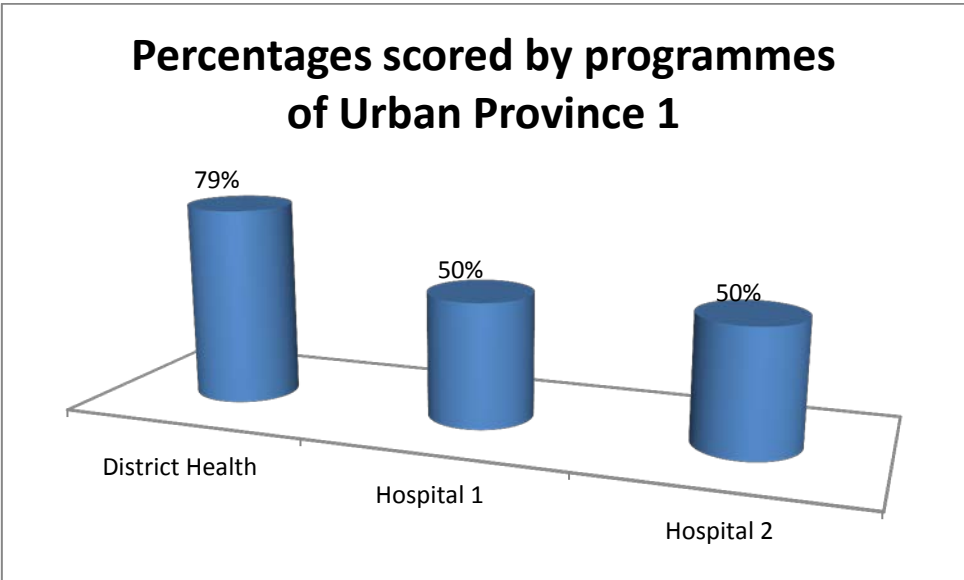
Figure 4.3: Percentages scored by programmes of Urban Province 1

The district health orientation programme for this province obtained 10 points out of the 28 points in the checklist, the percentage being 36. The orientation programme was lacking in both core orientation and role-specific aspects. It was too superficial and it mainly addressed the clinic routine. The problem is that the provincial guidelines were not incorporated during the orientation period to augment the information absent from the institutional programme.

The orientation programmes from the hospitals scored 18 and 12 points respectively, giving 64 and 43 percent respectively. The hospitals were well conversant with the provincial guidelines, but they used the guidelines during the week of the core induction phase only, when the staff development department inducted the newly qualified professional nurses. The ward personnel used the institutional orientation programme when the newly qualified professional nurses came to the wards.

The provincial guidelines scored twenty points, thus obtaining 71 percent. The percentage obtained by this province was 54.

Performance of orientation programmes from public health institutions of Urban Province 2
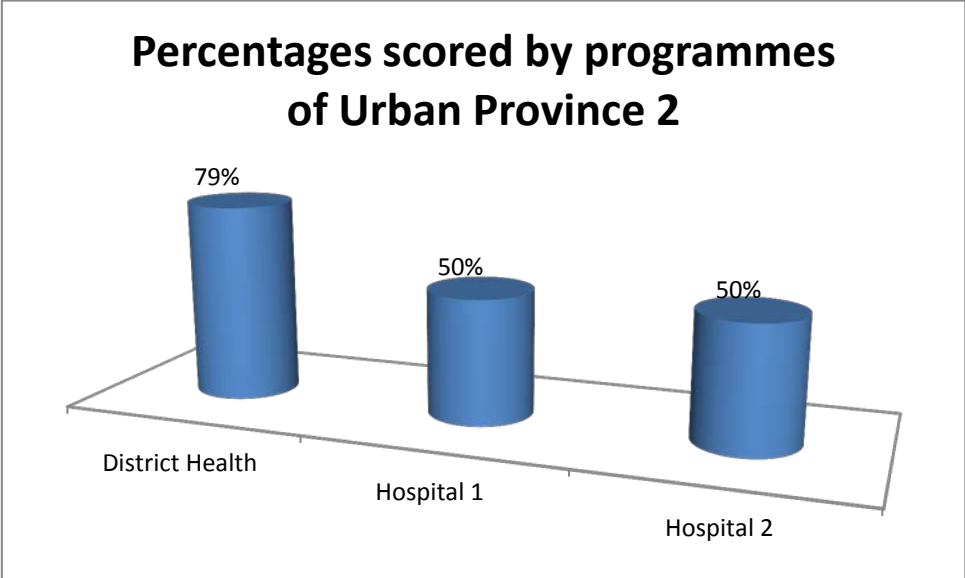
Figure 4.4: Percentages scored by programmes of Urban Province 2

The district health in this province was represented by a district hospital. The orientation programme obtained 12 points out of the 28, thus obtaining 43 percent. The orientation programme was comprehensive on the core induction phase but lacked most aspects on the role-specific phase.

The provincial hospitals' orientation programmes differed widely from each other. One hospital scored four points out of the 28. The orientation programme addressed a few aspects of the core induction phase only. The percentage obtained was 14. The other hospital's orientation programme scored 13 points and obtained 46 percent. The provincial guidelines were not incorporated in all the public health institutions' orientation programmes. The operational nurse managers available during data collection did not know about the availability of the provincial guidelines.

The provincial guidelines scored 18 points out of the 28 in the checklist, thus obtaining 64 percent. The provincial percentage was 42.
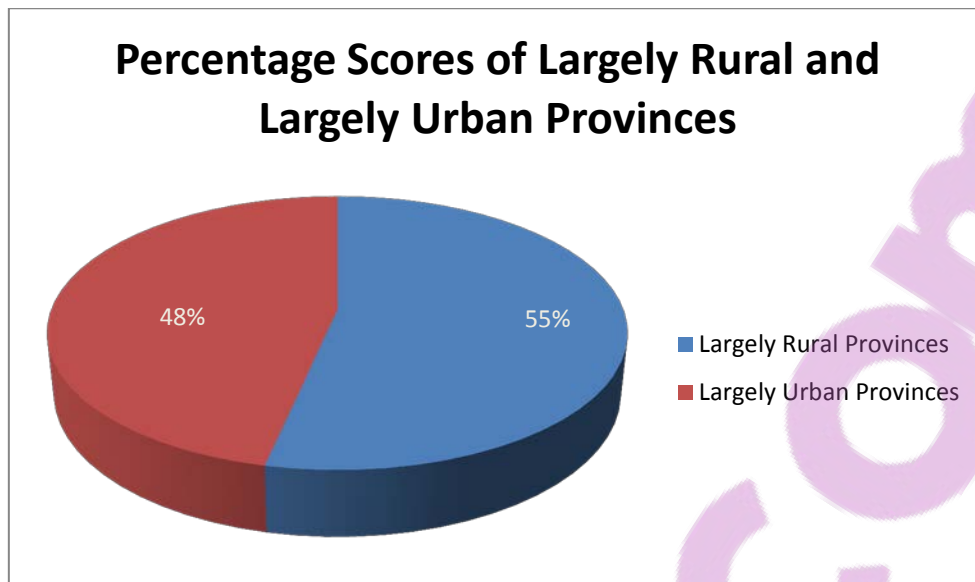
Figure 4.5: Percentages scored by programmes of largely rural and largely urban provinces

The average of both largely urban provinces was 48 percent, seven percent less than the largely rural provinces. The average of all the four provinces was 52 percent.

The findings reveal that the induction/orientation programmes are lacking information and need to be revised to include more information as described in the literature used to draw up the checklist.

4.4 ANALYSIS OF DATA OBTAINED FROM NEWLY QUALIFIED PROFESSIONAL NURSES (QUANTITATIVE QUESTIONNAIRE QUESTIONS 1–43)

The survey of newly qualified professional nurses was conducted through a questionnaire posted to all provinces in South Africa. The sample size was 350, from a population list of 2500 newly qualified professional nurses obtained from the South African Nursing Council (SANC). The criteria for inclusion were as follows:

- Having graduated in 2013 or 2014 from the four-year nursing programme of SANC R425, 1985, leading to registration as a Nurse (General, Community, Psychiatric) and Midwife.
- Completion of the compulsory remunerated community service in 2014 or 2015 Information in the form of emails, postal addresses and telephone numbers of

newly qualified professional nurses was obtained from the SANC, after a lengthy process of permission request. The permission was requested from October 2013 and permission was granted in March 2014.

Most of the provided information could not be utilised due to the presentation. The spreadsheets provided were incomplete; most information was not available or not provided by the nurses. Telephone numbers were invalid, not available or non-existent. Emails were non deliverable and the postal addresses were mostly of nursing education institutions where respondents had graduated.

The researcher had to salvage the information that could be used and construct a new list for each province. Eventually ten percent from each list were sent questionnaires via the post. Questionnaires were posted in June 2014 and there was very little feedback by September 2014, regardless of telephonic reminders. There was a post office strike between September 2014 and February 2015, which exacerbated the poor return of responses through the post office. The questionnaires were, however, numbered, so tracing those not returned was easy. The researcher reposted the questionnaires in March 2015 and resorted to making follow-ups through the 'Whatsapp' social network for respondents with the application. The response rate improved, but responses were trickling in in very small amounts. By June 2015 the researcher had received 38 responses out of the initial 350 questionnaires posted, which was only eight percent.

The researcher consulted the promoter and other research experts regarding the way forward. The next option implemented was delivering the questionnaires to the public health institutions of the four sampled provinces. So 312 questionnaires were hand-delivered to newly qualified professional nurses who met the inclusion criteria in August 2015, and 86 responses were returned by September 2015. The response rate went up to 124, which was 35 percent.

Twelve of the questionnaires received back were filled in by professional nurses who did not meet the criteria; they were not included in the analysis. The total questionnaires analysed were 112. The services of a statistician were utilised to handle the descriptive statistics using SPSS version 23 and the inferential statistics using ANOVA. The descriptive statistics were represented through pie charts and bar diagrams, whereas tables were used for the inferential statistics.

4.4.1 The questionnaire

Table 4.2   Structure of the questionnaire

Items	Collected data
Items 1–10	Demographic data of the respondents
Items 13–19	Level of competence upon commencement of community service
Items 11, 12, 30–43	Induction and professional development support during community service
Items 20–29	Progress from novice to competent professional nurse during community service
Items 44–46	Experiences regarding induction and professional development support during community service

The questionnaire was developed by the researcher from the literature and validated by the promoter, experts in nursing management and through a pilot test. The Cronbach's Alpha test was also run and it was 0.7, which is a good value.

The first section of the questionnaire comprised 43 closed questions, while the last section comprised three open-ended questions. Items 1–10 were about the demographic data of the respondents. Items 13–19 were about determining the newly qualified professional nurses' level of competence upon commencement of community service. Items 11, 12, 30–43 were about the induction and professional development support given to the newly qualified professional nurses during community service. Items 20 to 29 were about the progress made by the newly qualified professional nurses from novice to competent professional nurses during community service. Items 44 to 46 were written narratives by the newly qualified professional nurses describing their experiences regarding their induction and professional development support during community service; the section is analysed qualitatively in Chapter 5.

4.4.2 Descriptive statistical report
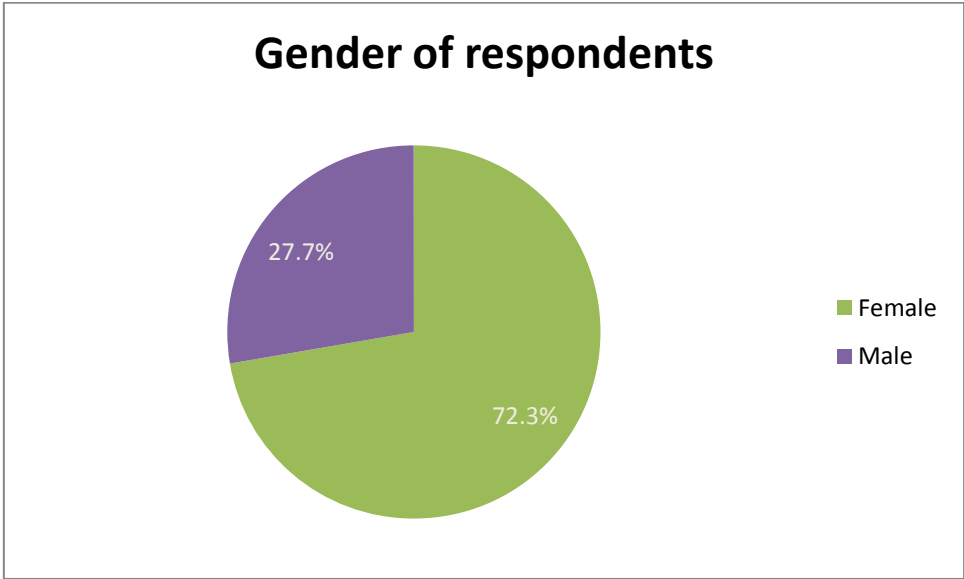
Figure 4.6: Gender of the respondents

The respondents to this survey were mostly female. They constituted 72.3 percent *(n=*81) of the sample and the males were 27.7 percent *(n=*31). See Figure 4.6 for the visual presentation.
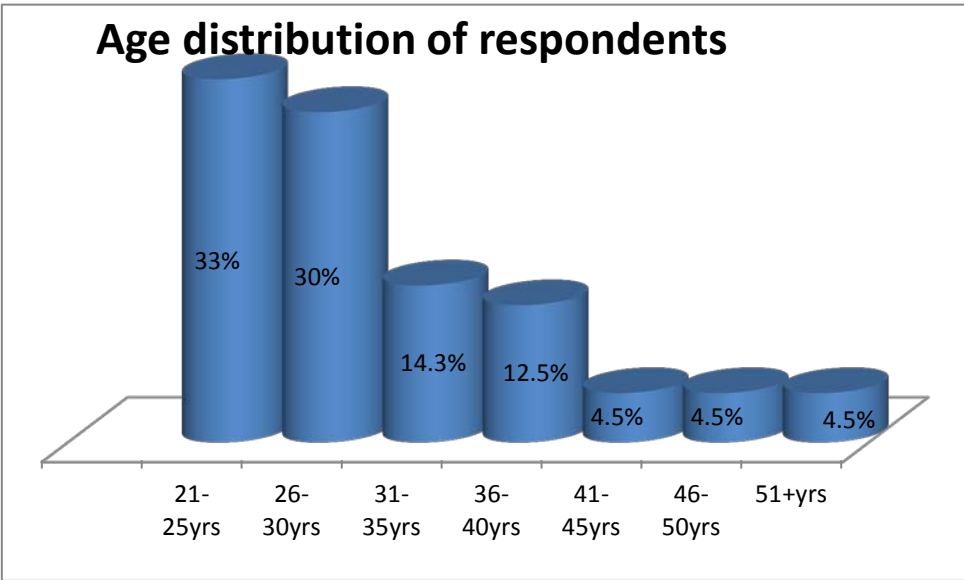
Figure 4.7: Age distribution of respondents

In terms of age, those aged 21–25 constituted 33 percent *(n=*37); those aged 26–30, 30 percent *(n=*30); those aged 31–35 constituted 14.3 percent *(n=*16); age 36–40 constituted 12.5 percent *(n=*14); age 41–45 constituted 4.5 percent *(n=*5); age 46–50

constituted 4.5 percent (*n*=5), while age 51+ constituted 4.5 percent (*n*=5) also. There was a decline in the percentage of respondents as the age increased.

Race of respondents

86.5%

9.9%

3.6%

Black People   Coloured People   White People
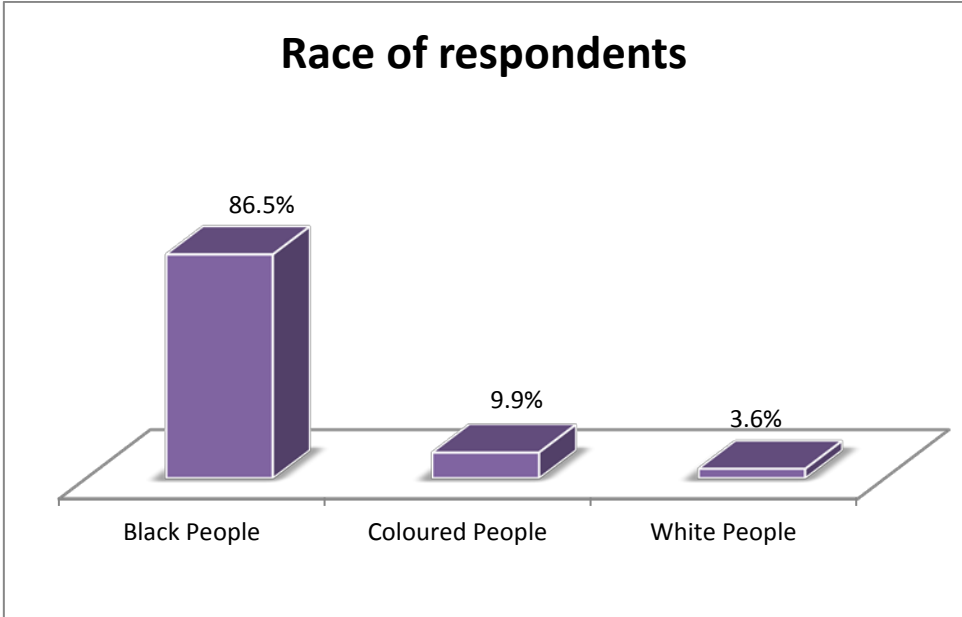
Figure 4.8: Race of respondents

The great majority, 86.5 percent *(n*=96) were black nurses; Coloured nurses comprised 9.9 percent *(n*=11), while white nurses constituted only 3.6 percent *(n*=4). It was noted that there were no Indian nurses in the sample collected. See Figure 4.8 for the visual presentation.

Qualifications of respondents

31.3%

68.8%
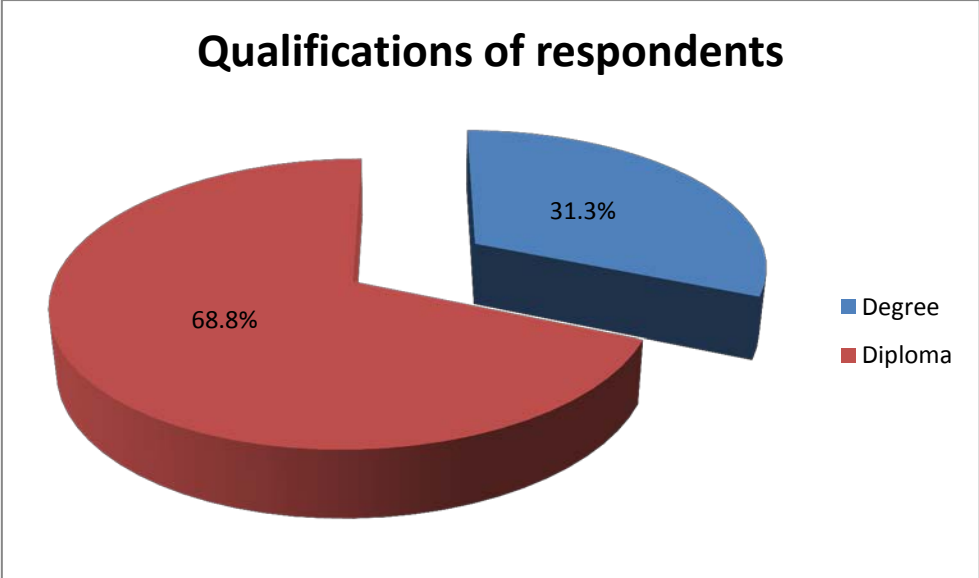
- Degree
- Diploma

Figure 4.9: Qualifications of respondents

In terms of qualifications, 68.8 percent *(n=77)* had a diploma, while the rest, 31.3 percent *(n=35),* had a degree.
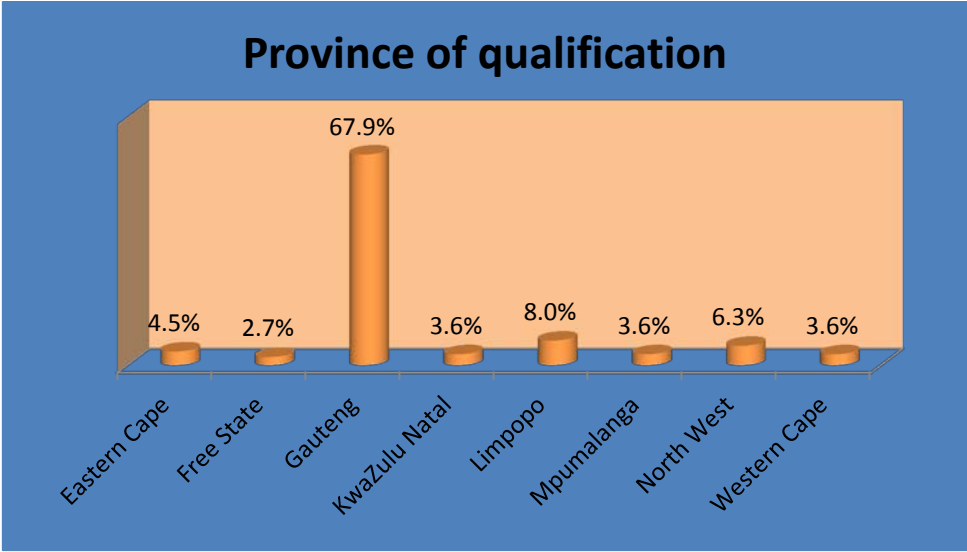
Figure 4.10: Province of qualification

The majority of the respondents had obtained their qualification in Gauteng. This set constituted 67.9 percent (*n*=76), while 8.9 percent (*n*=10) had obtained their qualifications in Limpopo. Other respondents had obtained their qualifications in North West: 6.3 percent (*n*=7); and 3.6 percent (*n*=4) each had obtained them in the Eastern Cape; Free State; KwaZulu-Natal; and Mpumalanga. The lowest number was from the Western Cape: 2.7 percent (*n*=3), whereas there were no respondents from the Northern Cape or the South African Military Health Services (SAMHS).
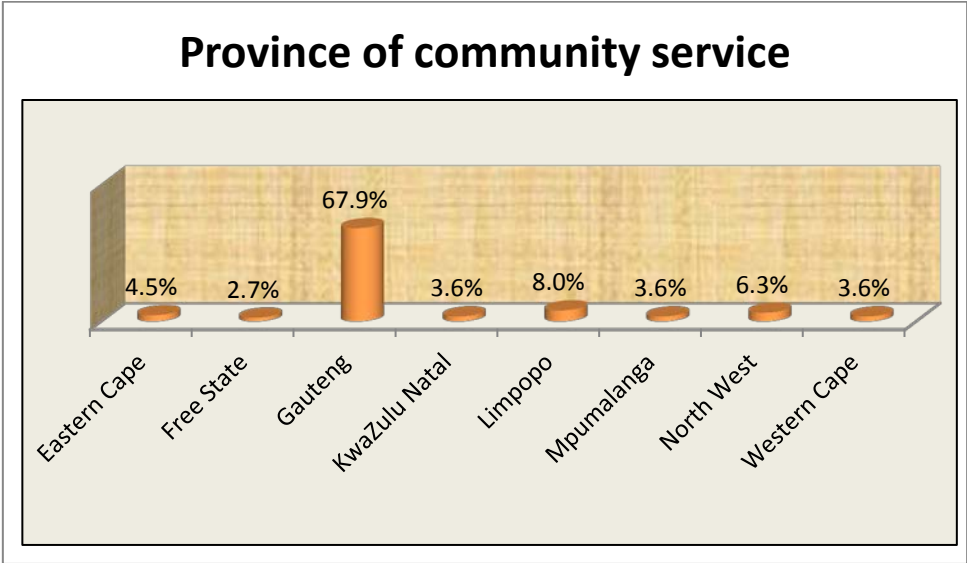
Figure 4.11: Province of community service

It can be observed from Figure 4.11 that about 67.9 percent *(n=76)* had done their community service in Gauteng, 8 percent *(n=9)* in Limpopo, 6.3 percent *(n=7)* in North West, while the rest had done their community service in other provinces, with only 2.7 percent *(n=3)* in the Free State.
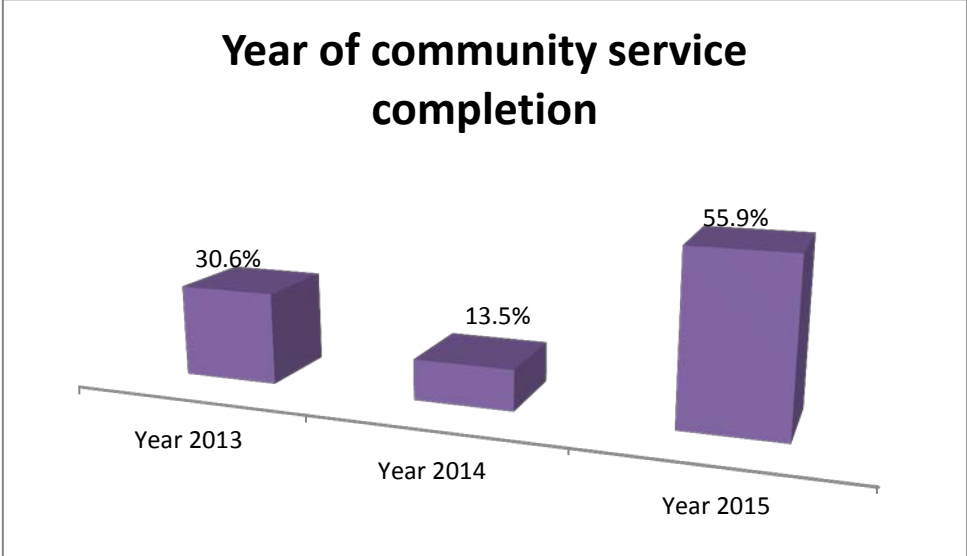
Figure 4.12: Year of community service completion

About 55.9 percent *(n=62)* of the respondents had completed their community service in 2015, 30.6 percent *(n=34)* had completed it in 2013, while 13.5 percent *(n=15)* had completed it in 2014. The duration of the community service was one year for 95.5 percent *(n=105)* of the respondents, while 4.5 percent *(n=5)* served for more than one year.
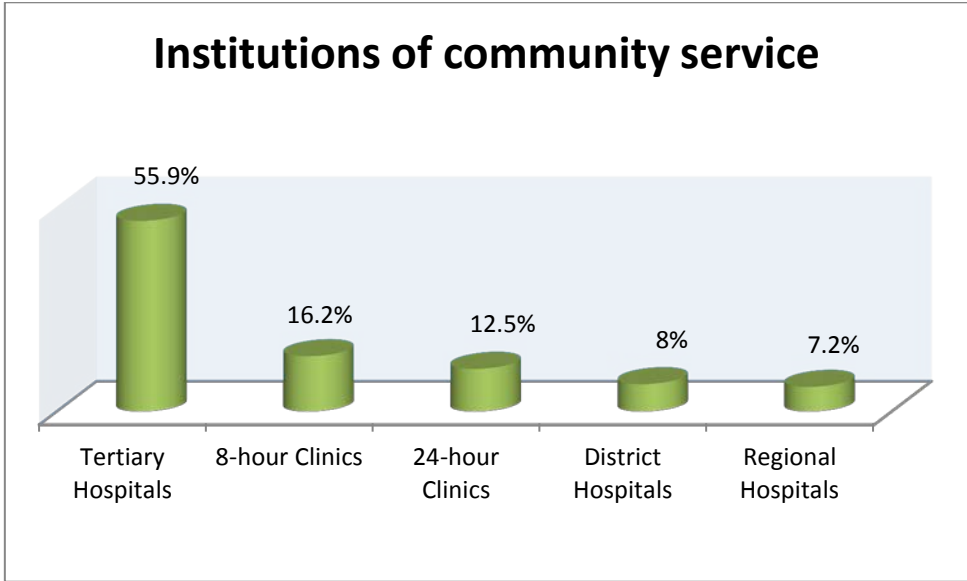
Figure 4.13: Institutions of community service

In terms of the institutions served, 55.9 percent *(n=62)* served in tertiary hospitals, 16.2 percent *(n=18)* served in 8-hour clinics; 12.5 percent *(n=14)* served in 24-hour clinics; 8 percent *(n=9)* served in a district hospital, while the lowest percentage of 7.2 *(n=8)* served in regional hospitals. The entire 75.7 percent *(n=84)* of the respondents were rotated to other wards/departments/clinics during the community service. It could also be seen that 85.5 percent *(n=94)* received orientation, while 59.1 percent *(n=65)* received induction.

In terms of perceived level of competence of respondents when they commenced their community service, the majority of the respondents (in all the categories) felt competent. For instance, the percentages of confidence levels were as follows: provision of patient care 87.3 percent *(n=96)*, management of nursing care in the unit 65.5 percent *(n=72)*, working as a team member 86.4 percent *(n=95)*, independent decision making 62.2 percent *(n=69)*, problem solving 70.9 percent *(n=78))*, integration of knowledge and skills into practice 85.5 percent *(n=94)*, and professional practice 84.7 percent *(n=94)*.

4.4.3 Inferential statistics

The statistical significance test of the level of competence when commencing community service was performed (Test 1); Induction and professional development support given to the newly qualified professional nurses during community service (Test 2); and the progress made from novice to competent professional nurses during community service (Test 3). These were tested based on the demographics and variables such as Community service province, Year completed and so on.

The analyses revealed that:

There was no significant difference, at the 5 percent significance level, in the three tests by location (Urban or Rural) of the respondents. That is, those based in urban or rural areas had the same level of competence when commencing the community service (p-value=0.940), enjoyed the same support (p-value=0.266) and made the same progress from novice to competent professional nurses (p-value=0.401). (See Table 4.3.)

Table 4.3:   **Significance test of the three constructs by location (rural/urban)**

Constructs	Community service province by rural and urban	N	Mean	Std. Deviation	Std. Error Mean	t	df	Sig. (2-tailed) P-value
Level of competence when commencing community service	Urban (Gauteng and Western Cape)	80	17.96	3.534	.395	.076	109	.940
	Rural (other provinces)	31	17.90	4.094	.735			
Induction and professional development support given to the newly qualified professional nurses during community service	Urban (Gauteng and Western Cape)	80	38.75	10.215	1.142	-1.118	109	.266
	Rural (other provinces)	31	41.42	13.711	2.463			
Progress made from novice to competent professional nurses during community service	Urban (Gauteng and Western Cape)	80	26.36	7.463	.834	-.842	109	.401
	Rural (other provinces)	31	27.68	7.148	1.284			

There was a significant difference, at the 5 percent significance level, in the three tests by qualification: at the 5 percent error level, the level of competence when commencing the community service differed between the degree and diploma holders (p-value = 0.000). The diploma graduates were more competent than the degree graduates upon community service commencement. There was also a difference in the support enjoyed (p-value = 0.028), and they did not make the same progress from novice to competent professional nurses (p-value = 0.001). The diploma graduates were given less support and the degree graduates progressed faster to competence. (See Table 4.4.)

Table 4.4:   Significance test of the three constructs by qualification

Constructs	Qualification	N	Mean	Std. Deviation	Std. Error Mean	T	df	Sig. (2-tailed) P-value
Level of competence when commencing community service	Diploma	76	18.88	3.024	.347	3.773	51.062	.000
	Degree	35	15.91	4.175	.706			
Induction and professional development support given to the newly qualified professional nurses during community service	Diploma	76	37.91	11.819	1.356	-2.220	109	.028
	Degree	35	42.94	9.327	1.577			
Progress made from novice to competent professional nurses during community service	Diploma	76	25.13	7.024	.806	-3.539	109	.001
	Degree	35	30.20	6.978	1.180			

There was no significant difference, at the 5 percent significance level, in the three tests by gender of the respondents. That is, both male and female respondents had the same level of competence when commencing the community service (p-value = 0.176), enjoyed the same support (p-value = 0.473) and made the same progress from novice to competent professional nurses (p-value = 0.543). (See Table 4.5.)

Table 4.5:   Significance test of the three constructs by gender

Constructs	Gender	N	Mean	Std. Deviation	Std. Error Mean	t	df	Sig. (2-tailed) P-value
Level of competence when commencing community service	Male	30	17.17	4.111	.751	-1.363	109	.176
	Female	81	18.23	3.490	.388			
Induction and professional development support given to the newly qualified professional nurses during community service	Male	30	40.77	11.941	2.180	.720	109	.473
	Female	81	39.02	11.091	1.232			
Progress made from novice to competent professional nurses during community service	Male	30	27.43	7.762	1.417	.611	109	.543
	Female	81	26.47	7.249	.805			

There was no significant difference, at the 5 percent significance level, in the three tests by race of the respondents. That is, all races had the same level of competence when they commenced the community service (p-value = 0.219), enjoyed the same support (p-value = 0.182) and made the same progress from novice to competent professional nurses (p-value = 0.110). As stated earlier, there were no Indian nurses in the respondents. (See Table 4.6.)

Table 4.6:   Significance test of the three constructs by race

ANOVA						
Constructs		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Level of competence when commencing community service	Between Groups	41.407	2	20.704	1.540	.219
	Within Groups	1438.856	107	13.447		
	Total	**1480.264**	**109**			
Induction and professional development support given to the newly qualified professional nurses during community service	Between Groups	439.807	2	219.904	1.730	.182
	Within Groups	13599.656	107	127.100		
	Total	**14039.464**	**109**			
Progress made from novice to competent professional nurses during community service	Between Groups	241.602	2	120.801	2.257	.110
	Within Groups	5727.271	107	53.526		
	Total	**5968.873**	**109**			

The level of competence when commencing the community service (p-value = 0.811) and the progress made from novice to competent professional nurse (p-value = 0.212) did not differ between the respondents in terms of where the respondents qualified, but the support received in KwaZulu-Natal differed significantly from that received in Gauteng, Limpopo and Mpumalanga when considering the qualification province (p-value = 0.041). There were no respondents from the Northern Cape, thus no qualification was obtained from this province. (See Table 4.7.)

Table 4.7:   Significance test of the three constructs by qualification province

ANOVA						
Constructs		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Level of competence when commencing community service	Between Groups	51.725	7	7.389	.529	.811
	Within Groups	1437.951	103	13.961		
	Total	**1489.676**	**110**			
Induction and professional development support given to the newly qualified professional nurses during community service	Between Groups	1816.599	7	259.514	2.186	.041
	Within Groups	12225.149	103	118.691		
	Total	**14041.748**	**110**			
Progress made from novice to competent professional nurses during community service	Between Groups	519.526	7	74.218	1.402	.212
	Within Groups	5452.366	103	52.936		
	Total	**5971.892**	**110**			

The level of competence when commencing the community service (p-value = 0.709) and the progress made from novice to competent professional nurse (p-value = 0.369) did not differ between the respondents in terms of the province where the respondents had their community service, but the support received in KwaZulu-Natal differed significantly from that received in Gauteng and Mpumalanga provinces when considering the province where the respondents did their community service (p-value = 0.041). (See Table 4.8.)

Table 4.8: **Significance test of the three constructs by province of community service**

ANOVA						
Constructs		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Level of competence when commencing community service	Between Groups	63.519	7	9.074	.655	.709
	Within Groups	1426.156	103	13.846		
	Total	**1489.676**	**110**			
Induction and professional development support given to the newly qualified professional nurses during community service	Between Groups	1821.213	7	260.173	2.193	.041
	Within Groups	12220.535	103	118.646		
	Total	**14041.748**	**110**			
Progress made from novice to competent professional nurses during community service	Between Groups	415.544	7	59.363	1.100	.369
	Within Groups	5556.348	103	53.945		
	Total	**5971.892**	**110**			

In terms of whether the respondents received induction or not, it was found that the level of competence when commencing the community service (p-value = 0.025) and the support received (p-value = 0.000) differed significantly between the respondents. That is, the induction had an effect on the level of competence and the support received. But progress made from novice to competent professional nurse during community service did not differ whether induction had been received or not (p-value = 0.332). (See Table 4.9.)

Table 4.9:   Significance test of the three constructs by whether a respondent received induction or not

ANOVA						
Constructs		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Level of competence when commencing community service	Between Groups	98.899	2	49.449	3.830	.025
	Within Groups	1381.365	107	12.910		
	Total	**1480.264**	**109**			
Induction and professional development support given to the newly qualified professional nurses during community service	Between Groups	2566.699	2	1283.350	11.988	.000
	Within Groups	11454.573	107	107.052		
	Total	**14021.273**	**109**			
Progress made from novice to competent professional nurses during community service	Between Groups	118.173	2	59.086	1.114	.332
	Within Groups	5676.018	107	53.047		
	Total	**5794.191**	**109**			

In terms of rotation of nurses during community service in clinics/departments/etc., it was found that the rotation had an effect: the level of competence when commencing the community service (p-value = 0.043), the support received (p-value = 0.036) and the progress made from novice to competent nurses (p-value = 0.027) differed significantly at the 5 percent significance level between those rotated and those not rotated. (See Table 4.10.)

Table 4.10: **Significance test of the three constructs by whether a respondent was rotated or not during the community service**

ANOVA						
Constructs		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Level of competence when commencing community service	Between Groups	55.058	1	55.058	4.183	.043
	Within Groups	1434.618	109	13.162		
	Total	**1489.676**	**110**			
Induction and professional development support given to the newly qualified professional nurses during community service	Between Groups	556.379	1	556.379	4.497	.036
	Within Groups	13485.369	109	123.719		
	Total	**14041.748**	**110**			
Progress made from novice to competent professional nurses during community service	Between Groups	262.940	1	262.940	5.020	.027
	Within Groups	5708.952	109	52.376		
	Total	**5971.892**	**110**			

4.5   CONCLUSION

Chapter 4 described the analysis of the induction/orientation programmes and the questionnaire responses. Data was also visually represented through graphs, pie charts and tables. The analysis yielded valuable information regarding induction and professional development support given to newly qualified professional nurses.

Chapter 5 describes the qualitative analysis of the focus groups, interviews and responses to the open-ended questions of the questionnaire.

CHAPTER 5

DESCRIPTION OF THE QUALITATIVE DATA RESULTS – FOCUS GROUPS, INTERVIEWS AND THE SURVEY

5.1   INTRODUCTION

In Chapter 4, quantitative data analysis was done. The results of the document analysis and the survey were described. In this chapter, the researcher describes the results of the qualitative data analysis. This is data obtained from the operational nurse managers of the various health institutions through focus groups; individual interviews with the coordinators of community service in the four sampled provinces; and the last section of the questionnaire, open-ended questions 44–46. This was the part of the survey questionnaire where respondents were asked to air their views about their experiences regarding their induction and professional development support during community service.

The focus groups and interviews were from the largely rural provinces (Eastern Cape and Mpumalanga), and the largely urban provinces (Gauteng and Western Cape).

Focus groups for operational nurse managers of hospitals were conducted at the hospitals; those of operational nurse managers from the district health were conducted either at the clinic, community health centre or district health offices. This arrangement was made because the operational nurse managers from the hospitals were invited from different clinical departments within the hospital, and the setting was different from the one at the clinics and community health centres. Their number was also more per hospital, whereas clinics and community health centres have only one operational nurse manager per health institution. The operational nurse managers from the clinics and community health centres in a province were combined to form one focus group where possible, and one operational nurse manager was individually interviewed at one of the 24-hour clinics in one of the largely urban provinces.

Table 5.1:   Eventual sample size for qualitative data collected

Data sites	Focus groups	Interviews	Survey responses
Hospitals (operational nurse managers)	9 focus groups (72 participants)	-	-
Clinics and health centres (operational nurse managers)	3 focus groups (19 participants)	1 (1 participant)	
Provincial offices (coordinators of com-serve)	-	4 (4 participants)	
Survey (newly qualified professional nurses)	-	-	112 (112 respondents)

- Hospitals = nine focus groups comprising 8 members each – 72 participants (saturation reached, researcher did not continue to other hospitals)

- Health centres and clinics = three focus groups comprising 4, 8 and 7 members – 19 (saturation reached, researcher did not continue to other clinics or health centres)

- Interviews = 4 coordinators of community service and one operational nurse manager – 5 (a census of the coordinators of community service was used for the sampled provinces)

- Respondents to open-ended questions from survey = 112

- Total = 208

5.2   PHENOMENOLOGICAL METHOD OF DATA ANALYSIS

The descriptive phenomenological approach was followed in the analysis. In this study the Stevick-Colaizzi-Keen method was applied. This method was advanced by Moustakas (1994) and later by Creswell (2013:193). The method provided a most practical and useful approach to data analysis (Creswell 2013:193). The method comprises the following steps: describing personal experiences with the phenomenon under study; developing a list of significant statements; grouping the significant statements into larger units of information called 'themes'; writing a description of *what* the participants in the study experienced with the phenomenon (textual descriptions including verbatim examples); writing a description of *how* the experience happened (structural description) and writing a composite description of the essence of the phenomenon (Creswell 2013:193).

The researcher listened to the audio recordings, spent hours transcribing the data verbatim. She became immersed with the data by spending hours and hours transcribing and reading the transcripts. The researcher incorporated the phenomenological data analysis steps mentioned earlier into the general frame of qualitative data analysis as follows (Creswell 2013:190).

Data organisation. This involved creation and organisation of files for data. Audio recordings were transferred from audio tapes and saved in the computer. Verbatim transcription of the audio recordings was done and files were saved in the computer using an MS Word program.

Reading/memoing. The researcher read through the text, made marginal notes and formed initial codes. The transcripts were later coded, creating computer files for analysis using tables in an MS Word document.

Describing the data into codes and themes. Themes and codes were described to form the essence of the phenomenon.

Classifying the data into codes and themes. Significant statements were formed and grouped into meaningful units as codes and themes. The researcher classified the data into codes and themes. The promoter and a critical reader confirmed the correctness of the classifications, providing suggestions where necessary.

Interpreting the data. The researcher developed a textual description of "what happened" and developed a structural description of how the phenomenon was experienced; for example, how did the operational nurse managers support/not support the newly qualified professional nurses during community service, the challenges they experienced and the suggested way forward.

Develop the "essence". This would ultimately give the overall picture of the outcome/findings.

Representing/visualising the data. The narration of the findings was presented in tables, figures and discussion.

5.2.1 Data collection from operational nurse managers

Data was collected from 15 health centres as follows:

- A regional hospital, a community health centre and an 8-hour clinic in the Eastern Cape.
- Two hospitals (one tertiary and one provincial) and a community health centre in Gauteng.
- Two hospitals (one tertiary and one provincial), two community health centres and two 8-hour clinics in Mpumalanga.
- Two tertiary hospitals and a district hospital in the Western Cape.

Operational nurse managers from 14 health institutions of the four sampled provinces participated in the focus groups, with one operational nurse manager being interviewed individually, as her other colleagues could not make it to the venue due to work-related responsibilities.

Demographic data was not obtained from the groups, but the groups consisted of males and females of all races. They were purposively selected for meeting the criteria of being operational nurse managers employed at public health institutions designated for community service and having supported newly qualified professional nurses serving their community service. Health institutions were purposively selected to be a public health institution designated for community service, being of a particular level and being in a largely rural or largely urban province of the sampled provinces.

Relevant appointments were made through the gatekeepers to introduce the researcher and field worker to the nursing management of the various public health institutions, and to secure the appointments for conducting the focus groups. The public health institutions provided the venues for the focus groups. These were mainly boardrooms and they were free from noise or other disturbances. The operational nurse managers were always welcomed by the researcher and her assistant. After establishing a rapport with greetings and introductions, the researcher explained the information about the research as in the distributed information leaflets and obtained consent to participate in the focus groups.

The ethical principles of research were adhered to throughout all the focus groups and the interview. Members who did not consent to participate in the focus groups were excused without any penalty being incurred. All the participants agreed to audio recording of the focus groups and to maintaining confidentiality of information given during the focus groups, and not to divulge this to other colleagues or the management. Two audio recorders were used during the focus groups as backup for each other. The field worker helped with distribution of the information leaflet, obtaining of consent, audio recording and taking of notes. The recorded data were transferred to the computer, and files were created and saved for transcription. The average time of the focus groups was one hour, with the minimum being 45 minutes and the maximum being two hours. The minimum number of participants was four operational nurse managers, while the maximum number was eight in a group.

5.2.2 Analysis of the data obtained from the operational nurse managers (12 focus groups and one interview)

Data saturation for the largely rural provinces

Data saturation for the largely rural provinces was reached after five focus groups conducted in the two provinces. The researcher discovered that the same information had started to emerge while listening to the audio tapes after six6 focus groups. There were no more new concepts, codes or themes that emerged. Nine health institutions participated.

Data saturation for the largely urban provinces

Data saturation for the largely urban provinces was reached after five focus groups. A repetition of the information started to emerge after five focus groups and the researcher continued with one more focus group and an interview of the operational nurse manager at a community health centre, to ensure that there was no new information. No new codes or themes emerged. The operational nurse managers were from six health institutions.

The data yielded two themes, nine sub-themes and 43 codes. See Table 5.2.

Table 5.2:   Themes, sub-themes and codes depicting data obtained from operational nurse managers

Themes	Sub-themes
1 Lived experiences of the operational nurse managers while providing induction and professional development support to the newly qualified professional nurses	1.1 Experiences regarding induction and orientation (4 codes) 1.2 The expected support role to be played by operational nurse managers (6 codes) 1.3 Actual support provided by operational nurse managers (6 codes) 1.4 Professional socialisation (2 codes) 1.5 Feelings experienced by operational nurse managers during the support period (4 codes) 1.6 Challenges in relation to induction and professional development support (9 codes)
2 Support strategies to enhance clinical competence	2.1 The ideal but practical induction and professional development support that could be given to the newly qualified professional nurses (10 codes) 2.2 The role that the nurse managers could play to realise the suggestions in order to support the newly qualified professional nurses most effectively (4 codes) 2.3 Stakeholders that could be roped in and the role they should play to enhance the transition of the newly qualified professional nurse from student to professional (4 codes)

Note: Theme one has six sub-themes and 25 codes, while theme two has three sub-themes and 18 codes. The verbatim quotes of interviews and focus groups are represented as per focus group folder and participant number e.g folder 1 participant 2 will be quoted as F1/P2.

5.2.3   Theme 1:   Lived experiences of the operational nurse managers while providing induction and professional development support to the newly qualified professional nurses

In this theme, the operational nurse managers described how the newly qualified professional nurses were inducted and supported to develop as professional nurses,

enhancing their transition from student to professional. The induction and professional development support was given by the operational nurse managers, other professional nurses in the clinical areas and staff development personnel of the human resource department in some public health institutions.

Operational nurse managers indicated that they did support the newly qualified professional nurses in various ways during the community service. They went on to describe their experiences in giving the induction and professional development support to the newly qualified professional nurses as described in the following codes and participant quotations.

5.2.3.1 Sub-theme 1: Experiences regarding induction and orientation

The experiences varied a great deal. Orientation was different in units of the same public health institution and in health institutions of the same province. It might not be available in other health institutions or it might last for only a day or two.

Code 1: Orientation or induction?

Some of the operational nurse managers used the terms interchangeably, not differentiating between the two terms. The operational nurse managers who differentiated between the two were from institutions that had an induction and an orientation programme.

> F2/P2
> "...induction and orientation goes hand in hand. They are the same."

The public health institutions of the largely urban provinces were reported to have staff development departments where the newly qualified professional nurses received induction about the human resource-related issues as well as the policies and protocols. The orientation followed the induction period and was done by the wards to which the newly qualified professional nurses were allocated.

F3/P6

"…we have an induction, which is basically done by the staff development department upon arrival, for the duration of one week, then the new nurses come to the wards where we start with the orientation. In that week the newly qualified are familiarised with the activities done in the institution. Say for example, general health policies, the leave aspects and other Human Resource related matters. Actually different departments come to present at the induction. Like the newly appointees will meet with quality assurance, infection control coordinators and so forth. Then in the wards we do the basic orientation as already explained by the others."

The operational nurse managers from some of the primary health institutions reported that there was an induction programme organised and implemented by either the provincial health or district health human resource department (HR). The newly qualified professional nurses convened at the district health offices for a week to attend the HR induction, where various topics concerning their employment were addressed.

F2/P1

"…actually when they come to the clinic, they get orientation only and they go to the district offices for the induction programme."

F7/P1

"The newly qualified professional nurses also attend a three to five days induction offered by the HR at the district office, they sign after attending and the clinic gets a copy."

The programme also had a portion for evaluation. The newly qualified professional nurses had to give feedback in the form of written assignments.

F7/P3

"They even had assignments to work on and submit to the HR team during the induction."

Code 2: Orientation time frame

There was no uniformity reported for the orientation period, even within the provinces, districts or health institutions within the same district. Each health institution had its own

orientation period according to its health care needs. The orientation period was from half a day to one week to three months. The average period for orientation in most health institutions was reported as one week.

F2/P3

"They gather at the staff development centre for a week for orientation."

F10/P1

"The orientation is for the first three months of allocation. When they arrive they work seven hours for the duration of the orientation period, which is the three months, then work shifts for the rest of the community service period."

F5/P1

"The ward orientation takes about one week."

F7/P2

"We orientate the new professional nurses using the orientation manual. The orientation takes about a week."

F1/P1

"…they spend a week plus coming every day at the staff development for orientation."

The researcher asked the respondents what determined the period of orientation; the response was that the newly qualified professional nurses should ideally be orientated until they felt comfortable working alone.

F2/P1

"…it should be until they are comfortable working alone, but unfortunately because of the work pressure and lack of personnel in the clinic, we actually orientate them for at least half a day."

Code 3: Standardised orientation programmes

Some health institutions were reported to have standardised orientation programmes. Hospitals standardised them for the institution and clinical departments. Wards added the departmental or ward specifics to the generic programme. Community health

centres and clinics in one of the largely rural provinces had the generic programme standardised by the health district for all the primary public health institutions.

F7/P1

"We do have a standardised orientation programme for all the clinics compiled by the previous operational nurse managers of all the clinics."

F3/P2

"…it's a generic programme. You mainly add to the general one your ward specifics. So if you get one for instance from sister May [not her real name], it will be the same, but there will be those specific aspects added for medical department."

F1/P2

"They have a programme that they follow at the staff development department and in the wards we also have a programme of orientation for the new staff according to their categories and scope of practice, so we have a programme for the com servers."

The health institutions keep a record of the orientation; in some, the newly qualified professional nurses sign the orientation register after the orientation.

F10/P1

"Firstly, we orientate them to the clinic services, routine, policies and protocols as well as personnel. We have an orientation programme and a register where they sign for the orientation given."

F1/P1

"After teaching the com server, we write in our ward in-service book, she must sign that she has attended, we have given her the lecture. Also as a group, when she comes back, she must write in the book that she attended the in-service."

Code 4: Orientation content

The operational nurse managers described how they orientated the newly qualified professional nurses in the hospitals and primary public health institutions. The orientation content ranged from simply showing the orientee the physical environment of

the health institution, internal and external, to introduction to colleagues and where they keep the medical supplies.

F1/P3

The orientation starts with the geographical lay out because they don't know this institution. …We introduce each other as to where are you from, because most of the newly qualified professional nurses are from different institutions."

F5/P1

"I show them where we keep our stock and other medical supplies."

In some health institutions, the operational nurse managers went further to discuss the job description of the newly qualified professional nurse in order to draw up a work-plan upon which the performance management would be based.

F4/P1

"We introduce ourselves and her to the other staff that she is going to work with in the ward. We orientate them to the layout of the ward and show her where is the stock items and everything. We take her privately to go through her job description and explain to her what she is expected to do as a com serve sister in the ward. Usually we take one day to do the performance plan; that is, going through her job description with her and explaining the expectations."

F3/P1

"The support we are giving them is unit orientation. We first give them the general layout of the unit, then, from there, orientate them to the procedures applicable to the ward. For instance, I am working in an emergency unit, some of them they don't know the triage; we show them how to do triage."

Some of the health institutions include the national guidelines and policies in the orientation. The protocols from the Department of Health are also explained to the newly qualified professional nurses in order for them to be able to function within the prescribed guidelines.

F3/P3

"During orientation, there are files in the units. The files are subdivided into different subjects, procedures; for instance, we have our national standards and guidelines. In those files there are procedures that we have to follow, like TB guidelines, occupational safety and other protocols from the National Department of Health."

F3/P2

"…still on the orientation programme, we tell them about the standards, policies, protocols that we use and procedures specific to that unit. For instance I am in orthopaedics ward, nurses should have clear understanding of fractures and a clear, sound mind of observation."

F2/P1

"Normally what happens is that when the new nurses come to the clinics, first and foremost as the clinic manager, you have to show them the environment of the whole clinic as orientation. You should introduce them to the staff so that they know who are the personnel that they are going to work with."

The operational nurse managers explained the rationale for the importance of knowing one another as being to establish good relations and to enhance the working relationship, as follows:

F2/P1

"Establishing good relations is important in a work situation, so that they should acquaint themselves with who is working at that clinic because you should remember that if it's a community clinic they should know who they are working with because there's lots and lots of people coming in the clinic. Another thing is that you should orientate them to the clinic policies, programmes that are run by the clinic and clinic times. And about how we do patient queue services. It is important to show them how patients are allocated to different cubicles."

The operational nurse managers from the primary public health institutions also described the content of the district office orientation given by the human resource (HR) department. The newly qualified professional nurses were introduced to how the district health operated.

F2/P1

"The induction is like a big orientation about community clinics. The programme takes about two days where they are familiarised with policies and protocols concerning medication control, transportation if you need to use the clinic transport, HR matters, and in-service education."

Code 4: Time frame of rotation in allocation

The operational nurse managers explained that the newly qualified professional nurses rotated to other wards or clinical departments within the hospital or other service areas if the health institution was a clinic or health care centre. The period of allocation ranged from one to three months.

F4/P2

"Our newly qualified com servers are on a change list, allocated for a period of two months in a ward. They rotate to a different ward as allocated on the change list, then we get new ones. Every Thursday we do the orientation, you see. If the shift starts on a Sunday, we start with the performance plan, that is the job description."

F10/P1

"There is an in-service person responsible for their orientation for the first day, thereafter they rotate in allocation to the various places like emergency, chronic services, antenatal and labour room, mental health as well as acute services. The rotation is three monthly."

They mentioned that service needs were also considered in the allocation, and some of the newly qualified professional nurses were moved before the normal allocation period or had to remain during the changeover to accommodate the health care needs of the institution.

F7/P2

"Usually it is three months per area unless there are problems where we have a crisis and need a person to remain longer or to be moved earlier according to the service needs. But we don't move a person before mustering an area and we don't move a person to a new area with a crisis because he or she will just add a number but not being functional as they still need to be taken through that area of work."

5.2.3.2 Sub-theme 2: The expected support role to be played by operational nurse managers

In this sub-theme, the operational nurse managers described the roles that they were expected to play in the induction and professional development support of the newly qualified professional nurses. Some ended up describing what they actually did, according to their experiences of supervising the newly qualified professional nurses. The experiences described are those of the operational nurse managers who understood their expected support roles. The expectations of the operational nurse managers are not formal in health institutions, and some of them end up not doing what is expected of them. Some even end up delegating the support responsibility to the experienced professional nurses, as described by some of the experiences in the codes and quotations.

Code 1: Schedule newly qualified professional nurses for in-service training

The operational nurse managers are responsible for scheduling the newly qualified professional nurses to attend the hospital in-service programme or district health programme, depending whether the newly qualified professional nurse is allocated to a hospital or primary health care centre. They also organise the ward teaching programmes and ask for volunteers to present agreed-upon in-service topics.

> F2/P1
> "…the operational nurse managers schedule the new nurses for in-service education according to their needs and what is necessary at a particular time, so as an operational nurse manager, you have to determine what is the most need in your clinic, however you can also consult with the other professional nurses in the clinic."

> F5/P3
> "…the operational nurse managers organise in-service training in the wards."

F2/P1

"The nurse managers prepare information to present on the given topics, but sometimes a consultant may be called to come and present if necessary; for example, quality management and client quality service are topics that are usually presented by consultants."

F4/P6

"We have the hospital in-service training that we usually send the com servers to as well."

F5/P2

"…allocate the com serve sisters to attend the hospital in-service programme."

The operational nurse managers ensure that the newly qualified professional nurses are exposed to campaigns, short courses and other monthly programmes run by the primary health centre or district office in terms of those allocated at the primary public health institutions.

F2/P1

"There's also monthly programmes run at the clinic like family planning, STI or immunisation campaigns, then you would slot the new nurses accordingly to learn from the exposure."

F5/P2

"…draw up a teaching programme with needs identified from the staff; every morning the experienced staff members teach about a selected topic. Usually it is the professional nurses who volunteer to do the teaching for the day. It is for a brief moment after the report."

They also demonstrate clinical procedures during the ward in-service, according to the identified theory/practice gaps.

F5/P1

"…in our ward we also demonstrate procedures during the ward in-service. We show them how to do some procedures so that they can develop clinical skills."

Code 2: Encouragement of experienced professional nurses to support newly qualified professional nurse

F3/P1

"…we encourage the experienced sisters to buddy the newly qualified professional nurses."

F10/P1

"We also encourage the experienced professional nurses to support the newly qualified professional nurses, to take them as their younger sisters and brothers in the profession, by disregarding their negative attitudes, to deal with emerging problems as mature adults and to continue with the socialisation of these nurses."

Code 3: Operational nurse managers oversee mentorship

The operational nurse managers oversee the supervision of the newly qualified professional nurses by the professional nurses and ensure that mentorship occurs. They explained that they were hands on, unlike the other nurse managers who are office bound and whose work is mainly administrative.

F6/P4

"We are in a different grouping than the other matrons in that we are hands on, we don't only do admin. We are the hands-on group, we are not the admin people. We have to fit our admin in. we are not the ones that stay in little offices, we are the floor. We have the hands-on experience of supervising the newly qualified professional nurses and see them grow from student to professional."

F10/P1

"The senior people at the clinic, that is, the operational nurse manager, the deputy and the in-service person, check on the progress of the com servers, they ask them how are they coping as they go around the clinic and they check upon the experienced professional nurses that they supervise them. They also get feedback from the mentors so that problems can be identified early and we go back to the drawing board or remedy the situation while we still can. You see, it's easier to deal with problems very early and nip them in the bud before they can grow to fruition."

F3/P2

"The operational nurse manager and the other professional nurses take turns in shadowing this newly qualified professional nurse."

In institutions where they do not practice mentorship, the operational nurse manager is responsible for the allocation of the pairing system.

F3/P2

"The operational nurse manager allocates the pairing system, but also encourages the com server to work independently."

F3/P2

"You put the com server with the experienced staff member, especially the professional nurse, so that she can teach her the ropes of nursing."

F7/P2

"With me what I do when we receive the newly qualified professional nurses, I assign the experienced professional nurse to look after them. Some of the things are not outlined in the orientation manual and I know that this is crucial. Like when they come I allocate one or two of them to the experienced professional nurse to work with them and show them how we consult the patient and so forth. This allocation is for two weeks".

Code 4: Allocation and duty scheduling

The operational nurse managers allocate the newly qualified professional nurses to the different clinical departments. They oversee that the duty schedule is planned in such a way that novice professionals are not left alone without the supervision and guidance of the proficient and expert professional nurses. They also check if the newly qualified professional nurses are coping with the allocated work load.

F7/P4

"Our role as operational nurse managers is to allocate them to the different services of the clinic when they arrive. We also check upon them to see if they cope."

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F7/P4

"You check if they can catch up with what is happening at the clinic, like in the area where they are giving immunisations, I must see to it that she is following, she must not just be there as an observer, she must take part so that she can be able to work alone later."

Code 5: Writing of quarterly reports

The community service regulation (SANC 2007:4) stipulates that the public health institution where the community service practitioners are allocated should write quarterly progress reports that are to be kept at the public health institution and to be produced upon demand to the nursing and midwifery regulatory body, which is the SANC. Some of the operational nurse managers were reported to be writing those reports.

F4/P3

[The operational nurse manager)] writes the quarterly report for the newly qualified professional nurse with input from the senior professional nurse. She conducts an interview of the newly qualified professional nurse and the senior professional nurse; the report also includes the hospital orientation which is at the beginning of every month, the area orientation and other things that she has been exposed to in the ward during that two months."

In some of the public health institutions, the operational nurse managers displayed ignorance about the community service legislation. When asked whether they did write the quarterly reports as legislated in the community service regulation, R 765, they did not even know about the regulation. They explained that they filled in the final form required by the SANC upon completion of community service.

F5/P2

"'R' what? I don't even know about that regulation, I have never heard about it. I wonder if my colleagues know about it?"

All: "No, we don't!" '

F5/P1

"…we fill in the final SANC registration form that is also signed by the coordinator before taking it to SANC for their final registration as professional nurses at the end of the year when they have completed community service."

Code 6: Identifying differences in the level of competence

The operational nurse managers have to acquaint themselves with the newly qualified professional nurses to identify their levels of competence. They explained that the newly qualified professional nurses differed in their levels of competence. They assess them informally to be able to allocate them accordingly. Those who need a lot of supervision are not allocated to the same clinical area, to ensure that they are evenly distributed among the ward professional nurses for supervision and guidance. The operational nurse managers even went further, to draw a contrast between the university and the nursing college products. They mentioned that the university-trained newly qualified professional nurses had been allocated to clinical practice for fewer hours than the nursing college students, who had been allocated to clinical practice for longer hours. This issue was raised mainly by all the operational nurse managers of the same province. In the other three provinces the operational nurse managers stated that some of the university-trained newly qualified professional nurses were competent.

F6/P4

"It is understood that the new nurses met the SANC minimum requirements as professional nurses, but it is in most cases minimum. Like with the university students, you don't know their level of competence, especially that they come here for…what? Five days for their admin? You see, the college students, it's different; you can gauge their level of competence quicker and know where to concentrate, because as students they worked shifts, seven till seven, and that prepared them. They worked shifts like the permanent staff, to prepare them for now. You see, even the absenteeism is much less with them, because they are used to the shifts. You see the difference again? From second year they work shifts already. Unlike the university com servers, even if they come to your ward being in their ninth month or even twelfth month, you still hover over them for a while, to cover their backs."

The operational nurse managers explained that they even had to extend their shifts at the beginning of the community service to help the other professional nurses to supervise the newly qualified professional nurses, because they lacked clinical competence.

> F6/P5
>
> "You see, although we knock off at four, we come in at half past six in the morning. During their first days as com servers, we don't even knock off at four, we stay on until they are comfortable. You can't leave her alone with the sister that's covering her. When she [the sister] gives doses on the other side, you must see that you supervise the com server this side. Like the early doses that are given at eleven o'clock, that's the time that the new nurse will go with the operational nurse manager, working hand in hand. That is the time that you pick up that they…, most of them are pathetic with calculations, and sometimes I blame it on the calculator story, because ours is manual dosages. So you will find that operational nurse managers work until late time, to ensure that the new nurse does not fall into that trap, because we know that even in our absence, we still need to take responsibility for their actions."

5.2.3.3   Sub-theme 3   Actual support provided by operational nurse managers

Code 1: In-service training and courses

The newly qualified professional nurses are taught on the spot while working. The experienced professional nurses teach them as the learning opportunities arise.

> F1/P1
>
> "…in the ward I do the individual teaching of the com server, because there are so many things that she needs to know as a professional nurse."

There is in-service training over and above the spot teaching. The newly qualified professional nurses also attend the institution's in-service programmes for all nurses.

> F6/P3
>
> "We also have in-service training programmes that they attend that are over and above."

The in-service training is done in the form of attending departmental clinical meetings in the paediatric wards of some public health institutions. They discuss case studies and explain the patient records, indicating ways for improvement in patient care.

> F1/P2
>
> "In the paediatrics department, the com servers are invited to take part in the 'CHIP' meetings. This is the forum where we discuss childhood diseases and their management. In the child health improvement programme (CHIP) meetings, we come together as paediatric wards to discuss patients' problems and where we went wrong, in order to improve."

Code 2: Mentorship

Operational nurse managers explained different forms of mentoring the newly qualified professional nurses. There is a mentor and a mentee in this form of mentoring, but the mentorship is not formal. Usually the newly qualified professional nurses are allocated to work closely with an experienced professional nurse. The experienced professional nurses are in the proficient and expert developmental stages, whereas the newly qualified professional nurses are either at the novice or advanced beginner stages of Benner's stages of nurses' development.

> F1/P1
>
> "Wherever she is in the ward, we pair her with an experienced professional nurse. Like the one we have now, when we want to teach her how to take doctor's rounds, in the first instance she must be paired with an experienced professional nurse."

> F4/P5
>
> "It is not a formal programme but the newly qualified professional nurse is linked to a specific senior professional nurse, because they work the shifts together. The operational nurse manager cannot oversee what happens after four, at night or during weekends."

The newly qualified professional nurse is not regarded as a competent professional in some clinical departments until she demonstrates clinical competence in the

department-specific clinical procedures after she has been mentored by the experienced professional for a period.

F4/P3

"You see, in a maternity ward it differs from other wards. We don't expect her to be a midwife, we let her work with somebody senior at first then as days go by we can see that she can do deliveries on her own then we allow her to work independently. Usually it is after a few weeks, as their level of competence and confidence differ. Some people are very scared of some work areas, they need guidance longer than others, they are individuals, you know; some will just do and get it right, while others will shy away and only come forward after a while. You need to assess the capabilities of this new sister and guide her within these two months that you have with her. We also write them quarterly reports."

F1/P2

"In paediatrics, what we usually do, we, we kind of allocate a mentor, like we give one to Lesedi [not her real name], and Lesedi will go with her in her rota. When you are on duty, she is on duty; we pair them. The mentorship is informal for the ward; it's not a formal institutional thing; it's how we do it in our department and it's working for us."

F1/P3

"The newly qualified professional nurses get allocated to an experienced professional nurse like in the other wards, but you can find that one professional nurse gets allocated to more than one newly qualified professional nurse in her team for the month, as we have many of the newly qualified professional nurses in our ward."

The pairing of a newly qualified professional nurse with an experienced professional nurse is done from a minimum of one week to a maximum of two months in the various public health institutions. The operational nurse managers expressed a feeling that mentoring the newly qualified professional nurses for a long period would deprive them of their independence as professionals.

F3/P7

"They are paired with someone with experience for the first week, then they are left on their own during the second week."

F4/P4

"We have a pairing system during the two months when we have com servers in the ward. We pair the seniors with the juniors when we draft off duties. We avoid a situation where we will only have seniors in a shift and vice versa. We pair a senior sister with a com serve sister at a time."

F3/P7

"…the pairing system is for only that week. In the second week we sort of abandon them. We really can't cope with buddying them, but in the first week we buddy them to the fullest, while undergoing that unit-specific programme. They become in charge of patient care in the observation. You see, if you buddy them for a long time they become students forever."

F6/P3

"We normally pair the older nurses that have been in the department for years, we link them up with one of those newly qualified professional nurses, then there is an older experienced person working who is supposed to cover the two areas; for example, the one is in acute critical and the other is in just acute. The new nurse will understudy the one in acute and then later move over to the acute critical when she now has the basics in paediatrics. But there will always be a permanent staff member that is covering her."

Some operational nurse managers feel that exposing the newly qualified professional nurses to the ward activities is empowering them and fosters independence.

F3/P7

"She is empowered through exposure. If we buddy them for a long time they do not stop being students. We abandon them to foster independence. Time doesn't allow us to buddy them throughout."

The mentorship is said to be informal, but mentors write progress reports for mentees to give them feedback about their professional development. The reports are also used by the operational nurse managers to write the SANC quarterly reports as a requirement of community service.

F10/P1

"The mentorship is informal. It is not a formal programme from the Department of Health, but the mentor documents the progress of the mentee. These mini reports aid in the discussions between the mentor and the operational nurse manager when they write the quarterly reports for the mentee."

The time frame for mentorship differs from public health institution to public health institution. In some the mentorship is for a week, in others a month or three months, the average period of mentor/mentee allocation being a month.

F1/P2

"The newly qualified professional nurses are allocated to the ward for three months, then they rotate. The mentorship is on a monthly rotation. The experienced professional nurses get a new mentee monthly, so that the NQPNs can get an opportunity of learning from all of us in the ward during the three months."

Code 3: Team allocation

This was described as another form of support given to the newly qualified professional nurses. They get allocated to a team with all categories of nurses. They will be supervised by the professional nurses in the team, will become a team member and be treated accordingly.

F1/P4

"The allocation is per team, per rota and per shift. We group the new professional nurse with a certain team in a rota, like there will be rota 1, 2 and so forth. If we are two experienced professional nurses in a rota and we have one com server, both of us must teach her, monitor her and supervise her work. Both of us will teach her. She is allocated to the team, not to a specific professional nurse."

The newly qualified professional nurse is shown how to carry out various ward activities and is allowed to practise under the supervision of the team professional nurse.

F1/P1

"She takes rounds and she must give us the report, she must do handing over, hence she must see herself as a professional nurse. But she needs to be monitored closely. She must have somebody who supervises her. If she has a problem…then the next time she does it alone but under supervision."

Some of the operational nurse managers indicated lack of trust in the education and training of the newly qualified professional nurses. This was evident in the quotations below. The participant sounded doubtful of the qualification and the scope that the newly qualified professional nurses should cover.

F1/P1

"…we treat her like a qualified professional nurse. Of course she is qualified, because she does everything."

The time frame for the team allocation ranged from a week to three months, depending on the stability of the ward and personnel availability.

F1/P4

"…it will be for a month if the team is not disrupted by unplanned leave or night duty. Sometimes we allocate them to a team for a week, or a month or even the three months that she will be in the ward. The teams change the delegation; e.g., if they were in admission yesterday, today they might be in the labour rooms. We try very hard not to destabilise the teams and we avoid daily allocations to enhance cohesion and stability in the groups as well as the newly qualified professional nurses."

Code 4: Closing the gap of inadequate clinical skills

The operational nurse managers observed that some of the newly qualified professional nurses had inadequate clinical skills and were not yet competent. They were reported to be at different levels of clinical competence. The operational nurse managers described their interventions to close the theory/practice gaps that they observed to enhance clinical competence.

F1/P1

"Even if the patient changes condition, she will not? Tell you that the patient is changing condition. I phone the doctor, I just get in to close the gap, where I feel that she didn't do, may be the patient is not feeling well, she must take the glucose level, may be the patient is not feeling well. She would have done TPR and BP and she forgets the other baselines."

F5/P2

"I have one com serve sister. She is from another ward, so she was orientated there. You see, some are good, some don't know anything."

F4/R2

"…we let her work with somebody senior at first, then as days go by we can see that she can do deliveries on her own, then we allow her to work independently. Usually it is after a few weeks, as their level of competence and confidence differ. Some people are very scared of some work areas; they need guidance longer than others, they are individuals, you know; some will just do and get it right while others will shy away and only come forward after a while. You need to assess the capabilities of this new sister and guide her within this two months that you have with her."

Code 5: Leadership skills development

The operational nurse managers teach the newly qualified professional nurses to coordinate ward activities and to manage patient care as well as the personnel. They rotate them as junior coordinators for a week. They develop their leadership skills by putting them in charge of the ward under direct supervision of the operational nurse manager, teaching them to take responsibility.

F1/P3

"They also rotate weekly on being a coordinator. We call them junior coordinators. They are mentored on ward leadership, problem solving, being in charge of the ward and so forth. I show the leader for the week what do we do when this happens, how do we do this, how do we write the different reports and stats required from the ward daily and monthly. When we are having a bereaved family, how do we handle them and what is the procedure to follow in helping them. I work with her for the week as the operational nurse manager, teaching

her how to be a manager for that time. I allow her to do some of the things and I supervise her. That's what entails being a junior coordinator for the week."

F3/P7 "…we have a programme for them, because on the second week in the ward, they have to start to be in charge of the observation unit. They have to take charge of the activities there… they won't be working with a buddy, they will be solely responsible."

Code 6: On-the-spot teaching/teachable moments

Another form of professional development reported to be used to enhance clinical competence of the newly qualified professional nurses is the use of teachable moments. The professional nurses grab every available opportunity to teach, because of time limitations and the shortage of personnel. They prioritise patient care and teach the newly qualified professional nurses as the moments arise while rendering patient care.

F3/P4

"…when the newly qualified professional nurse comes to you, you give her the ward specifics. Every teachable moment we try to use it to guide the new nurse. For instance the ordering of drugs, it's like an in-service every day."

F5/P2

"…also use teachable moments because there is limited time between patient care and teaching."

F6/P1

"…ward teaching and the spot teaching, as the… as the moment arrives and something happens, for me it's ideal to get the person through the process."

F6/P2

"…my experience is the same as that of my colleagues, because as the com servers come to your ward, you teach them the specifics if they are already from another ward, but bear in mind the staff shortage that you have. You can plan your things in advance, but now you have to deal with this and that. So at the end of the day you end up with spot teaching as has been mentioned already. So, people differ from the next person, you guide this person and see that this person

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is a witty person I can say. I give him this scope and he can cope and he gradually becomes more confident. But that is not always the case."

5.2.3.4   Sub-theme 4: Professional socialisation

Code 1: Role-modelling of professional behaviour

It was explained that the ethos of nursing and professional socialisation were included as part of the nursing culture during the orientation process. The core values of the nursing profession were explained to instil professionalism.

> F7/P1
> "We also orientate them about the core values of the organisation and professionalism. This is to say what is expected from them and how they must conduct themselves during the execution of their duties, what to do in a workplace."

> F3/P5
> "We teach them about etiquette as well, how to behave in this profession, because they are still neophytes: professional socialisation, you see."

Code 2: Allaying the anxiety and fear of newly qualified professional nurses

The newly qualified professional nurses are said to experience anxiety and fear of the unknown. The operational nurse managers help them to acclimatise to the new role of being professional nurses.

> F10/P1
> "Sometimes the attitude is a defence mechanism to deal with their anxiety and fear. As you get to know them, they are just young-adults, newly qualified, who need our guidance and support to mature in the profession. We need them to take the baton when we retire. We must each strive to leave a new better us in the profession so that there will be no void. We must prepare them while we still can, which is now."

5.2.3.5 Sub-theme 5: Feelings experienced by operational nurse managers during the support period

Code 1: Anxiety – "Are we doing a good job?"

The operational nurse managers felt worthless and expressed a feeling that they were not coping well. They felt anxious, wanted to help support the newly qualified professional nurses, but they just felt overwhelmed by the large numbers allocated to the health institutions and lack of resources.

> F6/P1
>
> "The supervision of the newly qualified professional nurses, and it differs from institution to institution. Because I just think and share the same sentiments with the others. I just feel we did a great job yes, but to this year's CS/PNs, but we did not do what we are supposed to do."

> F6/P2
>
> "It also differs from department to department in this institution! Like I said earlier, that's why I said paeds is a far cry from everybody else when it comes to routine, not that I want to be seen! So the bottom line is, what it boils down to, besides this departmental differences and discipline, there is so many of them, these com servers, they unfortunately cover the slot wherein we could get in an agency professional nurse. Like, was it last year when we had sixty? [Group answered: 'No it was last of last year, in 2012'] you see, we get this large number, huge numbers coming through! That is our major problem. We've got many being fuelled into the institutions, yet we have no resources."

> F3/R2:
>
> "…eish, yeah, the numbers are too big. We cannot cope. It's the students this side, it's the com servers this side, yeah neh!"

Code 2: Ambivalence

Some of the operational nurse managers were not cooperating in the provision of support to the newly qualified professional nurses, citing several excuses for not being involved in their induction. Excuses ranged from being overworked or not being involved

in the planning of orientation programmes to feeling that they were wasting patient care time as the newly qualified professional nurses would leave upon completion of the community service. The operational nurse managers might see this as a waste of their time because they would not enjoy the fruits of their labour.

> F2/P1
>
> "As an operational nurse manager, I have limited time and I am not directly involved with the training. The district office sends a list of things to be done at the clinic and the others they do them at the district level. If they can involve us as managers then I could add on the list."

> F2/P2
>
> "If I have allocated this newly qualified professional nurse to this ward, [and] after the completion of the community service she will stay there, we would make sure that she is coached more to how the unit works, but because they are here for only a year, they don't stay. Sometimes they stay for the community service period, then they leave the institution."

Code 3: Anger

The operational nurse managers explained that they were trying their best to support and enhance the transition from student to professional, but their efforts were hindered by those who were reluctant to learn.

> F4/P6
>
> "We are trying the best that we can do to ensure that they are competent by the end of the com serve year, but you see, we have new sisters that are very good post com serve, but you still get others that are not yet there, they still have the mind-set of a student. …we still have those that are nothing but a nuisance!"

> F5/P5
>
> "It's a problem, you don't know. The minority are the ones willing to learn, the majority don't care. They even exit community service still in a daze!"

F7/P4

"They also have an attitude of 'I don't care'! But it is not all of them, just some. But the number of those with the attitude is significant enough to make one wonder is it really worth it, taking away precious time for patient care and supporting this person who does not even care what's going on around him or her?"

The operational nurse managers described feelings of anger at DoH for putting them in the situation of having no personnel and no resources, yet expecting them to show others how to do the work, or even role-model professionalism.

F10/P1

"You see, ma'am, our government is very good in talking but do not implement, implementation is not there. We still do not have those uniforms and we are very far from getting them! They do not walk the talk!"

They went on to describe how the shortage of personnel led to inadequate supervision of the newly qualified professional nurses.

F6/P2

"Council found them competent and so on, and they have completed their degrees and their certificates are there and so on, and their SANC receipt is there and so on, but their knowledge! To these community service/professional nurses they are doing injustice to them, and I don't blame them when they do not feel competent and confident, they are like, arghh!..., and I also feel so when I have to leave at four o'clock, and I feel so sorry that I have to leave, you know, because the poor community service professional nurse has to cling on to the enrolled nurse to supervise her and to leave her like that in the first three months? Mh! We can be glad that we did not end up in Council for hearings and stuff (Mhh! Mhh! All agreeing with her). We can be so glad that they were not giving us grief...doing things that were not supposed to be done! They listened to us! But the supervision, it's really, it was not adequate enough!"

The operational nurse managers displayed feelings of anger when they related how the newly qualified professional nurses lacked the clinical skills that they were expected to have. They even expressed feelings of mistrust towards the education system.

F10/R1:

"Competent? no, not at all! We could talk till sunset. You see, when we were newly qualified professional nurses like them, we could be left in charge of a ward, even the labour room, because we were used to being in charge from when we were student nurses. With them you can't. That day, you will be called by the minister of health himself where ever you will be! That's why the saying that 'dogs came to nursing'. The com servers are a hazard to the community."

F6/4

"It is understood that the new nurses met the SANC minimum requirements as professional nurse, but it is in most cases minimum. Like with the university students, you don't know their level of competence, especially that they come here for…what? Five days for their admin? You see, the college students, its different, you can gauge their level of competence quicker and know where to concentrate, because as students they worked shifts, seven till seven, and that prepared them. They worked shifts like the permanent staff, to prepare them for now. You see, even the absenteeism is much less with them, because they are used to the shifts. You see the difference again? From second year they work shifts already. Unlike the university com servers, even if they come to your ward being in their ninth month or even twelfth month, you still hover over them for a while, to cover their backs."

Code 4: Guilt – for not providing the expected support

The operational nurse managers expressed the feeling that they were doing an injustice to the newly qualified professional nurses as they were short staffed and therefore could not give them the support that they needed to enhance their transition from student to professional. The work load in some health institutions was also regarded as being too much for an inexperienced professional nurse, leading to poor coping.

F6/P1

"Mhhhrr! Mhhhrr! Mhhhrr! (clearing her throat). The supervision of the newly qualified professional nurses, and it differs from institution to institution. Because I just think and share the same sentiments with the others. I just feel we did a great job yes, but to this year's community service professional nurses, but we did not do what we are supposed to do. 'Ons doen 'n onderrig in ons community service professional nurses'. We are doing an injustice to them because we do not bring

them to the same standard as us. Now sorry to say this…, but the supervision lacks, because I am the only operational nurse manager, I have one permanent member as a professional nurse and on the other shift I must deal with newly qualified persons that came on board, and, they are both com servers, and if I have to leave, the ward is not properly covered with professional nurses. You see, if I can have a professional nurse and a com server, and another professional nurse and a com server, and me until four o'clock, I will achieve more out of their com serve, I will achieve more for them. So the staffing and the supervision itself for me go hand in hand, and is a challenge."

5.2.3.6 Sub-theme 6: Challenges in relation to induction and professional development support

The challenges are about the newly qualified professional nurses, experienced professional nurses, nursing management, human resource and other issues in relation to the support of the newly qualified professional nurses. Some of the challenges were raised by the operational nurse managers, while others were picked up by the researcher from the focus group conversations. The experiences of the operational nurse managers were similar across the four provinces of data collection.

Code 1: Lack of professional development support

In some health institutions across all the sampled provinces, there were areas where there was no induction, no orientation, no supervision, no in-service education, no mentorship, no role-modelling and no professional socialisation, due to various issues reported by the operational nurse managers, the most prominent being the shortage of professional nurses and increased workload.

Shortage of personnel

The operational nurse managers cited a shortage of personnel that led to inadequate mentoring. Team allocations were also dismantled frequently due to the shortage of personnel, so that team members had to be allocated elsewhere.

F1/P5

"…a challenge is that, when we are short staffed, they don't get this proper mentoring. You find that you have to take her from this team, to give her to another team. In that case you find that she gets confused, because we want her to get used to that group to build a better working relationship and trust."

F1/P4

"Sometimes we become short staffed with the professional nurses, so the operational nurse managers will take them up to do the ward administration with them. I orientate them on the ward admin as well."

Inadequate supervision

The shortage of experienced professional nurses led to inadequate supervision and guidance of the newly qualified professional nurses. In some instances the operational nurse managers ended up working longer shifts to cover the shortage of experienced professional nurses and to provide the supervision of the newly qualified professional nurses.

F2/P2

"…actually we do find challenges in ensuring that the newly qualified professional nurses find their feet in the service. One of the challenges is staff shortage that I alluded to earlier. That is our main, main challenge in their supervision and development."

F3/P4

"We have a terrible shortage of staff. You find that it is you, the operational nurse manager and the newly qualified professional nurses on duty, you have to support her; you can't leave her alone after four."

F5/P2

"We encounter a problem of shortage of personnel. We have to leave the com serve sisters alone after four in the afternoon and some of them cannot manage. We leave them alone during the second month. We do overtime during the first month when they are still settling, but then we have to leave them."

On average, the operational nurse managers observed that the newly qualified professional nurses took about four to six months to show clinical competence, confidence and independence.

F5/P2

"...it depends on an individual. On average the competence level is moderate by the fourth month of community service."

F7/P2

"This also depends on the adaptability of a person, some do not know how to consult clients in the primary health care setting and might take longer than two weeks being inducted in that aspect, but the majority are functional in an area within two weeks of being taken through by the experienced professional nurse. We don't just take it that they have been taught at school then leave them, we take the person through, let them work under guidance and assess him or her; then is then that we take a decision about her capabilities in that area as to whether they can be released to the next area of the clinic, after mustering the current."

F7/P1

"I am from an 8-hour clinic. When we receive the newly qualified professional nurses, they are mostly anxious and without confidence. That happens especially if they were not allocated to the particular clinic for practica while they were students. They take on average a period of six months to be competent, confident and work independently as safe practitioners."

They also stated that there were exceptions, where you might find that a newly qualified professional nurse adapted more quickly than others or else became independent long after the six months.

F7/P2

"…but people are individuals, you know, I had one who amazed us at the clinic. She was fully functional within two months! I told her that I have never seen such a thing from my experience with the previous groups. So there are exceptional individuals, though on average they become fully functional at six months of community service.

F6/P5

"It is unfair to the com server who now has to take charge of thirty-six to forty patients. And sometimes that com server has to cover two wards when there is absenteeism and the other nurse for the other ward did not come. She will now have to take charge for seventy plus patients! Which is absolutely disastrous to expect this young nurse to cover two wards."

Negative impact on mentoring and no in-service education

The shortage of personnel leads to a negative impact on the mentoring of the newly qualified professional nurses and eventually on their professional development. Some public health institutions end up without the mentorship, while others do not plan in-service programmes due to the shortage of personnel.

F2/P2

"In the hospital we haven't established well a formal in-service training programme after the induction period, due to the staff shortage. We cannot afford to take them away again from patient care. They get hands-on coaching by the professional nurses that they work with. Further training is direct supervision by the unit personnel."

F3/P5

"…the shortage of professional nurses also affects them, you find that the professional nurse is there but she has to attend to other ward duties, and thus cannot support her."

F1/P5

"…the wards have a shortage of manpower and you find that the com server is allocated to the ward to augment the number of professional nurses, while on the other hand she has to be mentored. That's why we say that proper mentoring is needed and it is lacking."

The operational nurse managers explained that they prioritised patient care over all other responsibilities. The support of the newly qualified professional nurses would be done as and when they had a moment to get to it.

F6/P1

"It's all about ourselves and the institution about how we are staffed, because if we are not well staffed, the com servers are the people that normally bear the brunt, often because you can't normally get to them, to teach them and everything, because your patient care comes first, because you focus on your patient care and patient issues first, and then you take them alongside with you throughout the day and so the next day continue and so comes Wednesday and Thursday and so on, and this is how we do with them and if you have a moment, where you have a quiet moment, and that which I normally don't have, because I am working in a surgical ward and it's the theatre cases every day. So we work and talk together, I drag you with me, this is how I do it."

F3/P9

"…yes, patient care takes top priority, we really do not have time to attend to the newly qualified professional nurses adequately. That's why sometimes you find that even the ward admin takes the back seat. The overall ward admin is not up to standard, mh mh! [shaking head]."

The operational nurse managers experienced reluctance by experienced professional nurses to do mentorship. This was reported to be mainly due to the fact that the mentorship was not formal. They indicated that the experienced professional nurses would be compelled to mentor the newly qualified professional nurses if mentorship could be formal.

F1/P5

"I suggest that the nursing management should start counting professional nurses from those that have completed community service so that the ones on community service can get enough personnel in the ward to mentor them. But if they are counted as professional nurses on the staff establishment then the patient care and mentoring will suffer, as the number of professional nurses experienced to give patient care will be the same that is also required to do the mentoring within the same time. One of them is bound to suffer, and usually it is the mentorship, because it is not formal."

Code 2: Inadequate orientation content and time

The orientation content and time was cited as being inadequate. The newly qualified professional nurses were expected to be functional as soon as possible to alleviate the shortage of professional nurses, while the length and depth of the orientation was not looked into.

> F2/P1
>
> "…according to me, the induction period is too short and the programme is not comprehensive enough."

Code 3: Lack of self-confidence accompanied by fear of the unknown in newly qualified professional nurses

The operational nurse managers described the newly qualified professional nurses as having a reluctance to work independently. They were said to be lacking self-confidence and having a fear of the unknown. They were also reported to be suffering from separation anxiety, still longing for the guiding hand of the clinical tutor.

> F4/P1
>
> "For me is like they are used to the tutor as the mother figure that always guided them as students, they do not act independently, they want somebody to always take their hands. They do not come forward to say, hey, I am struggling to write an incident report, please guide me. They are covered as babies, they can't be in charge of the unit by themselves, they always ask the other professional nurses for everything, I feel that they should be slowly given the chance one day at a time to be in charge of the unit under the supervision of the operational nurse manager."

> F5/P1
>
> "…guidance and support is needed at all times. Like in my ward, when I knock off at one, they will be saying "you can't leave us alone, why do you leave us alone?" they have the fear of unknown. They lack assertiveness and confidence. If you leave them, the following day when you come, you will find a lot of problems and incidents. For example, the other time one pricked herself while drawing blood

and then again pricked herself with the Jelco needle while putting up a 'drip', and the patient is HIV positive. You see, two incidents in one department."

F1/P1

"…we have a problem of lack of confidence in some of them, like when the mentor is lagging behind for whatever reason, she will say please sister come, she will be reluctant to do things on her own initially, like going to theatre for a caesarean section to collect the baby. So we have to constantly remind them that they sometimes have to work independently as professional nurses; in case the mentor collapses, they must be able to carry on. They must not put their hands on the head and say there is no professional nurse in the ward, they are also professional nurses."

Some of the operational nurse managers were of the opinion that the newly qualified professional nurses should be gradually guided towards independence, leaving them to be in charge of patient care, being supervised indirectly.

F4/P3

"…allow this com server to act and to make decisions independently as a sister in charge. This will ensure that they improve in their leadership capabilities. You see, there is always another professional nurse by their side, I feel that they should come out of their closets or comfort zones of being a baby or junior or com serve sister at some stage. Some of them are competent but some of them are slow or something."

F6/P4

"The biggest challenge is when they are left on their own; that is when they have to prove themselves and sometimes that is really difficult. That's normally during weekends when they have to work with the lower categories and be in charge of the ward as professional nurses."

Other operational nurse managers did not have confidence in the newly qualified professional nurses. They described them as lacking accountability and responsibility.

F10/P1

 "… they are inexperienced, they do not want to take responsibility and accountability. They also have a fear of the unknown, they always fear that something wrong can happen or what I don't know. They are insecure and display some form of separation anxiety. It's like they still want the tutors to come and support them. Maybe the colleges and universities must still send the tutors to come and check on them, reassure them."

Code 4: Allocation and scheduling challenges

The allocation of the newly qualified professional nurses to clinical departments is a challenge to public health institutions where they are in large numbers. They end up repeating disciplines and start to have a negative attitude. They start to question duty schedules and absent themselves unnecessarily.

F1/P5

"…there are so many of them, the com servers, like, they are allocated for a period of three months, and some of them will be from surgery coming to level one surgical, so I don't know how the allocation works, I mean you can't repeat a discipline or department if you have to learn. Then they start to give an attitude, so I suggest that they must not repeat a section, discipline or department."

F3/P5

"Sometimes is about the off duties. They say that we should allocate the newly qualified professional nurses to do office hours in the first month of com serve. But when she comes to the ward, the newly qualified professional nurses prefer to work normal hours worked by all in the ward, seven/sevens included."

Some operational nurse managers felt that the period of allocation was too short for them to be able to effectively support the newly qualified professional nurses.

F6/P1

"…for me, my experiences of supervising the newly qualified professional nurses is that the time is very limited in which you should take them through. They rotate on three-monthly basis to each ward, but that should not be an excuse not to mentor them. It's just that we have to rearrange our programmes in the ward and take them through."

F3/P8

"The general challenge here is that they are currently allocated for one month in a ward. The time becomes too little for her to learn. When she starts to adjust to the ward, she is taken away to start in another ward."

Code 5: Experiences of negative attitude from newly qualified professional nurses

Some newly qualified professional nurses were observed to have a negative attitude, especially to the area of allocation if it was not their area of choice.

F2/P3

"…needs assessment should be done when they come to the institutions, you see, ma'am, with the attitude of most of our new nurses, it is difficult to engage them in what you are doing as the routine of the ward. I don't know how they find them at the clinics but hey! We are having difficulties at the hospitals! You don't know what they know and what is it that they don't know because of the negative attitude that they have, especially when allocated to us in the rural areas, they did not get their choices of the big city hospitals and they ended up with us in the rural areas!"

There are those who have power issues. They look down upon the operational nurse managers who do not have nursing management as a qualification, or experienced professional nurses who have single qualifications, like general nursing only (SANC R683 programme), compared with themselves who qualified with general nursing, psychiatric nursing, community nursing and midwifery (SANC R425 programme).

F5/P2

"There are those that are okay but there are those who for instance will tell you "ah! What does she gonna tell us, she is bar one, mos". So generally the com serve sisters have ego issues about their training. When they find that I am an operational nurse manager and I am from bridging course, not from R425, they display that attitude. There are others though who are willing to learn from us, they don't have power issues. They know that they are starting and we have the experience."

F10/P1

"…when they come most of them have an attitude of "we know all" and they have power issues. They look down upon us and say that we are old, what can we tell them? They even look at your epaulettes to check your qualifications and decide "How much do you weigh on their scale of knowledge"."

Code 6: "Hiding behind others"

Some newly qualified professional nurses were reported to be playing truant, while others were still in a confused state, between being a student and a professional nurse. Others were still hiding behind others and being observers when they were expected to be hands on.

F4/P3

"You see, ma'am, we still have those that still hide behind others during com serve, and you find that they are the ones who were not hands on as students. They want to continue to be observers even during com serve, and where will they hide as sisters the following year when com serve is complete? You see, I appreciate a person who wants to learn, somebody who will say "teach me", saying that coming from within her, not somebody who wants to be dragged on! Expecting me to identify everything, and I need to teach the whole lot of them. Why can't she say, "come and teach me how to do this? Come and show me this or that? I am here but I am not sure". As we have already said that some are excellent, I need to know who needs help with what."

F4/P2

"…there are those that you ask yourself what are they going to do next year when they are not under the umbrella of community service? That's because the com serve is protecting them, some of them are willing to learn but they are not so quick, before long the com serve will be over! Yes the com serve is to help the country with the staffing but in some instances "we get the eyes to look not the hands to work!"

F10/P1

"Some of them are still observers when we work, they are not yet there with us. They continue hiding behind others as if they are students. And it is difficult to assess the capabilities of such a person and the support needed. You don't know

which gaps to fill. There is still the problem of 'us and them', and yet they should be incorporated and we work as a team to advance their development and for quality patient care."

F7/P1

"I have experienced those that are confused or delinquent, I don't know. Like they are confused as to when are they no longer students and when are they professional nurses. They duck and dive between being professional nurses when it suits them and hiding under being new when the responsibility grows. The majority that I had do not want to take responsibility, claiming that they can't be in charge when asked to, as they are still new, but they will tell you that community service is not an internship when they have to learn."

Code 7: Poor clinical skills due to lack of clinical exposure

The newly qualified professional nurses were said to have poor clinical skills due to lack of exposure to the clinical procedures during their training. They had missed valuable clinical learning experiences and they met only minimum requirements when they qualified. They started community service having more theory than clinical skills.

F10/P1

"The com servers are newly qualified professional nurses with a lot of theory and less clinical experience."

F3/P2

"The other challenge is about the newly qualified professional nurses themselves, during their training, there is something that they miss. When they are students they do not expose themselves to other clinical learning experiences, they concentrate more on what is written than the actual patient care. They forget that after the four years they have to do the actual practice in the wards."

F5/P5

"…they lack clinical skills, decision-making and problem-solving skills mostly, though there are those who have the skills, they just need to polish them to perfection. More often you find that you have to teach them to do things but others have the knowhow, they just need the confidence. Others they don't even

know the medications that they have to give, and they have to teach subordinates, the younger students allocated in the ward."

The experiences of the operational nurse managers were that the newly qualified professional nurses from the nursing colleges adapted easily to the new role of being a professional nurse. The reason given was that the nursing college students spent more time in the actual clinical practice areas than the university students.

F6/P5

"…those from the colleges fare better when they do com serve because their clinical practice was the real experience with patients, while the university products had more skills lab experience and they have to acclimatise when they get to the hospital."

F6/P2

"It is unfair because at the end they get the same qualification and they are com servers of the same province. You see, the university students get more skills lab hours, they have book knowledge; whereas the college students are more hands on in the real clinical area for practice. They practise, do the demonstrations and get evaluated here in the clinical area. We do the observing, we do the practising, then the competency is done by the tutors, on this grounds, not at college, unlike the university."

F3/P3

"…there is a difference between the university students and college students when they are newly qualified professional nurses. We observe the more theory but shortage of skills in the university students. Most of them are blank when coming to procedures. They depend more on the professional nurses when they come in as newly qualified professional nurses. They become observers most of the time, because they are not used to the practical part of it."

The operational nurse managers elaborated on the lack of the basic clinical skills that they were expecting from the newly qualified professional nurses from nursing education.

F5/P2

"They need to be supported in doing basic staff when they come in as newly qualified professional nurses, things that they should have mastered as students. So instead of us taking them to the next level of being a professional nurse, we end up teaching them basic procedures."

F6/P3

"Coming back on that,…there are things that they are still lacking on, for example, the disciplinary, the blood giving, the…eh…, like there's a lot of skills that they are lacking on because many a times they will come through, but they never worked at this hospital as students. So we have to start them afresh in a lot of things that they should have covered in their fourth year, not as com servers, they should have done already, and that is their shortfall."

F7/P3

"Some of the newly qualified professional nurses are struggling to put theory into practice when we receive them. Like the HIV programme, it is part of their curriculum, but I had one who had to be sent on a refresher course of the very same programme that she has done at school, and I had others who did not need any refreshment over and above the orientation, they were able to implement it, integrating the theory into practice very well."

F4/P3

"There is a shortage of basic clinical skills, maybe the clinical exposure was inadequate, but that's what we find in most cases."

Some of the operational nurse managers, however, had different experiences of supervising the newly qualified professional nurses. They met some who were from the university who had very good clinical skills and some who had very poor clinical skills from the nursing colleges.

F3/P8

"Not all of them. I've had one university graduate who was allocated to me. She was a very, very, good sister and was mostly independent, and we do have those from the college, some of them after finishing from the college, when they are on com serve, they are empty! You have to start them from scratch, you will even

ask yourself if they really have done admin. So we do get college graduates who have had minimal exposure to the clinical area, especially admin."

F4/P4

"At some stage I was working during the weekend and the professional nurse in the medical was off sick and the com serve sister had to be in charge. I was there to pick up problems, being in the opposite ward. She was not a good com serve sister but that day she coped well. She managed well. I think that they do come to the party when they realise that the safety net is not always there, it is there but almost at the ground, so when you fall you gonna fall a bit, so they do pull up their socks and manage the ward. It is good that they sometimes get to feel how it is to take responsibility."

F4/P1

"…but it actually depends on the type of ward, like in high care, labour ward or ICU you have to supervise them throughout, because if something can go wrong, it will really go wrong! In general wards like medical or surgical departments, you can actually leave them to find their feet, because it is general routine unless in an emergency or some crisis situation."

Code 8: Experiences of absenteeism

The operational nurse managers reported experiencing absenteeism from the newly qualified professional nurses. They attributed it to their being absent as students, now continuing with the absenteeism as professionals. Most of the newly qualified professional nurses were reported to be used to the allocation of the primary health institutions where they did not work shifts, since they were allocated mainly to those clinical areas during their final year of study.

F4/P5

"Nursing education side should teach the students responsibility and to enforce discipline. Absenteeism is rife in the student nurses and they continue with it while they are on community service as newly qualified professional nurses."

F7/P4

"…we have a problem of absenteeism, you plan something for this nurse, but when you have to teach her she is absent."

They acknowledged that there was absenteeism among other staff members, but they felt that discipline should be enforced during nursing education so that this behaviour did not grow with the nurses as they matured into professionals.

> F4/P1
>
> "…absenteeism is also there among other staff members. What we are saying is that it starts as a little seed that grows with the person as a student and it needs to be curbed from there. When they absent themselves, they do not care about the other colleagues, that the workload will increase for them. They are not committed. A person, even if she is sick, she cannot say "Ah! I am not very sick, let me so maar go to ease the workload on my colleagues"; a person will just stay even for a minor ailment. That's lack of commitment. Nursing has just become a pay check, not a calling anymore. People do not come and really do their best, the compassion is not there."

Code 9: Unprofessional behaviour displayed by newly qualified professional nurses

Truancy

The operational nurse managers described the truancy in the newly qualified professional nurses as their acting like students, refusing to take responsibility when expected to and yet refusing to learn.

> F10/P1
>
> "They are still children I can say, the majority of them, they are in their early twenties and behave like children. When they come here they still exhibit their student behaviours, they have not yet shed that. They are still playing truant, dodging, absenting themselves for no apparent reason and many other delinquent behaviours. We work very hard to change their behaviour, that is, we try to do professional socialisation."

Unprofessional dress code

The way nurses dress in the clinical setting should support a professional and competent image. Clothes are never neutral. They either add or detract from a professional impression. Some newly qualified professional nurses were reported to have an unprofessional dress code. They wore clothes that were not fitting for a professional image. There were some operational nurse managers who expressed having the support of the district manager in enforcing a professional dress code, while others did not have that support from management. The operational nurse managers felt that a uniform issue for all the nurses could solve the problem of unprofessional dress code, as suggested in the 2013/16 nursing strategy.

> F10/P1
>
> "Their dress code is not appropriate for work; they wear see-through clothing, very short miniskirts and T shirts, then the epaulettes drop towards the back. The men wear jeans and baggy trousers, all these making them to look unprofessional. When you correct that and explain to them how to dress as a professional, they respond that they are still young and we are old."

> F10/P1
>
> "You see, with the issue of the professionalism, we have the support of the management because the current district health manager put her foot down about the attire and insists that nurses should look the part, so you see, we are not alone in that regard. In connection with poor dress code, uniform issue could solve the problem. DoH does not walk the talk. There is still no nurses. uniform as suggested in the nursing strategy 2013/16."

Lack of compassion, commitment and team spirit

Many newly qualified professional nurses were reported to be lacking in compassion, commitment and team spirit. They displayed an attitude of not caring about the patients and their team mates. They did not want to conform to the nursing etiquette.

> F10/P1
>
> "They do not want to be incorporated into the teams; we have to work as a team. Yes, we are old but we have the experience and we want to impart the skills to

them. Now how can we do that when we are hindered by their attitude? What do they have? Mostly the theory obtained from nursing education! But not all of them display this negative attitude; we have nurses amongst these thorns, people are individuals, you know."

F4/P2

"…true, they come late, have their earphones on and they can't even see or hear patients!"

5.2.4 Theme 2: Support strategies to enhance clinical competence

5.2.4.1 Sub-theme 1: The ideal but practical induction and professional development support that could be given to the newly qualified professional nurses

The operational nurse managers described the ideal induction and professional development support that could be given to the newly qualified professional nurses during community service to ease their role transition from student nurse to professional nurse. The practicality of the support was also looked at to ensure that it could be achieved.

Code 1: Increase orientation/induction time

The average orientation and or induction period stated by the operational nurse managers during the focus groups was one week. They suggested that this time be increased to more than a week.

F7/P3

"I feel that the current induction and orientation is not enough. My ideal would be taking them for a month at least."

F2/P2

"…uhm, it means now if it was according to me, the one week is not enough for orientation on its own. I would prefer that they be orientated for that week then we have periodical afternoon sessions to come, at least every afternoon for two

hours when they are on duty, we have a session with them. That would supplement the one week, to make it more factual and more helpful."

Code 2: Improve the orientation content

Operational nurse managers were of the opinion that the current programmes were inadequate. They suggested an improvement in content as well as in duration.

F2/P1

"…if it was my choice as a manager at a particular clinic, I would stress the importance of client service, because we meet with lots of people from the community, people from different cultures, those that are literate and those that are illiterate. The other thing would be more on the day-to-day running of the clinic and handling of emergencies. Many times we tend to forget teaching them about emergencies and it becomes difficult for them to handle the situation when an emergency arises. I also think that the new nurses should be orientated on the patient's rights charter and the *batho pele* (people come first) principles as well as the scope of practice, because most of the time, by the time that they become professional nurses, you find that they have completely forgotten the scope of practice and their role as professional nurses, they have read it to just pass the examination, now they need to see it being practised."

F7/P2

"There are some aspects that needed to be added to the orientation programme. We were attending to ethical issues but not that deep, then the district office helped us in that regard after hearing our concern. The district induction now encompasses ethical issues, quality assurance, infection control, policies and protocols at a deeper level, then at the clinic we do the application."

The operational nurse managers verbalised the success of the improved human resource (HR) induction programme at various health districts. The improved induction programme conducted by the human resource department at the district health level showed some success in that the newly qualified professional nurses who attended it were better equipped with information than those who had attended the shorter, less comprehensive programme conducted before.

F7/P1

"My experience is that the group that attended the five-day induction with the added aspects differ from those who did not, in that they are easier to work with, they understand the objectives of the organisation and they are ethically aware of the things that the others are not aware of. They also do not resist the delegation, they rather discuss and clarify issues with you in a professional manner."

F7/P3

"It is true that the two groups of nurses differ when you compare them. My experience is that the group that attended the enhanced programme have good attendance record, absenteeism is less. They seem to understand the implications of absenteeism on the service and remaining personnel."

Code 3: Formalising the induction programme provincially

The operational nurse managers from the hospitals felt that the formal induction programme conducted at the district health offices should also be extended to the newly qualified professional nurses serving community service in the hospitals of the same province. However it emerged that the hospitals and the clinics did not have the same budget. The suggestion was to request the hospital human resource department to budget for a formal and uniform induction programme for the hospitals of the same district health or province.

F5/P3

"I feel that the induction of these com serve sisters should be organised into something formal, you see. Like those of the district, they have programmes organised for them to attend from their various clinics and CHCs, they go to the District office for the formal induction and go back to continue with the clinic professional nurses. They are even given assignments to ensure that they master the topics. Topics range from HR, conditions of service, quality assurance, infection control, polices and protocols up to professionalism. With us in the same province, though, being in the hospital, we are left to do things the old way, you teach them what you like or know. They get different things from different people in the same institution."

F5/P2

"The district office pays for the induction; we once raised the issue in a management meeting and we were told that the hospitals do not have a budget for that, maybe the province will do it someday."

Operational nurse managers felt that good practices should be emulated; primary public health institutions should come together and share their best practices to form a uniform orientation programme for the district health clinics.

F7/P2

"What we are doing at my CHC is ideal, according to me, and I wish that it could be a standard even for other CHCs because it works, it is effective. You see, if a nurse is allocated to a specific area for two months, the first two weeks is orientation and direct supervision by the mentor, then indirect supervision for the rest of the period before moving on to the next allocated area, depending on the nurse's adaptability, of course."

Code 4: Provision of professional development support and formalisation of mentorship nationally

Although the operational nurse managers mentioned that they supervised and guided the newly qualified professional nurses, when asked how they supported them, they still mentioned that supervision and guidance were needed when asked to suggest the ideal support. This could be due to the fact that in some of the focus groups the operational nurse managers mentioned that they were unable to supervise the newly qualified professional nurses, due to shortage of personnel and the high numbers of the newly qualified professional nurses in the public health institution compared with the professional nurses that had to supervise them. The agreed-upon strategy was to institute supervision and guidance where they were non-existent and reinforce them where they were minimal.

F5/P5

"According to my experiences, those that I have met need to be assisted throughout as they have more theory than practice. They need that supervision and guidance for them to function independently by the end of community service."

The operational nurse managers also felt that the experienced professional nurses should supervise and guide the newly qualified professional nurses because they had the experience as professional nurses. Supervision and support should not be done only by the operational nurse managers.

F5/P1

"I feel that there should be more supervision of the com serve sisters by the other professional nurses in the wards. Their supervision should not be only by the operational nurse managers. The other ward professional nurses should be involved."

Formal mentoring of the newly qualified professional nurses was suggested. The operational nurse managers acknowledged that some health institutions are doing some form of mentorship, but it is not formal and it is not compulsory nor regulated. They suggested that the Department of Health should recognise the mentorship and support it.

F2/P3

"I suggest mentoring…but the process to be formalised, because if it is not formal, some operational nurse managers and their professional nurses will not do it. The com serve sisters need a formal programme of support that will be uniform throughout the province. As we speak, institutions choose to induct them their own way, some neglecting them. That is unfair, because we are in the same province but we support them differently, with some not being supported at all. You give your all to develop this com serve sister; next year they leave for a permanent post with hospital X, you get an unsupported sister who was com serving at hospital Y, who is blank, and you have to start from scratch!"

The suggested mentorship period was unanimously agreed to be six months in all the provinces where the focus groups were conducted. Formal monthly or quarterly reports were also suggested, with the mentors giving the mentee feedback.

F2/P2

"The other thing that I would recommend is to have somebody to mentor these young nurses,...[for] a period of six months or more according to individual needs. Due to the shortage of personnel, we don't have mentors, but it could be ideal to have them."

F5/P4

"…thinking of a pairing system where an experienced professional nurse gets allocated with the new professional nurse. Even the duty scheduling to be such that they work together at all times."

F5/P4

"If it was not for this shortage of personnel, I would say that the new professional nurses must be supervised by the experienced professional nurses for a period of six months. From there they would evaluate the level of competence and confidence, then continue the supervision according to the individual needs but gradually leaving them to work independently, no longer under direct supervision, but indirect, from a distance. The allocation of newly qualified professional nurses to curb the shortage is putting the community's health in danger. They should be allowed to walk before they can be expected to run!"

Code 6: Role-modelling of professional behaviour

Under the challenges that the operational nurse managers experienced in the induction and professional development of the newly qualified professional nurses, the operational nurse managers mentioned lack of professionalism in the behaviour of the newly qualified professional nurses. For ideal induction and professional development, they said that the experienced and the expert professional nurses should role-model professional behaviour for the novice professional nurses to emulate.

F2/P1

"We as older nurses, we need to role-model professionalism to the young nurses."

Code 7: Allocation for community service should be comprehensive

The newly qualified professional nurses are allocated to either a hospital or primary public health institution, being a clinic or health centre (24-hour clinic). There is an exception in a few provinces in South Africa, where the newly qualified professional nurses are allocated to a health district or health complex, and get allocated to both the clinic and the hospital in one year. The operational nurse managers were of the opinion that this comprehensive allocation would give the newly qualified professional nurses experience in working in both the clinic and hospital as a professional nurse. They argued that the experience that they had had as students, being allocated to one or the other, was not the same as when one had to take responsibility as a professional nurse. Students come to meet clinical objectives, while professional nurses work to gain experience.

> F7/P1
>
> "My ideal would be a six-monthly rotation between the hospital and clinic. The newly qualified professional nurse should get an opportunity to be allocated at both institutions in one year; so that she or he can make an informed choice of institution at the end of community service. I am saying that because we usually get professional nurses post com serve who apply for permanent positions at the clinic but having done community service at the hospital. Such people are just as new as the com servers themselves and cannot curb the shortage at the clinic as they need to undergo the same orientation as the com servers. You now end up having new nurses only at the clinic, while the older nurses should induct the new ones. I think the hospitals will also agree with my experiences as they also receive nurses who did com serve at the clinic only and have to start them afresh. So my suggestion is that the newly qualified professional nurses should get the best of both institutions, with six monthly rotations between a clinic and a hospital."

Code 8: Regulation of the mentorship support by the South African Nursing Council (SANC) and reinforcement by the DoH

It was suggested that the SANC should oversee the support given to the newly qualified professional nurses. Currently the community service regulation (SANC 2007:4) stipulates that quarterly reports should be written on the newly qualified professional

nurses on community service. The reports are kept at the public health institutions and produced only when requested by the SANC. The operational nurse managers felt that the reports should be about the development of the newly qualified professional nurses and that they should be compulsory. The public health institutions should submit the evidence of the professional development to the SANC together with the signed completion of community service form.

F10/P1

"I suggest that there be formal mentorship that is recognised by the Department of Health [DoH] and the nursing council [SANC]. When the newly qualified professional nurses become com servers, they get allocated mentors immediately after the orientation period. They work under supervision of the mentor for a period of six months before they change allocation and the mentor. The mentors become responsible for giving them feedback and writing their reports."

F2/P3

"The coordinators of community service should reinforce this programme and SANC should request the evidence of the support and development of the com server before final registration, just like the coming CPD points; the support should be managed."

F5/P5

"I support what my colleagues have said, but in addition the experienced professional nurses should write monthly reports about the new professional nurses they are supervising."

Code 9: No clinical supervision of students by newly qualified professional nurses during community service

The operational nurse managers felt that it was stressful for the newly qualified professional nurses to supervise other neophytes, whereas they were also new. The suggestion is to allow them to go through their fears and anxieties of being novice professional nurses during community service and only to supervise students when they are experienced professional nurses.

F10/P1

"The other suggestion is that the com serve sisters should not be allocated to supervise students as they are still finding their feet. Let them deal with being newly qualified and the related adjustment, then they will supervise students later when they are more confident."

Code 10: Re-introduction of clinical teaching departments (CTDs)

The operational nurse managers felt that the DoH should bring back the clinical teaching departments to the public health institutions so that the clinical tutors could assist in the enhancing of clinical skills, and reassuring and allaying the anxiety of the newly qualified professional nurses. Clinical teaching departments were used in the past; the operational nurse managers felt that they should be reintroduced in the public health institutions.

F10/P1

"I also suggest the clinical teaching department where the clinical tutors will help to reduce the separation anxiety of "We are from the college and now we are here". They will continue with the familiar structure, though not the familiar faces at all times. That will reduce their insecurities, in my opinion."

5.2.4.2 Sub-theme 2: The role that the nurse managers could play to realise the suggestions in order to support the newly qualified professional nurses most effectively

Code 1: Operational nurse managers to acknowledge their teaching role

The operational nurse managers were of the opinion that they should acknowledge their teaching role and encourage the other professional nurses to supervise, guide and mentor the newly qualified professional nurses.

F2/P1

"Operational nurse managers should just accept their teaching role and extend their hands in orientating the new nurses. At the end of the day there is too much to do but if you teach others they will help to reduce the workload if they know how to."
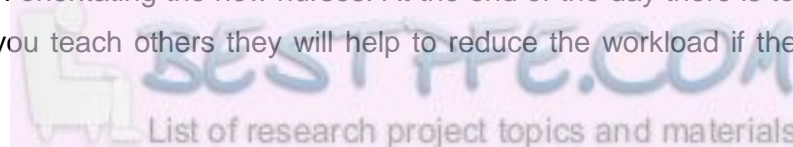
F4/P6

"Operational nurse managers can plan the support for the com serve sisters. She will educate the ward personnel to be supportive to them and allocate mentors while she herself will supervise the mentorship process. She can identify the learning needs together with the com serve sisters and plan the support around their identified learning needs."

Teaching by example as role models to both the experienced professional nurses and the newly qualified professional nurses was reported as another way of realising the suggestions raised by the operational nurse managers to encourage professionalism.

F4/P4

"…by being a role model, the operational nurse manager will teach them professionalism and encourage other personnel to be exemplary to the neophytes."

Code 2: Advocate for formalisation of mentorship

They felt that they should take the initiative to approach the management and advocate formal mentorship programmes to enhance the support given to the newly qualified professional nurses during community service. They explained that informal mentorship is problematic and cannot be reinforced.

F7/P1

"With me I feel that the operational nurse managers should request from the district manager that the mentorship be standardised and made compulsory in all the clinics, because some experienced professional nurses do not take the extra responsibility well. They forget that teaching is one of the functions of a professional nurse, not only patient care. If the programme is compulsory and standard, they will be willing to write the quarterly reports for the com servers as required and the mentorship will be included as part of their performance assessment. Currently some of them are reluctant to do the mentoring and to write the report, and you can't force them; it's not a formal thing!"

Code 3: Request for the provision to acquire temporary substitute professional nurses in the units for the duration of the orientation period

The orientation and induction of the newly qualified professional nurses was reported to be taking time and personnel away from patient care. The operational nurse managers were of the opinion that relief by an agency professional nurse during the orientation period could alleviate the shortage.

> F2/P1
>
> "You know, one point that I could just highlight would be, if for instance, in a month you know that you are going to receive three community service nurses, I think the department must add one professional nurse to the clinic personnel so that the operational nurse manager can concentrate more on orientation and induction of the new nurses. The extra professional nurse can be an agency staff to stand in where necessary to prevent the shortage and to allow the operational nurse manager more time to spend with the new nurses, focusing on their orientation for that week."

Code 4: Going all out for the development of the newly qualified professional nurses

The operational nurse managers were of the opinion that they should go the extra mile in the support of the newly qualified professional nurses. They acknowledged the shortage of professional nurses, but felt that if the novice professional nurses were well supported by the expert professional nurses, they would help to alleviate the shortage that everybody was complaining about.

> F2/P2
>
> "It's important to do whatever, you know, we have meetings of nurse managers, we've got forums where if we say we voice this out, really this will help especially for our new nurses' professional development."

> F4/P3
>
> "The operational nurse managers work closely with the com serve sisters; they can suggest and recommend the necessary support to the management, like recommending that the com serve sisters should work shifts, not seven/fours

only, to be able to learn to take and give the handing-over report, to learn to be in charge of the ward, as when they are working seven/seven, the staff will decrease in the afternoon and gradually she will have to take charge of the ward."

They mentioned that they could achieve the goal of supporting the newly qualified professional nurses by putting all hands on deck, and concentrating less on the shortage of personnel in order to use the available time effectively. Another strategy cited was to canvass for management support of their endeavours in advocating for the professional development support of newly qualified professional nurses.

F2/P3

"I think that we should not concentrate on the shortage of personnel too much. Then we will use the limited time that we have to stretch and reach out to the new nurses. They did not cause the shortage; in fact they are here to curb the shortage. Let us support them to be competent and effective, then we will no longer hide under the shortage of personnel next time when new nurses need our support. We will have others to delegate the teaching to."

F5/P4

"The operational nurse managers should continue to raise these issues in the management meetings, asking for support from the institutional management about the recruitment of personnel so that the suggested pairing system can be realised. They should also be made aware that they can't allocate the newly qualified professional nurses and expect them to curb the shortage. They are inexperienced and need guidance and support from experienced professional nurses that they find in the service."

F10/P1

"Ah!...continue giving suggestions in our meetings with the management, some day they will implement the suggestions!"

They also reported experiencing some reluctance by the ward professional nurses to support the newly qualified professional nurses, hiding behind the shortage of personnel and citing the differences in the nursing education curricula. They were of the opinion that they should encourage the experienced professional nurses to actively take part in the professional development of the newly qualified professional nurses. The operational nurse managers agreed to periodically revise the orientation and induction

programmes to ease the transition from student nurse to professional nurse in line with current trends in nursing.

F5/P3

"The other thing is to encourage our professional nurses to support the newly qualified com serve sisters. They should stop the saying that they were ready immediately upon completion of training and they could man wards. That was then, this is now. The training is different. The old three-year course was hospital and curative based, unlike the current four-year course that is comprehensive and has all the aspects from preventative, promotive, curative and rehabilitative care. We can't expect the graduates to master all these aspects in just four years! We should help them to gain competence upon completion. As long as the foundation is laid, we should build!"

F7/P3

'I suggest that we also encourage the experienced professional nurses to take care of the new nurses, create time to take them through so that they can be functional in that particular area within a reasonable time. That way they will be able to see and enjoy the fruits of their labour when they work side by side with the com servers as professionals."

F7/P2

"The operational nurse managers have to revise the current orientation programme and include the aspects that are lacking as we discussed."

5.2.4.3 Sub-theme 3: Stakeholders that could be roped in and the role they should play to enhance the transition of the newly qualified professional nurse from student to professional

The sub-theme describes the role that stakeholders could play in order to help the nursing service to provide the induction and professional development support required to enhance the clinical competence of the newly qualified professional nurses. The stakeholders suggested by the operational nurse managers were: nursing education, nursing management, the South African Nursing Council (SANC) and the Department of Health (DoH). The codes describe the role that the stakeholders could play to improve

nursing education, the transition from student to professional, as well as nursing practice.

Code 1: Nursing education

Identify education-practice gaps

Nursing education was suggested to help identify the gaps to be closed by practice during the transition period from being a student nurse to being a professional nurse. The operational nurse managers felt that the nursing education institutions could actively take part in the development of induction and orientation programmes through their clinical teaching departments.

> F2/P2
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> "…we can rope in the educational institutions to actually take part in the very professional development programme. You know they are the very people who could assist us when we are drawing the in-service programmes because they will know the shortcomings of what these newly qualified professional nurses lack in terms of what they could not cover during their training period; they have been with them. They can give input as to which aspects to emphasise that are not normally covered well during training."

> F1/P3
>
> "It's like the nursing education institutions relax in doing clinical teaching, knowing that there is com serve where the gaps will be filled. Even problematic students relax on the clinical practice side, knowing that there is still com serve."

> F6/P1
>
> "Definitely, the nursing education institutions you see, there is a difference between the university students and the college students during their fourth year when they come for their admin. During the year you see tutors from the colleges following up their students but you don't see the university tutor coming for their fourth years, they are not visible. The college students, also the first thing that they do when they come here, they will give you a piece of paper saying, "Sister, this are the activities I have to cover" – but not with the university students."

Nursing education to do competency assessments

One of the challenges experienced by the operational nurse managers concerning the newly qualified professional nurses was lack of clinical skills. They suggested that nursing education institutions should do competency assessments of clinical procedures to assess the level of competence before the students could progress to the next level of training.

> F1/P5
>
> "…the nursing education should do like before in the olden days, evaluate a student on a procedure three times for her to gain competence. Nowadays you hardly see a tutor coming to evaluate a student; they come to solve problems; they have so many students that they hardly know them by name. Evaluation is left to the professional nurses in the wards only. …previously there were procedures that were evaluated by the professional nurses and those that were evaluated by the tutors for proficiency, in the wards…"

> F1/P2
>
> "…some of the students take advantage while they are still studying. They concentrate on the theory just to pass the exams, knowing that "There is a com serve year where I will get direct supervision". So if the curriculum can be looked at and let there be a balance between theory and clinical practice, where they both have the same weight in determining promotion to the next level, then the students will start to get serious about clinical practice."

Orientate students to working shifts

The operational nurse managers suggested that nursing education should orientate students to work shifts, to instil discipline and to familiarise them with the demands of the service. Shifts were reported to be an important part of professional development, where students would gain skills when they did handing over of reports.

> F4/P5
>
> "They should also work shifts as students so that they will get used to the seven/sevens and working over weekends. If you are allowed to come and go as you please, how dedicated are you to the profession? They must also learn to do

handing over reports in the morning and evenings so that they will know the patients and what patient care was handed over from the other shift."

F3/P6

"With education, I think there must be more clinical exposure and less skills-lab hours. The skills lab can be used to practice procedures. But the students to be allocated more to the clinical areas for practice. This can be possible if the Nursing Education Institutions (NEIs) can take a number (of students) that they can supervise and that will not overload the clinical areas so that they can get adequate clinical learning opportunities. Currently there are many students in the clinical areas, they are even more than the patients in some wards. The clinical areas are overloaded; the tutors do not come for clinical accompaniment. Even if they come, they just greet from the door and ask about absentees or problems generally."

F3/P2

"Eish, yeah, the numbers are too big. We cannot cope. It's the students this side, it's the com servers this side, yeah neh? The student recruitment also must be looked into because most of the com servers and the students who are giving problems are those who came to nursing as a second or third choice because they couldn't go where they wanted to go. They were taken because of their good matric results. Education should look at other ways of recruitment to supplement the matric results, like short interviews."

Students should cover deficient clinical hours during training

In order to balance theory and clinical practice requirements, the operational nurse managers felt that nursing education should ascertain that the students covered the prescribed clinical hours during training to develop clinical experience. They were of the opinion that if the students covered the deficient hours when they had been absent, they would develop the necessary discipline to function as professionals and there would be fewer discipline problems during community service.

F6/P4

"The college students have to cover deficient hours at a specific department, when they did not cover the x amount that they were to cover. They even come during their vacation to work those hours. You do not see that with the university

students. They just juggle their hours, medical, surgical, paeds! You do not write their hours as deficient hours with the university students, you just mark them as absent. Whereas the college students are compelled to work those hours because they cannot progress to the next level with deficient hours. If there is a problem with the hours, the college tutor will come to the department, ask for the off-duty books, even for the previous year, going through page by page if the student was in that department at a point in time, she would physically count those hours. That was just a little bit of background, to show you how this affects them later in their professional life."

Curriculum changes

The operational nurse managers were of the opinion that the current basic nursing education programme (SANC R425 of 1985: Nurse Education Programme leading to registration as a nurse [General, Psychiatric, Community] and Midwife) is congested, with more theory than practice. They suggested a basic nursing education programme that would balance theory with nursing practice, both having an equal weight in determining the students' progression to the next level of training.

F3/P3
"The other thing is that nursing education should look at the curriculum. It is too packed. It is general, community, psychiatric and midwifery within the four years. Most of the students get confused. It is only a few that come out knowing everything. There should also be clinical tutors hired by the Nursing Education Institutions to do clinical accompaniment"

F10/P1
"The government messed things up when they changed the nurses' training! The old training was better than the comprehensive four-year trained nurses in that the old three-year trained nurses were a better product in the clinical practice areas. They were functional; they were not pumped with a lot of theory that they never used. The curriculum contained the essentials and they had to go for further training when they needed other qualifications, but after mastering general nursing and being experienced! I hope that the new coming qualifications will be better, as the many qualifications will be stopped in the basic training. The person is given a chance to concentrate on general nursing, with an introduction to the

other aspects, then proceed to do that specific qualification that she likes when she is more mature and knows what she wants!"

F6/P5

"So, the recommendation is that during their training as student nurses, it must be taken into cognisance as to where do they get their clinical practice. How much will be from the skills lab and how much should be from the clinical area with actual patient care, because that makes the difference when they are now com servers. They transit quicker from student to professional nurse when they have the actual experience from the clinical areas. The gaps are minimal and the communication is more effective between them and the patients or other team members, you know, because, communication is part of practice and it is learned with the other skills simultaneously."

Revise student recruitment criteria

The operational nurse managers felt that the nursing education recruitment criteria should be revised to improve the current status, where the academic achievements are prioritised over other attributes required in nursing.

F7/P3

"Definitely education must be roped in. I suggest that they revise their selection criteria and get people who want to be nurses, people with the passion, not those who come to nursing as a last resort. Such people complete the nursing programme because they are academically gifted but they become a burden to the service because they actually do not want to be here, it's just that they need a livelihood."

Stop stipend and introduce bursary system

They also suggested that nursing education should stop the stipend given to students and introduce a bursary, since they felt that the stipend served as a pulling factor to nursing, ending up pulling people without compassion to the nursing profession.

F7/P2

"I heard that the stipend given to student nurses is going to stop and be replaced by bursaries. I think that will also help since most of the students who come to nursing were attracted by the stipend, not the career itself."

About those that were already on training but not actually wanting to be nurses, the operational nurse managers suggested that the student counsellors should do assessments and counselling to ensure that they did not continue with training to be nurses as a last option in life. They should rather develop the necessary attributes while on training, or leave the profession while there was still time to pursue other careers.

F7/P4

"I suggest that the student counsellors must be empowered with skills to assess and talk such students into leaving the profession early in their studies and helping them to get financial assistance to go to where their passion is. Also to hold workshops about the values needed in nursing so that students can do self-evaluations early in their studies as to whether they want to continue or not."

Code 2: Nursing management

Establish/'beef up' staff development departments

Some of the public health institutions visited during the focus groups did not have staff development departments. All forms of nurses' professional development were the prerogative of the operational nurse managers; yet in most cases the operational nurse managers reported a number of hindrances that prevented them from conducting in-service training or other forms of staff development. Those that had staff development departments were of the opinion that they should be staffed adequately to cater for the professional development needs of all the nurses.

F3/P7

"The staff development department should be beefed up to be able to make follow-ups of these NQPNs after they have been allocated, to make sure that they are supported to gain the clinical competence. They should even have a programme wherein they demonstrate clinical skills and aspects in which some of
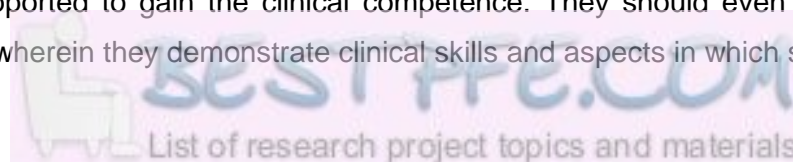
the NQPNs are still lacking in, even if the demonstrations can be once or twice a week and they are invited to attend according to the need."

F1/P1

"I am also supporting the establishment of a clinical teaching department to do the induction of the NQPNs. Then the staff development department, together with the clinical teaching department, will develop a joint programme of orientation and induction."

F2/P1

"I think that the operational nurse managers should be involved in the planning of the district office induction programme, as they have hands-on experience of working with the new nurses."

Nursing management to support formalisation of professional development support and mentorship

The operational nurse managers felt that the nursing management should support formal mentorship of the newly qualified professional nurses, with the experienced professional nurses being formally recognised as mentors. They suggested that mentorship be included in the performance management system as one of the key performance areas of a professional nurse and to be evaluated as such.

F4/P6

"The hospital management should also buy into this formal programme, because without their support, the programme will not succeed. The support can be in the form of mentorship, where all professional nurses are involved in the support and development of these neophytes. If experienced professional nurses become formal mentors, then the operational nurse managers will supervise the mentoring process."

Reintroduce clinical teaching departments (CTDs) at health institutions

To alleviate the problem of inadequate clinical skills, the operational nurse managers were of the opinion that the nursing management should reintroduce clinical teaching departments (CTDs) in public health institutions, to benefit students and newly qualified

professional nurses, and also nurses who have been reintegrated back to clinical practice after years of non-clinical nursing.

F1/P4

"…let the clinical teaching department come back, like in the olden days; the tutors can't cope, and at the end the students meet minimum requirements only as required by the SANC and they come to the ward as com servers. So according to my experience, com serve is like a time where we have to fill up the gap between being a student and a professional nurse."

F10/P1

"Nursing education should go back to the basics and establish clinical teaching departments within public health institutions, with tutors doing full-time clinical accompaniment. The clinical tutors will also help us with the support of the com serve sisters. That will reduce the separation anxiety because they will still see the people from nursing education in their midst. They will not be relating with strangers only and they will gradually be incorporated, thus reducing the "us and them" situation."

F5/P4

"I feel that the nurse educators should do clinical accompaniment; if not, the college or university should have clinical teachers to facilitate learning of clinical skills while they are still students, so that when they come for com serve, they will be having skills and confidence to practice. The current clinical teaching is not enough; more clinical accompaniment is needed. The professional nurses in the wards are trying to do the clinical accompaniment of students, but they are short staffed and do not manage well due to time constraints. Someone has to be responsible for clinical teaching and be readily available to students. Even if the old clinical teaching departments can come back to the hospitals, we will appreciate them."

F2/P2

"The clinical instructors can assist the newly qualified professional nurses with polishing up of the clinical skills that they still struggle with according to individual needs, because the new nurses have undergone the same training but they are not at the same level of competence; some lack the clinical skills here and there."

CTDs to be fully equipped and adequately staffed

They suggested that the clinical teaching department should have a fully equipped clinical skills lab to be utilised by all nurses in need of practice.

> F1/P3
>
> "I also suggest a sound clinical laboratory in the hospital at the clinical teaching department, once we get it. It will be easy for students and new nurses to practise procedures in the skills lab according to their needs. They will use the mannequins to practice procedures to perfect their competence."

> F1/P2
>
> "…we say let there be a clinical teaching department for the students, the newly qualified professional nurses and other staff who have the need to practice clinical procedures. The clinical teaching staff should do follow-ups of students and com servers daily and solve clinical practice related problems."

Code 3: South African Nursing Council (SANC)

Provide implementation guidelines for R765

The operational nurse managers expressed a concern that the SANC does not provide guidelines for community service. They felt that other SANC regulations have a guide for implementation, thus the community service regulation (SANC R765 of 2007), should have guidelines on how to enhance the transition of the newly qualified professional nurse from student to professional.

> F1/P4
>
> "…the SANC should come up with guidelines, to say, the community service nurses should work this way. She is a professional nurse, yes, but we are doing internal things to her, we don't know how to handle her, they must give us some guidelines to say, treat her this way, because she is coming for only a year. The SANC should come clear as to how do they want this person to be treated while she is a com server. I understand that the community service is an obligation from parliament through the Department of Health, but I feel that the SANC should come up with the guidelines as they are the ones regulating nursing and

midwifery training, not the Department of Health. And they also oversee the starting and completion of the com serve. The quarterly reports that we write for the com servers are also a requirement from SANC. So it will be easy for them to introduce the guidelines for implementation."

They also felt that the SANC should ensure uniformity in mentorship. The guidelines should spell out the mentoring process and it should be the same in all the provinces.

F6 /P1
"There is no formal mentorship/lack of uniformity/SANC has uniform training, why not uniform mentorship programme? Even if it can be provincial?"

Code 4: Department of Health (DoH)

Empower provincial departments of health with relevant resources

The operational nurse managers were of the opinion that the national DoH should empower the provincial departments with the human and financial resources to be able to standardise induction of newly qualified professional nurses. They felt that the newly qualified professional nurses should be inducted as employees by the provincial human resource departments before they could be orientated by the clinical practice. They said that a common provincial programme on HR issues would be appreciated.

F2/P1
"I think the Department of Health should be involved in standardising the induction of the new nurses, you know, providing some guidance, so that there can be some formality, you know, some structure into the whole thing."

F2/P3
"We can also meet the coordinators of community service, and have meetings with them to air our challenges to ensure that professional development is undertaken."

F5/P3
"I feel that the Department of Health should support the HR in the provinces and institutions regarding the recruitment of personnel. It is difficult for us to support the new nurses under these circumstances of severe shortages of staff. Patient

care suffers and the new nurses also do not get the induction that they deserve to mature in the profession."

Link health institutions to form health complexes for comprehensive allocations

The DoH could also assist by linking health institutions so that the community service allocation can be according to health complexes, where the nurses on community service can be allocated to both hospital and primary public health institutions in one year.

> F2/P2
>
> "I also suggest that the Department of Health should look into the allocation of the newly qualified professional nurses. You find that some are allocated in hospitals, some in clinics, and the development of these nurses is not the same. We as managers get a problem when they complete community service and they come to work with you, you have to start afresh if the nurse is from the clinic and I think the clinic managers have the same problem with the ones from the hospitals. I suggest that the newly qualified professional nurses should rotate in these institutions within the same district to be manageable. Like the first part of the year be either the clinic or hospital to get exposure of both institutions during community service and for maximum development, as someone who might be working in a different institution at the end of the community service. They should get the feel of being a comprehensive professional nurse. The Department of Health could link hospitals, community health centres and clinics in a district to form a health complex where the newly qualified professional nurses can be allocated."

5.3 ANALYSIS OF THE INTERVIEWS WITH THE COORDINATORS OF COMMUNITY SERVICE

There is one coordinator of community service for nurses in each province, although the coordinator from one of the largely rural provinces was coordinating community service for all the health professionals on community service, including nursing. The researcher sought permission to interview the coordinators of community service of the sampled provinces from the provincial departments of health, their immediate supervisors and from the coordinators themselves.

The interviews were conducted at the provincial departments of health, using the offices of the coordinators as the agreed-upon venue.

The coordinators of community service for nurses agreed to the digital recording of the interviews. Interview recordings were saved in a file in the researcher's computer and external hard drive for backup. They were later transcribed verbatim by the researcher. The researcher kept field notes and did member checking during the transcriptions of the interviews to validate the information. She read transcriptions over and over again to immerse herself in the data. Codes and themes were formed and new files were created in the computer using Microsoft Word, using the Document Review option to be able to track changes or add notes in the margins.

Two themes and six codes emerged. See Table 5.3.

Table 5.3: **Themes and codes from coordinators of community service**

Themes	Codes
5.3.1 The strategic role of coordinators of community service in induction and professional development support of newly qualified professional nurses	• Allocation of newly qualified professional nurses • Guidance and support of institutions • Monitoring and evaluation of professional development support
5.3.2 Professional development of newly qualified professional nurses	• Professional development support • Challenges • Strategies for improvement

5.3.1 Theme 1: The strategic role of coordinators of community service in induction and professional development support of newly qualified professional nurses

Code 1: Allocation of newly qualified professional nurses

Some of the coordinators of community service responded that their main role was to allocate the newly qualified professional nurses to health institutions. The allocation is according to the needs of the Department of Health; the allocation choices of newly

qualified professional nurses are considered after the needs of the Department of Health. They mentioned that they do not have a professional development support role; being a coordinator of community service is an additional responsibility to their job description. Personnel development is an HR issue, according to them.

F2/P3

"What we do is that we allocate them, oh, the com servers that we get are normally from the nursing college because they are our bursary holders. So, more or less 200 that we receive every year, so, we allocate them at the respective facilities, eh, according to their choices. They have to make the five allocation choices, we go according to the first choice but then if they do not qualify for the first choice we look at the other choices. But then if there is a need in any other hospital that the person has not chosen, then we allocate the person where there is a need because we look at the service delivery, yes, because they are bursary holders and they have obligations, so we place them where there is a need. So the priority is the needs of the Department of Health more than their needs. But we try as much as possible to allocate them nearest to their residential addresses where possible."

F2/P3

I am a coordinator of community service for all categories of health care professionals in the province. I have a job description for my main post and in it there is the allocation of com servers. It just says allocation of com servers, nothing more. I have other functions that I do. The part of coordinator of community service is an additional responsibility. The orientation is more of an HR issue because they are the ones that do the development of staff. So they are directly involved with the development of staff. So that is why I was not part of the orientation."

Contrary to the other coordinators, there were those who admitted having a role in the professional development support of the newly qualified professional nurses. They reported that they started orientating the final-year students about community service and the expectations of practice from a newly qualified professional nurse.

"You see, I go and see every graduate in the [number] colleges and the…[number] universities in [name of province] [giving the names of the colleges and universities]. I arrange with them to address the fourth years personally. I give them my own [name of province] handout."

The colleges used to have what we call stakeholder meetings at each college with the nursing managers of their clinical facilities. They give me a slot where I go and give them information about community service placements and changes in the SANC registration fees. So once the institutions have been gazetted, they usually ask me to give them the year programme so that they can know what is happening where. They must have an idea as to when should we be informing the students. That is if there was no delay in the process. This is the plan, but it can sometimes get derailed, like last year in May with the elections, the Minister was not available to sign, so the gazetting was late, so the process was late. So once we get that information, we then update the letter every year. But we then make arrangements at the colleges and universities to see the students."

Some coordinators mentioned that professional development support of the newly qualified professional nurses is their responsibility at strategic level and it is part of their job description. One coordinator even gave the researcher copies of the information booklets that she gives to the final-year students, and again when they have graduated and been placed for community service.

F2/P4
"…yeah, I will give you one [calling the secretary], "Can you help us here? Bring me a copy of the handout. It's in the green file, otherwise we will have to print one." I give them the regulation, we make a copy and make it small, like this, to save on paper, so that each one has a copy of the regulation. I will print one to show you; eh, this is an older one, let me show you; I will print a copy of 2015. This is my job. I am an Assistant Director, Nursing Education. So community service coordination is one of my responsibilities. It's in my job description. Yeah, look, with the amount of other work that I have to do, there is no way that I can go around and physically look at whether they do further their skills. But I do have a good relations with the nursing managers and the staff development people in the facilities, and in [name] province it's big numbers."

The researcher discovered that some coordinators still call newly qualified professional nurses students, yet they are professional nurses.

F2/P1

"Yes, I do have a role, but my role is strategic. My role is when they start and when they end. So when I say I am starting, I must lay a framework as to how they must manage these students."

Code 2: Guidance and support of health institutions

The coordinators who had a support role reported that they had provincial guidelines that they sent to the institution when the newly qualified professional nurses commenced with community service. The guidelines were said to be a framework for the nurse managers, to guide them as to how to support the newly qualified professional nurses in the practice.

F2/P1

"So, we will set out a framework. We have drafted the framework for ourselves and for the managers, for managing this people. So that they know that they must be in line".

F2/P4

"Oh, yes, we do have, let me get you a copy. Oh yes, there is no time, so you have our provincial guidelines and the national ones?"

There are national guidelines for community service, but they were reported to be guides for the managers on the regulatory processes of community service, not about professional development support.

F2/P1

"The national guidelines are for the managers to know how to manage them in line with the regulatory framework, as well as meeting human resource requirements".

F2/P3

"There are national guidelines which are for all com servers, not necessarily for nurses, and they are general guidelines on serving community service in South Africa. The guidelines are available on the website. Just go to Google and say "national guidelines on community service in South Africa", you will get them".

The coordinators said that there must be formal guidelines for professional development of newly qualified professional nurses.

F2/P1

"Yes, the framework is provincial. The national just gave us the generic, not how to develop the newly qualified professional nurses. Yes, something like this framework is necessary for uniformity."

The newly qualified professional nurses have met the SANC's minimum educational requirements to be professional nurses and they have recently graduated from a nursing education institution. One coordinator even went further to explain that they are employees with an employment contract in a professional nurse's post. They are entitled to all the employee benefits while on community service.

F2/P4

Yes, they get all the benefits. I always tell them, they get the cream and a cherry on top. They get pension, medical aid, housing allowance, all the leaves, everything, even uniform allowance. They get everything that an employee gets. They get that benefit. So they are already on our system. Eh, because of the huge numbers that we have in [names the province], we haven't been able to take from other provinces."

Code 3: Monitoring and evaluation of professional development support

The coordinators reported that they let the operational nurse managers write quarterly progress reports for newly qualified professional nurses. In this way they said they monitored and evaluated the professional development support given to them.

197

F2/P1

"Yes, each quarter, three months, three months, because every quarter, they must complete a progress report, like a probation report. So there must be a continuous report, wherein they will state the support and development support the nurse received. I also do random evaluations. Like I would pick a name from the list of nurses, then call the manager and say, please send me her progress reports so I can see her progress and how the manager fills in the forms. It is monitoring and evaluation to also see if they are doing it and are they doing it right."

F2/P4

"The office of the provincial coordinator has therefore a responsibility to visit facilities and monitor staff development to support the newly qualified professional nurses in the following manner:

- Supervising the availability of teaching programmes
- Implementation thereof and evidence to that effect".

5.3.2 Theme 2: Professional development of newly qualified professional nurses

Code 1: Professional development support

The coordinators who admitted to having a support role in the professional development of the newly qualified professional nurses stated that they did so to fulfil the objectives of community service, one of them being that newly qualified professional nurses must also learn from community service.

F2/P1

"We have completion forms that must be filled in at the end of community service and we must comply with the reason of community service, which is that they must also learn from community service. So we have developed a framework so that we must mentor them a little while they are on community service. The objective of community service is, first of all, to ensure that there are sufficient human resources for rural public health institutions, so that we are covered right. That was firstly the main objective; so that the people do not exit the service on completion of training. First of all we ensure that we are in line with the staffing

norms. Whilst placing them, we must ensure that we are developing them within the system, to ensure that they become more competent. When I say more competent I mean that they come being competent in basic nursing, not practical."

The coordinators of community service explained that operational nurse managers should enhance their competence in identified areas. They also mentioned that the unit professional nurses played a role in clinical assessments of these newly qualified professional nurses while they were doing clinical procedures as students. If the newly qualified professional nurses were incompetent in some clinical procedures, the experienced professional nurses should help them, not blame them.

F2/P1

"If you go and work at a maternity hospital, for example [mentions hospital by name], you must have induction specific for a maternity hospital. If you go and work at paediatrics, specific induction must be given. So the framework will say this is the general for patient care, then you must do the specifics for general or paediatrics."

Now if you want them to manage a unit or a ward, teach them how to run a unit! Don't tell me at the end that this nurse doesn't have a clue about nursing management. As part of the training you must teach them how to run the unit, how to be independent as a nurse.

F2/P1

"So when a manager complains that the nurse can't take blood pressure, I tell them look, I don't blame the university or the college because you signed their workbooks and said they are competent while they were still students! So how come now? The competency evaluations were 100 percent, they never got 50 or 40 percent. All of them were 100 percent. If that newly qualified professional nurse is coming to your ward, she is a [says the name of the province] qualified person, which means that we had as much a hand in her development as nursing education. She did her clinical practice with us professional nurses, because she has been a student here. So if you find the person not competent, you are going to build that competency in that specific area, because we let her go through! We signed and said she was competent and the council thought she has met the requirements and yet we complain. So if you as the operational nurse manager or

professional nurse identify a lack of competence in a particular area, you are going to work and help the nurse to reach competence".

Some coordinators reported not taking part in the induction and professional development of the newly qualified professional nurses. They left them to be supported by the health institutions where they were placed.

F2/P3
"No, after their placement we are not involved with them. They are orientated at facility level. We currently do not have an orientation programme that is done by the province for all the categories of com servers".

F2/P4
"You see, they go into the staff establishment of the hospitals and districts, so they are their employees. So development is not a provincial responsibility; it's part of the staff development there at the institution. In my communication with the staff development departments at the institutions or nursing managers, you will find that they often indicate, like I had a discussion with the nursing manager from [name] health institution the other day. She indicated that they are sending the community service nurses that are in the district for the IMCI course. Others have indicated that they send them for different TB programmes, so that they can function during the year. In fact, some of them said, we do this so that we can develop them. Some institutions have in-service programmes within the institution, they schedule them to attend and even other programmes outside the institution. Like your TB programme or immunisation programme; if there is something new, trying to develop them. That will be up to the staff development and the nursing managers of the institutions. It's just not possible for me to get to [number] hospitals and districts from [name] district health office to [name] district health office."

F2/P2
"The province had an annual programme of induction and professional development of all newly qualified health professionals – until it was agreed that for cost effectiveness this programme should be happening at district level. Induction and professional development of the newly qualified professional nurses is therefore coordinated at institution level."

The coordinators of community service accepted their support role, even though some were of the opinion that nursing management should put programmes in place for mentoring the newly qualified professional nurses. They were even able to describe how the newly qualified professional nurses were supported by the health institutions. They also acknowledged that some health institutions were not supporting the newly qualified professional nurses as they should, some not supporting them at all.

F2/P4

"In other areas like [name] health institution, they orientate them for a month then place them in the wards for three months, then they rotate. [Name] health institution orientates them for a week and places them in the wards with a monthly rotation. The reason is that they want them to gain skills in all the departments by the end of the com serve year. Other institutions, they place them in areas of interest and leave them there. Actually I do not have a problem when the institution has a crisis for instance in paeds, and there is this com server who is exceptionally competent and wants to be in paeds, for them to allocate her there for a longer period, as long as she is happy. There is nothing stopping them. Places like [names the health institution], for example, they actually assess their competencies throughout the year. Look, I have told the nurse managers that "They are your staff; manage them". I have had com servers phone me who say: "Thank you for placing me in this place, they have looked after me so well, and I have developed so nicely!" Yes, but there will always be places where it's not gonna happen. In the letter that I send to them, I do mention that the SANC says that they have met the minimum requirements and they are professional nurses; mentoring and support is recommended for newly qualified personnel; programmes should be put in place for their mentoring and support."

Code 2: Challenges

Operational nurse managers report professional development challenges late or at the end of community service.

Coordinators reported experiencing challenges from operational nurse managers who reported problems at the end of the community service. Some even refused to sign the completion records, stating challenges met during community service. The complaints received from the operational managers, among others, were: newly qualified

professional nurses lacking clinical skills, absenteeism, poor work attitude and substance abuse.

F2/P1

"So the managers must not wait until the person finishes community service and say "I will not sign the document." They must tell me in time if they encounter problems, not at the last quarter when they must sign the completion form. So when I get a problem in quarter four, then I start to blame the managers; what has happened here? I do get reports from managers saying that this nurse is abusing substances, or is not competent; she can't do dressings or deliver a baby. They also complain about adhering to protocol: things like absenteeism, don't come to work, attitude. Then we also get a nurse that doesn't see the necessity for community service, because somewhere along the line, they heard that nursing community service is just six months, so they are going to use that, so that they can stay six months on the system."

Poor planning at strategic level, lack of resources and attrition on completion of community service

Other challenges were about strategic planning at provincial and district level. The coordinators reported a lack of financial and human resources. Experienced professional nurses who were not receiving occupation-specific dispensation (OSD) were reported to be reluctant to mentor the newly qualified professional nurses, because they were not remunerated for it. The coordinators mentioned that they expected the novice professional nurses to be supported by the experienced professional nurses, not to be left to fend for themselves. Newly qualified professional nurses not serving bursary obligations were also reporting to be leaving the public health institutions due to the lack of support. The coordinators mentioned that those remaining were bound by the bursary obligations.

F2/P2

"Induction and professional development is only conducted at facility level:

- Due to lack of resources (human and financial) at district and provincial level.

- At some facilities function not coordinated – nurses reluctant because the incumbent not qualifying for OSD."

F2/P3

"The general challenge is that the new nurses are left unattended by the older nurses. They do not mentor them because, according to them, they came to render a service, not to learn. Although they are there to render a service they should not be left to fend for themselves. A fledgling must be helped by the older birds to fly. They must help them to grow from being a student to being a professional."

"When we allocate them to the clinics, they are even left to run the clinics by themselves, and when we ask why, the other nurses would say that they are not on internship, they are there to work. As much as I agree that community service is not an internship, they must be helped, not left alone. Last year some of our nurses resigned due to the bad experiences that they received from the institutions."

The coordinators of community service felt that professional development support of newly qualified professional nurses should be compulsory from national level as policy, to be coordinated by the provincial level and be implemented at health institution level. When mentorship or any programme of professional development is optional, the experienced professional nurses do not feel obliged to support the newly qualified professional nurses.

One coordinator of community service had a different experience regarding attrition post community service. She reported that the newly qualified professional nurses in that province are well supported in most health institutions, and those who leave post community service leave only due to family obligations.

F2/P4

"You see, ours are here to stay, so it's a different perspective. I can't speak for the people, but in most areas they know that these com servers are an investment. Besides others' attitudes, the others they know that the com servers are not only here for a year, but they will spend at least another three years, serving their bursary obligations. Many of them stay for…forever! Because once they are in that post they can stay, and our contract allows them to apply for post-

basic study once they have two years. So they do invest in them. That's why you will find that the majority of the places have programmes for them. They include them in their programmes. My role so far has been really, to encourage the institutions to do so."

Code 3: Strategies for improvement

The coordinators of community service acknowledged that the newly qualified professional nurses were an investment and they needed to be developed. The coordinators encouraged the health institutions to have development programmes to enhance the clinical competence of the newly qualified professional nurses.

Nursing education and practice should join forces in enhancing clinical competence

Coordinators of community service were of the opinion that enhancing of clinical competence should be done by both nursing education and practice. They suggested that operational nurse managers should be role models to the other professional nurses by being hands on in supporting the newly qualified professional nurses. The coordinators of community service were recommended to support the health institutions when they implemented professional development support programmes.

> F2/P1
> So the competency problem needs to be addressed by both nursing education and management. The other thing is ensuring that all nurses receive orientation and get induction through the central office and HR within the first week of employment. Lastly I feel that nurse managers should play their role, take the responsibility. They mustn't just say, "I don't want to sign", and that is that."

> F2/P2
> "The function to be coordinated at provincial level will be:
>
> coordinators of community service
>
> - to strengthen in-service education at facility level
> - exposure to conferences and workshops for professional development

- implementation of the CPD programme
- support health facilities to realise the implementation of the concept

other stakeholders

- Office of the Nursing Director to provide resources, e.g. nurse coordinators of community service
- District Management to provide support for the facilities
- Skills Development: facilitators at district and institutional level."

A well-planned, coordinated, implemented and evaluated compulsory professional development support that is comprehensive

For the future, the coordinators of community service suggested professional development programmes that were coordinated and implemented from provincial level, down to the health institution. They saw the HR department as the one to play a major role in the induction programme, organising and including relevant stakeholders and providing the human resources for the professional development programmes that would follow the general induction of the newly qualified professional nurses.

F2/P3

"We would like them to have provincial orientation before institutional orientation so that they can know the legislation and the policies required. They (HR) are the relevant department more than us. The district one started last year (2013) and I haven't seen it. I was not part of its planning. The province mainly gets invited to do the HR part of the programme. The programme still needs to be improved and standardised. I think they need to be orientated and mentored as they grow in the profession because as you find that the new nurse will be exposed to one facility, or in the hospital setting, would work in that ward. The person will not be exposed to primary health care at the clinics. That is a challenge that has been raised, the facilities actually say that the department needs to gazette the posts for the nurses for the clinics but the clinics do not have community service nurses' posts. We have since decided to place the nurses at the community health centres rather than the clinics, so that when they complete community service we can place them at the hospitals. But we have been advised by the service that they should rotate, not to be placed at the hospitals only; for them to gain comprehensive experience of both the hospital and the primary health care."

F2/P4

"But there are places where you find that, because the development is not compulsory or because it is not coordinated anywhere from national to institutional, it is not a formal requirement, they do not feel obliged to do it. They cite the reason that the com servers are there for only a certain period and they will leave at the end of the com serve or bursary obligations."

The coordinators of community service who were coordinating community service for all health professionals exempted themselves from the coordination of the professional development support, saying that they were swamped with work and that coordination of community service was an extra responsibility, not their primary job.

F2/P3

"Currently my hands are full as community service is an extra responsibility. Maybe I could be able to help if I was in the post as a coordinator of community service only."

Another coordinator of community service had an optimistic view, especially in view of their envisaged changing roles within that province, which might allow the team an opportunity to monitor the professional development support of the newly qualified professional nurses.

F2/P4

"As you are speaking about my role as a coordinator, our role is changing in…[name] province. We have now what we call it, a nursing chief directorate. The chief nursing directorate, the education side and the practice side, will be going to institutions just to monitor what is going on. In doing so, maybe we can pick up what's happening during mentoring of the com servers and we might have a bigger role to play. Most of the colleges prepare the final-year students for com serve. They have little topics on their role as professional nurses in the practice area. Another thing that will help the com servers is that at the moment in [name] province we are standardising the procedures. It's huge work, so that all the colleges, all the universities and all the facilities, they will do the same procedures the same way. They will talk the same language. We are also busy trying to re-establish clinical teaching departments. We have asked each hospital to identify an area for that. You see, there is just no money, but using what you've

got to get them established. The other thing is that we have CPD the [name] province version".

5.4   CONTENT ANALYSIS OF THE OPEN-ENDED QUESTIONS FROM THE SURVEY QUESTIONNAIRE (QUESTIONS 44–46)

This section discusses the part of the survey questionnaire, questions 44–46, where the newly qualified professional nurses aired their views qualitatively after responding to the questionnaire, questions 1–43, quantitatively. The researcher found it appropriate to analyse these questions qualitatively using thematic analysis, as the views and recommendations could be captured well with the themes and codes that emerged from the analysis, supported by the actual quotations from the respondents.

Section C of the survey questionnaire invited the respondents to air their views regarding their experiences of induction and professional development support during community service. The views were divided into sub-questions asking about their positive experiences (Q44), negative experiences (Q45) and their recommendations (Q46) regarding induction and professional development support of the future newly qualified professional nurses. The newly qualified professional nurses are called respondents, and not participants as is the norm in qualitative studies, because they responded to the open-ended questions on the last section of the questionnaire (Q 44-46). The responses were in writing and there could be no probing as in the one-to-one interviews.

The responses to the open-ended questions of the questionnaire were transcribed verbatim from the filled questionnaires onto an MS Word document to develop a computer file. The number of the questionnaire was retained for each transcription to allow the researcher to go back to the responses for clarity where necessary. The demographic data helped the researcher to be able to check the respondent's information against the narratives using the questionnaire number. Codes and themes were formed after intensive reading of the transcripts.

The responses were 112. Information saturation was reached after 50 responses to question 44, 63 responses to question 45, and 77 responses to question 46. There were no more new relevant concepts, codes and themes that could be extracted. The

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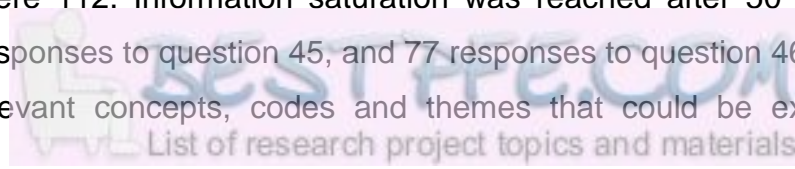
researcher went on to read the transcribed data for all the questions even after saturation. The researcher had to choose the quotes that best described the experiences of the respondents in each question. Both positive and negative experiences were reported.

The analysis yielded two themes, four sub-themes and 17 codes, as depicted in Table 5.4.

Table 5.4   Themes and sub-themes of data from survey qualitative questions

Themes	Sub-themes and codes
5.4.1 Induction and professional development support experienced by the newly qualified professional nurses during community service	5.4.1.1 Positive aspects experienced by the newly qualified professional nurses (2 codes) 5.4.1.2 Negative aspects experienced by the newly qualified professional nurses (5 codes)
5.4.2 Recommended Induction and professional development support to be given to newly qualified professional nurses	5.4.2.1 Nursing Education (5 codes) 5.4.2.2 Nursing Management (5 codes)

5.4.1 Theme 1: Induction and professional development support experienced by the newly qualified professional nurses during community service

The respondents' experiences were positive in some health institutions, while negative in others. The provinces and even the health institutions provided different support. Support programmes differed according to province and health institution, and in some cases there was no support at all.

5.4.1.1 Sub-theme 1: Positive aspects experienced by the newly qualified professional nurses in relation to induction and professional development support

Some respondents described a warm welcome that made them feel at ease, the respect that they were given as people, the choice of allocation and the induction as well as the professional development support that they received during community service. They

had many positive aspects to narrate; the researcher extracted only those that were relevant to induction and professional development support, as stated in question 44 of the questionnaire.

Code 1: Positive feelings experienced by the respondents

Appreciation of the warm welcome received

Some respondents described being warmly welcomed.

> F1/R20
> "The welcoming was very warm".

> "…and they were given the impression that they were appreciated by the public health institutions. They also felt important in that they were adding value to the profession."

> F1/R33
> "During induction programme we were given the impression that we were appreciated and that we will add value."

Feeling at ease

They felt at ease and the allocated mentors ensured that they fitted well into the areas of allocation.

> F1/R101
> "The professional nurse that was allocate to me was very helpful in ensuring that I fit well to the ward."

> "Their questions were answered during the induction period and that made them feel welcome."

> F1/R56
> "I was at ease because I was given induction. Everything was explained and questions were answered."

Feelings of independence, growth and development

Working independently as professional nurses gave them a sense of responsibility and accountability. They even welcomed the responsibility, as they were guided and they had confidence in what they were doing.

F1/R16

"Feeling of independence when nursing a patient as well as the responsibility and accountability that comes with it. Helps one to grow and mature."

F1/R19

"I managed to work independently and run the ward. Allocate the staff without irritation."

Some of them explained that they were supported by the nursing education institutions and were told what to expect in the service area during community service, thus they came prepared.

F1/R26

"I was happy that I was given all necessary information before I started with com serve."

In some health institutions, expectations from the nurse managers weighed less upon the respondents, and that helped to relieve the pressure that comes with being a newly qualified professional nurse.

F1/R79

"There were minimal expectations from me, which helped to relieve the pressure."

Boosting of confidence and enhancement of clinical competence

The respondents felt positive and confident when the experienced professional nurses supported them and encouraged them to polish their clinical skills.

F1/R7

"The theoretical knowledge and practica came into being effective and I felt positive and confident during my community service."

F1/R10

"I was given a chance to prove myself as a professional nurse."

F1/R13

"I was inspired to be more."

A familiar environment also helped the respondents to cope. They were more confident when they were allocated to public health institutions that they had been allocated to for practicals as students.

F1/R4

"…same hospital where I trained, nice to be there as a registered nurse."

F1/ R2

"A person can get confidence, competence, more knowledge and experience in the profession."

The respondents reported that support made them to be able to gain skills and confidence.

F1/R78

"Being newly qualified professional nurse was a good experience with the support I got from experienced nurses. It was very educational and I gained confidence, skills and more."

The respondents felt they were well accepted in the teams and developed positive self-esteem.

F1/R88

"I was well accepted in the team and given opportunities to practise my skills fully and that have given me a good self-esteem throughout my nursing career."

Confidence was boosted when their nursing skills were improved by the support that they received from the experienced professional nurses.

F1/R82

"Induction and professional development support improved my nursing skills. It did boost my confidence. It alleviated my anxiety and fear about the profession."

Respect for the newly qualified professional nurse as a person

The respondents felt respected as people in some of the health institutions and their fear for the unknown eased away.

F1/R18

"We got paid; it was nice to choose your ward, not moved around like when you are a student."

F1/R34

"One's opinion is taken into consideration. There is psychological transition from that of a student to professional."

F1/R43

"We were inducted by the hospital and also given a chance to choose where we wanted to work for every three months. We were very happy."

Being respected made them to feel proud to be part of the nursing profession.

F1/R44

"We were welcomed very well during induction and orientation. We even had a ceremony that made us feel proud, and respected to be prof. nurses."

F1/R49

"Support was given though one had to initiate it. There was teamwork. I was respected as a person."

Happy to have a choice of allocation areas

The respondents felt happy when they were afforded the opportunity to choose their allocation areas. They were consulted about the allocation and their opinion was taken into consideration. They felt that it would enhance their retention and competence when they worked in areas that they were interested in.

> F1/R23
>
> "I was given the opportunity to get exposure in departments I was interested in. that certainly will enhance our retention in the institution and competence."

> F1/R50
>
> "I was given a chance to choose a ward that my interests lie in."

The respondents were given a choice of clinical departments, which made them happy, but the duration of the allocation differed between one month and three months per ward. Those who were allocated for a month per ward felt that the month was inadequate to learn from a department.

> F1/R32
>
> "Each and every three months we rotate to different wards in order for us to get experience so that we don't excel in one condition."

> F1/R51
>
> "We were given a chance to get exposure to different disciplines by rotating to different wards monthly, though I feel like a month was not enough to learn about the allocated department."

Code 2: Professional development support received

The respondents who had positive experiences about the professional development support that they received mentioned attendance of in-service training, short courses relevant to their allocation and mentorship.

Attendance of in-service training and short courses relevant to place of allocation

Respondents attended short courses relevant to the clinical area and stated that they helped them to improve their nursing care.

> F1/R57
>
> "When I was rotated to a postnatal ward, I got to attend a course about PMTCT (prevention of mother to child transmission of HIV), which further helped me in attending an HIV-positive mother and her exposed baby."

> F1/R67
>
> "I was sent to NIMART (nurse initiated and management of antiretroviral treatment) workshop where I acquired more information about the initiation of ART [antiretroviral treatment]."

Respondents were given a chance in leadership positions. They led teams and were allowed to take charge of the ward under indirect supervision of the mentor.

> F1/R75
>
> "Given a chance to lead a team for a month and trained to insert Implanon [contraceptive implant] and remove it. Trained and a focal person for staff attitude and UMMC [Unit middle management coordinator]."

Mentorship

In some of the public health institutions, mentors were appointed to guide and supervise the respondents. The mentors answered their questions and they were willing to provide support.

> F1/R12
>
> "Relating to professional development support, I personally consulted for more info and clarity from my seniors, who were willing to help and support only when consulted."

> F1/R54
>
> "The nursing manager in my ward appointed me a mentor."

The respondents who felt supported reported that they learned to be responsible and accountable.

> **F1/R28**
>
> "As a professional nurse I have learned that I must be responsible, accountable for everything in the ward. As a professional nurse I have learned too much. They are so supportive, the sisters!"

They also reported that the mentorship received was good in that there was always a mentor available to support them with new adventures in the clinical area.

> **F1/R35**
>
> "Good mentorship from the operational nurse managers."

> **F1/R61**
>
> "There was always someone available to assist me when doing procedures for the first time as a qualified nurse, and I went to development classes e.g. breastfeeding programme."

The operational nurse managers provided learning opportunities and encouraged the respondents to attend professional development courses relevant to them.

> **F1/R64**
>
> "Certain assistant nursing managers [AMNs] provided positive learning opportunities and always encouraged me to do better and taught me to be the best. Currently AMN motivates me to do post graduate studies."

Some mentors went an extra mile when mentoring the respondents, to the extent that they could feel their absence when they left (causing separation anxiety).

> **F1/R70**
>
> "My given mentor, the sister who went to PHC training, was my pillar of strength. I could feel her absence thereafter."

Leadership development

The respondents reported having experienced growth and development when the operational nurse managers gave them opportunities to manage the wards.

> F1/R24
>
> "Growing in the profession, such as being afforded many opportunities to teach and lead my junior members. Delegate tasks and evaluation."

> F1/R52
>
> "I was involved in decision making in the ward that I am working in."

> F1/R55
>
> "I have learnt the importance of me being accountable and responsible in my role."

The respondents reported that they were gradually introduced to management of the ward and they appreciated the opportunities afforded them and the support received from the experienced professional nurses.

> F1/R72
>
> "I became in charge of the ward in the second month of my exposure with hardworking, experienced enrolled nurses and auxiliary nurses."

> F1/R4
>
> "The newly qualified professional nurses to manage the ward after 5–6 months and encourage members to work as a group."

Induction and orientation

The respondents reported having experienced less stress as newly qualified professional nurses due to being inducted. They said that induction equipped them with knowledge and coping skills. There were, however, different opinions about induction. Some felt that it was too short, whereas others stated that it was long.

F1/R58

"At my institution, there is induction programme for com servers, hope it spreads to other institutions as it makes it less stressful and equips newly qualified professional nurses with knowledge and coping skills."

F1/ R1

"The first unit I was allocated to, the operational manager did orientation and induction for three days, giving me opportunity to ask any questions."

F1/R17

"Learnt about the different services that the hospital provided. Learnt about the hierarchy. Learnt the clinical skills needed to be competent and confident in patient care, advocating for patients."

The induction programme was delivered by people from different departments and each of them had to explain his or her role and how the respondents were associated with that department.

F1/R21

"We were told about what each and every department does in the hospital and where to take our complaints."

F1/R22

"All departments of the hospital were present and gave us relevant information regarding our employments."

The respondents with positive experiences were given information in written form regarding policies and protocols of the institutions, as opposed to others where no written information was given, although a lot of information was given.

F1/R54

"During induction we were given policies and protocols, procedures were explained."

Some respondents said that the induction period was adequate, had relevant information and helped them to adapt to the new work environment.

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F1/R25

"The induction was long enough to prepare and orientate us to the functional units of the hospital as a whole."

F1/R58

"Attending induction workshop in the institution equipped one for the ward environment."

F1/R90

"The induction programme was 100 percent relevant to the unit I was placed in and it was well planned and organised."

F1/R89

"We had a week or more for induction, which assisted in adapting to the new environment."

The respondents experienced growth and development in their careers as they were supported. Their clinical skills were enhanced and they gained experience in nursing management.

F1/R9

"Learning new characters of different people, polishing my skills and knowledge, gaining experience."

F1/R42

"I enjoyed and preferred working with patient care as it helps to develop my skills and knowledge which in turn will help with me being an informed manager."

5.4.1.2 Sub-theme 2: Aspects experienced by the newly qualified professional nurses in relation to induction and professional development support

In this sub-theme, the respondents experienced the opposite of what the others had experienced in the sub-theme of positive experiences. They elaborated on the negative aspects that they encountered as well as how they felt. The researcher asked them to vent the negative experiences so that their plight could be addressed through the relevant channels to prevent their repetition in the future.

Code 1: Lack of supervision and other professional development support

Some public health institutions were reported to be experiencing a shortage of professional nurses and the shortage negatively impacted on induction and professional development support of the newly qualified professional nurses. The respondents reported that they felt uncomfortable in practising without supervision.

F1/P101

"When there were shortages I felt very uncomfortable to practice my leadership skills. There were times when the team did not accept my opinion. They told me that I am a junior nurse with no experience."

F1/P1

"Having to run the ward alone and be expected to render quality care. Shortage of staff is the most problem, and there is no appreciation in whatever you do; as long as the work is done the operational nurse manager will be happy."

F1/P63

"The negative thing I experienced was shortage of staff. Having to work/manage the ward alone as there are not enough professional nurses in the institution."

There was no induction given to the respondents when they started community service as newly qualified professional nurses. They had to assume responsibility more quickly than they expected and without supervision.

F1/P5"

"No induction done on my arrival. I think it was due to the shortage and they know me since my practical nursing. As no induction, I was left to run paeds ward in my two days of working with a new enrolled nurse, but it taught me to be independent".

F1/R61

"There is no formal induction and you have to grasp things along the way due to shortage of staff. Sometimes you are thrown in the deep end without proper knowledge of procedure."

The consequences of the staff shortage were that the respondents were not guided and supported as they should have been. They were allocated to alleviate the shortage of professional nurses, despite their being newly qualified and inexperienced.

F1/P8

"The institution does not have enough personnel to train newly qualified professional nurses."

F1/R27

"Not receiving enough support and guidance in the ward due to staff shortage."

F1/R33

"Due to the shortage of staff, one finds yourself filling the gap and it is forgotten that you are still learning and needs mentorship."

The shortage of professional nurses led to the respondents not being rotated, but placed in one ward or unit without any form of professional development to enhance their competence. They could not attend in-service training or workshops within or outside the health institution.

F1/R52

"As a community service professional nurse, I was told that we will not be rotated but only be placed in a specialised area where there is a shortage. I feel I will be disadvantaged as I will only excel in only one area."

F1/R57

"When I started community service, I worked in a medical ward. All we cared about was the patients' health and nothing else. I never got to develop myself in any way. I did not attend any courses because there was always a shortage of staff in the ward."

Code 2: Negative feelings experienced by respondents

Felt like being thrown in the deep end, very high expectations by nurse managers of the newly qualified professional nurses

The respondents displayed lack of confidence. They reported that they were not ready for the management of personnel as they were still finding their feet as professionals.

F1/P13

"I had to manage experienced lower category nurses even though I was com serve sister."

They had inadequate management skills. They preferred the operational nurse managers or mentors to introduce responsibilities gradually. Too much responsibility too quickly overwhelmed them.

F1/P14

"Too much responsibility too early in the com serve year."

F1/P15

"Feeling not well equipped to do managerial work."

The older nurses that they found in the wards did not make things easier for the respondents; they expected them to know everything.

F1/R58

"The worst thing was being expected to know everything in the working environment."

F1/ R71

"No workshops at all when the health institution you are placed in is short staffed. You as newly qualified are expected to know it all."

The respondents expressed feelings of anger due to the way they were treated. They were thrown in the deep end, according to them. They even felt that they were a danger

to the community by working without supervision and guidance while they were inexperienced.

F1/R80

"There is absolutely nothing positive but a feeling that as newly qualified you are being thrown into an ocean and people expect to find you on the other side. Any newly qualified professional, including nurses, is a danger to the community, so he/she should work strictly under supervision. Don't force competence but enhance it!"

F1/P6

"It was like I was learning to swim, but was thrown in the deep side. Did not get help when I asked."

Feeling ridiculed and disrespected, having low morale and even denied opportunities for development

Respondents felt belittled when they did not know how to do some of the procedures in the ward and the experienced professional nurses made fun and jokes about their lack of skills instead of guiding them.

F1/P19

"I didn't know how to order the drugs and diet slip and the staff made funny jokes about my training and the profession."

F1/P10

"I was not given enough freedom to make my own decisions."

Some respondents experienced bullying by the other nurses that they found at the public health institutions. They were reported to be taking advantage of the new nurses who did not know the new environment as yet, sometimes with verbal abuse.

F1/P2

"Abuse of kindness by the older nurses, i.e taking advantage of newness in the environment."

F1/R36

"Being excluded from the professional nurses' meetings in the ward. Being shouted at."

F1/P24

"Some wards you are still looked at as a student. No opportunities in drafting of duties, writing weekly and monthly statistics."

F1/R55

"Sometimes nurses who have been in the profession longer tend to undermine us as we are young."

F1/R49

"Not all members accept the coming in of a new and not experienced leader."

They were not listened to and their suggestions were disregarded.

F1/ R74

"No one orientated me, and qualified professional nurse if I gave advice, she sometimes does not want to listen to what I am suggesting."

The respondents reported that they were not supported to develop from novice professional nurses to competent professional nurses. Even if the in-service training was scheduled, they were not given an opportunity to attend.

F1/ R64

"To be honest, I was just allocated into a unit and had to take it from there. No formal orientation or induction took place, or any support regarding professional development."

F1/R32

"We don't get a chance to attend the in-services in the hospital."

F1/R30

"There is no provision made for us to attend workshops to develop ourselves."

F1/R3

"I never received an induction nor was any support given to me as a newly qualified professional nurse. Sometimes one had to work under no supervision."

Respondents reported having low morale when they were not given their choices of clinical areas, or they were not allowed to choose allocation areas at all. These factors and others were reported to be contributing to lack of interest in the clinical areas.

F1/P23

"Some of my preferences were not granted and I felt that my enthusiasm went down from there."

Feelings of being neglected and subjected to unequal treatment

The respondents who were university graduates reported having been treated differently from the college graduates. They experienced a lot of criticism and were not orientated to or inducted in the new work environment.

F1/R66

"What I can say is persons like me who trained at varsity experience a lot of heartaches and criticism just because we trained at university; we are not treated the same as others. Senior staff, matrons, tell us we know nothing. We are taken for granted."

F1/R69

"A team is broken down into small groups within the ward according to colour, age and friendship."

F1/R75

"Management not treating the staff equally."

F1/R78

"First of all, I was never inducted, I was never orientated around the hospital. I learned everything by myself by just asking around, the reason being the university group, 'cause we start our community service late, around March. Induction should be done to any nurse, whether from college or university, the treatment should be equal."

Code 3: Reluctance of the nurse managers and experienced professional nurses to supervise and mentor the newly qualified professional nurses

Respondents reported that the experienced professional nurses and operational nurse managers were reluctant to mentor and supervise them. They expected them to "run before they could crawl or walk". They do not see them as novices requiring their support to build their confidence and enhance their competence.

F1/P9

"Not all delegated staff members to monitor and supervise community service nurses are interested; therefore it makes it difficult for the newly qualified professional nurse to learn."

F1/P12

"The negative experience was when some senior nursing sisters didn't want to support us and just expected newly qualified professional nurses to know everything and to run the unit smoothly always as they do."

"No mentorship. No supervision. Problems not attended to in time. Operational nurse managers were not involved in professional development and support of newly qualified professional nurses."

F1/P17

"Didn't get appointed a mentor, left alone; we were called students for a prolonged time. In-charge too busy with running her ward to listen to problems and to attend to them promptly."

F1/R42

"We have no support from the unit managers and other professional nurses; one is put in the ward as a workforce but not for learning and development."

Other respondents resorted to asking for guidance from the medical doctors.

F1/ R70

"Manager was not supportive and has never mentored me. The doctors have been of great help because I asked help from them where I didn't understand."

Some of the experienced professional nurses are reported to have referred the respondents to their colleagues when they asked for guidance.

F1/R69

"Some of the nursing staff were willing to help where necessary. Although in most cases you will be told to ask one of your own."

F1/R82

"The negative thing was the attitude of senior nursing personnel."

The experienced diploma graduates were reported to have a negative attitude to the respondents who were degree graduates and did not want to mentor them.

F1/R110

"Lack of support and mentorship. Other older diploma sisters having inferiority complex towards degree com servers, thus being reluctant to help."

F1/R98

"Senior nurses reluctant to monitor and supervise com serve nurses due to personal insufficiencies."

F1/P10

"The staff in the wards were cruel to us com servers. Structures to be put in place to support com servers. You must have a shoulder to cry on."

Some respondents reported having been supported by some of the staff, though not all.

F1/R3

"Sometimes I got support from other professional nurses regarding management of the ward but not from all staff. I also received support from other subordinates".

Code 4: Poorly planned and inadequate induction period

Some respondents reported having undergone a short induction, although they did not mention the period or suggest the preferred duration.

F1/R21

"There was only limited time for induction."

On the other hand, others experienced overloaded induction programmes, with no information leaflets to be able to remind themselves after the congested programme was over.

F1/P25

"There was a lot of information given to us at the same time during the induction, most of which we can't remember now."

Other respondents experienced a lengthy induction period with no body breaks nor provision of refreshments during the long induction day.

F1/P26

"No refreshments given during the induction and took long hours to complete, especially when many speakers. You end up being tired."

Reporting on the content of the induction, respondents reported that some presenters were not well prepared and seemed to have inadequate information.

F1/R50

"In some wards there was a very minimal support/ supervision from the seniors. During induction, some representatives did not have adequate information as far as their respective departments are concerned."

In some instances, the induction was reported to be short, packed, with some information being irrelevant.

F1/R84

"It is a short induction with a lot of information."
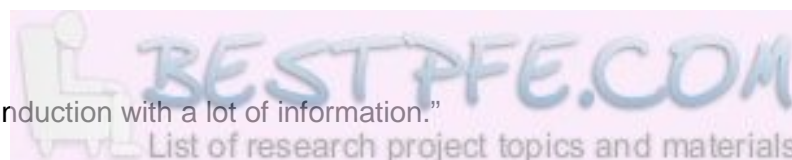
F1/R89

"The induction was too short (one week) for the information we received."

F1/R93

"The induction was done for a short time and it was not specific to the work that we were going to do."

Even in the induction programmes that were reported to be lengthy, the respondents felt that some information was irrelevant to them.

F1/R99

"Induction was done for two weeks but it was not specific to the work that we were going to do."

The general period of induction suggested by the respondents was two to three weeks. They also suggested that there be information booklets to refer to at a later stage, especially for unfamiliar content like that of the Human Resource (HR) department.

F1/R97

"A lot of the HR information was not clear, more so because we were straight from college and we knew less. They should have provided it in writing as well."

F1/R62

"The induction period is too short, at least two or three weeks because there is a lot of information."

Code 5: No platform for newly qualified professional nurses to air their grievances

The respondents reported that they had no formal professional person allocated to them by the management of the public health institutions to attend to their complaints.

F1/R54

"We do not have a specific professional to deal with our problems as com serve nurses."

F1/R60

"Being young makes it hard for team members to take you seriously and your views as well. And we had no mentor to help us with any challenges we had."

They had no meetings with the management to be able to voice their grievances or make suggestions regarding the induction, orientation or the support in general.

F1/R72

"Induction was poor, working without supervision, no meeting with management."

5.4.2 Theme 2: Recommended Induction and professional development support to be given to newly qualified professional nurses

The respondents gave recommendations regarding the support that newly qualified professional nurses need to transit from novice to competent professional nurses. They gave recommendations about what nursing education should do to prepare the nursing students for their role as professional nurses, as well as how nursing management should enhance their transition from students to professionals.

5.4.2.1 Sub-theme 1: Nursing Education

The respondents suggested the following: changes in the nursing curriculum; modification of the clinical allocation in the final year of study; nursing education institutions (NEIs) to regulate the number of student intakes to avoid producing quantity instead of quality of nurses; preparation of final-year students for professional nurses' role, and students to make use of available opportunities to prepare for professional nurses' role.

Code 1: Changes in the nursing curriculum

The respondents suggested an increase in clinical exposure during training and consolidation of nursing management and general nursing modules in institutions where they are taught separately. They also suggested that nursing management, specifically ward management, be given more clinical hours during training, like general nursing.

F1/P101

"There must be more practical hours in the clinical field to prepare a newly qualified professional nurse for her new role. The theoretical information is adequate but it does not concur with the realities that happen in the clinical area."

The respondents reported that the nursing education programme they had undergone as student nurses was well structured, but they experienced problems with the support in the clinical areas while they were students. There is inadequate clinical accompaniment of students by nursing education personnel and those of nursing practice.

F1/P13

"I think the programme is adequate. The problem is the support in the wards."

F1/P14

"Consolidation of general nursing and management is required."

F1/P18

"Clinical accompaniment of students is needed."

The respondents suggested more clinical management opportunities at primary health level for final-year students. With the current four-year (R425) nursing education programme, institutions allocate final-year students to hospitals for nursing management, but seldom to primary public health institutions.

F1/P16

"Personally I feel the training is sufficient if one is placed in a hospital setting, in a clinical setting maybe more opportunities to manage and run the clinic would help prepare us better."

F1/P15

"More of management practicals during final year."

They also felt that clinical practice should be simulated in the clinical areas and should be realistic.

F1/P21

"Clinical practice should be done away from the college and should be taught about what is really happening in hospitals."

Code 2: Students' clinical allocation to be modified in the final year of study

As part of curriculum changes, the respondents suggested that the final-year students be allocated to the wards for medical surgical nursing and ward administration to enhance their clinical competence. Medical surgical nursing ends at second-year level in the current R425 nursing education programme.

F1/ R57

"I think student nurses should be taken back to the medical, surgical wards, etc., because when we get to the wards during community service, we struggle because most things we did them in second and third year."

F1/R60

"A short course can be provided during final year to remind us of other things; e.g. we spend third and fourth year at the clinics and it gets a bit difficult when you are allocated at a hospital for your com serve because you are used to the clinics and their procedures. This might also be the reason of absenteeism during weekends, night duty and holidays in the wards during com serve because the newly qualified professional nurses are no longer used to hospital shifts, but clinic shifts."

Code 3: Nursing Education Institutions (NEIs) produce quantity not quality of nurses

The respondents reported that the intake of high numbers of students in NEIs leads to lack of clinical opportunities, and students do not reach the necessary level of competence, which is more than the minimum SANC requirements. There were reported to be more students than patients in some clinical areas. This was reported to be negatively influencing their transition from student to professional nurse.

F1/R80

"Overcrowding of students allocated in clinical institutions disadvantages us from becoming as competent as we should be. Colleges should reduce their number of students in their intakes so they can produce better nurses. Colleges must strive to produce quality rather than quantity."

Code 4: Preparation of final-year students for professional nurses' role

The respondents suggested that the final-year students should be given an opportunity to practise management activities under supervision of the experienced professional nurses.

F1/R96

"Final-year nursing students should be placed regularly in the clinical area, with their clinical objectives clearly stated to the unit managers."

F1/R 1

"Students should be given an opportunity to act as prof. nurse to get used to the role, under supervision always when on duty, do doctor's round, carry out orders, discharge patients, write on the daily stage, do statistics daily."

F1/P9

"They must be given the opportunity to work independently under indirect supervision to enhance their confidence. Unit in charge must support the final-year students in the work environment or practice areas in the institutions. Theory related with practice, therefore excellence in both situations, may make the final-year student to be more confident and to participate with pride in the nursing profession."

They also suggested that clinical facilitators should guide the final-year students and encourage them to engage in activities of nursing management under their supervision.

F1/P12

"To give final-year students the opportunity to actually run the shifts at least 3–4 times in a month of 'clinicals' in the wards, with the clinical facilitator teaching basics of what is expected of a professional nurse in practice."

F1/R42

"Student nurses should be more exposed to practical area in the last year so it can be easy for them to remember."

F1/P3

"Students should be given lectures during their practicals at institutions on what to expect when they approach the working environment; this will help them to become prepared".

F1/ R49

"Students should be allowed to manage the ward mostly in the final year and practice."

F1/ R54

"Colleges and universities should give us more hours in practica and unit managers should allow us a more responsible role as final-year students."

Other respondents felt that the nursing students should be taught to work independently as soon as possible, not to wait for the final year.

F1/R73

Teach students how to work on your own as an in-charge of a clinic or ward as soon as possible."

F1/R88

"I suggest that students must be more exposed to practical clinical environment and be given chances to practise management extensively so that they can be able to excel as qualified nurses once completing their training."

Conferences and workshops were suggested as part of professional development for the newly qualified professional nurses. Respondents suggested that final-year students be allowed to attend as part of their preparation for the professional role.

F1/R 37

"Final-year nursing students must be given an opportunity to attend workshops and conferences to be part of other professionals and improve their knowledge and skills."

Other respondents felt that they were not well prepared by the nursing education institutions for their role as newly qualified professional nurses. They suggested that final-year students be given a briefing about what to expect and how to fulfil the role of a professional nurse.

> F1/ R48
>
> "Newly qualified professional nurses from clinical areas should be allowed to come to make visitations to final-year students in order to prepare them regarding practical issues."

> F1/P10
>
> "The students must be briefed about com serve."

> F1/ R56
>
> "I think giving students an idea of how community service year will be like and what they will be expected to do, etc. will be helpful."

> F1/ R72
>
> "Preparation of students for community service in time can improve the profession."

Those who were briefed expressed feelings of confidence because they knew what was expected of them as newly qualified professional nurses.

> F1/ R55
>
> "I think this is being done well at the nursing education institution I attended [names the NEI], I came into this year knowing what is expected of me. I wish this could spread to other NEIs."

Code 5: Students to make optimum use of available opportunities to prepare for professional nurses' role

Other respondents felt that the nursing students have to be prepared for their roles as professional nurses because they came to nursing knowing that the training programme would culminate in their being professional nurses. They have to use available

opportunities to ensure that they graduate being competent professionals. They have to take ownership of self-preparation for the role and to start as early as possible during their training.

F1/R 22

"One has to prepare self, has to be ready since they are students for four years knowing they will someday become a professional nurse."

F1/P23

"Students should get more exposure in the clinical areas as preparation."

F1/P24

"Final year students to ensure what they have acquired in theory is put to practice when in the clinical field."

F1/P25

"In final year, each student should have been prepared for the working environment and taught their roles as professional nurses."

The respondents suggested that students should not wait until they get the qualification before they can act professionally, because it takes time to gain professionalism.

F1/R50

"Students prepare yourselves psychologically to be able to handle conflict and make sure you know what your role is as professional nurses."

F1/ R61

"(Students) be prepared to learn new things and ask if you are not sure of a certain procedure. Be willing to learn and everything will fall into place."

F1/ R75

"Ethos of nursing and professionalism should be practised during practicals as students."

Final-year nursing students were encouraged to have a positive attitude towards their learning and to prepare themselves early in the nursing programme to be professional nurses.

F1/ R76

"Final year students should be prepared to manage nursing units, as it happens prematurely during community service."

F1/ R78

"(Students) firstly I will encourage them to have a good attitude in all areas of the profession, be confident, ask where you don't understand. Always maintain to work under the scope of practice of a professional nurse."

5.4.2.2 *Sub-theme 2: Nursing Management*

In this sub-theme, the respondents suggested induction and professional development support that could be given to the newly qualified professional nurses by the executive nurse managers, operational nurse managers and experienced professional nurses in the health institutions.

Code 1: Allocation

The respondents suggested that the newly qualified professional nurses be allocated according to their choices as much as is possible to enhance their morale and retention in the public health institutions upon completion of community service.

F1/ R33

"Placement is very important, so may we please be placed according to our choices so we can perform best and be encouraged to remain after com serve because we will be in areas that we feel confident to work in."

F1/P4

"Community service nurses should not be allocated some of the areas or units like theatre and ICU as it needs more technical skill and speciality, according to me".

Code 2: Call for regular planned meetings to attend to common issues promptly

The respondents suggested an improved method of communication to be put in place between the newly qualified professional nurses and the nursing management, to have a platform to air grievances and complaints or even to suggest improvements in their support.

F1/P110

"Have monthly meetings with the newly qualified professional nurses and their mentors so as to identify any gaps soon. Conduct exit interviews for the newly qualified professional nurses so as to improve on the challenges they experienced. Any positive comments need to be noted and strengthened."

F1/R42

"Com servers should be followed up on monthly basis to gather their challenges and achievements. Not in a writing form but more of a discussion to be able to fix the problems in time."

F1/R30

"Let there be a meeting for com servers every three months for evaluation of satisfaction."

F1/R72

"Induction and orientation must take place within the first week of exposure. Meeting quarterly between management and newly qualified professional nurses. Allocation of a person who can supervise newly qualified professional nurses in a ward, and attend to their challenges can improve their integration into the profession."

Code 3: Provision of formal, structured training and development relevant to newly qualified professional nurses

Respondents suggested formal structured support in the form of induction, in-service training, workshops and mentorship. They mentioned that if the support is not formal, the operational nurse managers and experienced professional nurses do not feel obliged to support newly qualified professional nurses.

237
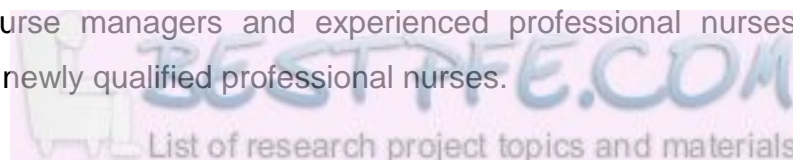
Induction

Respondents suggested that there should be an induction programme when they start with employment and stated the desired duration of the induction programme, the average being two weeks for it not to be too short or long.

> F1/P23
>
> "More preparation and organisation efforts are suggested. Provide us with more written information for us to keep. Allocate more time for the induction."

> F1/R24
>
> "People accountable for induction to ensure we're well welcomed in the wards. It would be better if we are treated equally and any complaints are looked upon. This enhances us to be free."

> F1/R62
>
> "Induction period should be longer, e.g. two or three weeks, depending on the institution's level. Allow us opportunities to attend workshops within and outside the institution."

> F1/R14
>
> "Need more induction, maybe two months once we start at the hospital as com server nurses."

They also suggested that some induction content be scheduled for the orientation period to reduce information overload during the induction. A request was also made to provide information booklets for the newly qualified professional nurses to refer to after the induction programme when needed. Some induction programmes were reported to last long days, and the respondents requested that the programmes should be planned with factual, relevant content, with a provision for body breaks to improve concentration.

> F1/R25
>
> "Induction should be factual and not prolonged with unnecessary information. There should be information booklets provided that one can refer to when they forget information. Induction should focus on precise, relevant content and responsibilities of a registered nurse in the unit."

F1/R82

"The induction should focus more on the coping skills and mechanisms that are needed to survive. The induction should start at least a month after employment."

F1/R2

"There should be a strict induction programme and specific ways to monitor progress. Continuation of monitoring and evaluation of growth and professional development should be done. To be exposed to an environment where it is required to manage the clinic under supervision."

Plan attendance of in-service training and workshops

Respondents felt that nurse managers should allow newly qualified professional nurses time to attend professional development activities, and not use them simply to alleviate the shortage in the wards or clinics while they were inexperienced.

F1/R30

"Allow com servers to go for workshops and other trainings please!"

F1/R48

"Structured training and development programme should be developed to allow continuous development as well as workshops regarding new equipment in the institution."

F1/R50

"Make provision for newly qualified professional nurses to have a programme of trainings relevant to the type of wards they are placed in and make attendance to be compulsory in order to improve or enhance their integration to being professional nurses."

Training suggested included nursing management activities like delegation of personnel, personnel management and ordering of medical supplies.

F1/R3

"Newly qualified professional nurses should be given induction regarding nursing management, so that they can have the ability and knowledge regarding how to

manage wards, because this requires support and skills from an individual together from other subordinates."

F1/R12

"To be given one-on-one teaching, especially regarding stock ordering, delegation of duties among staff, including basic and post-basic students. Sometimes we get problems when students who are already registered nurses get dissatisfied with delegations."

Mentorship

Respondents suggested a formal mentorship to be made available to newly qualified professional nurses, with a contract entered into by mentor and mentee. Rotation to other disciplines was welcomed, but with mentorship being provided throughout.

F1/R52

"Mentoring should be made possible as part of support to newly appointed community service professional nurses. Rotation to other wards and disciplines for exposure in such areas, because some wards we last went to in our second year of study. If one day I had to work there, it is going to be as if I am a stupid sister."

F1/R55

"We (newly qualified professional nurses) should be given mentors in each ward we work in to teach us and mentor us in the management of the ward and patients. The mentor to be someone who is understanding and patient."

F1/R57

"Management must have a mentor for us for the first two weeks of community service to mentor us on a full-time basis, because the permanent staff, some of them are just not friendly at all to new staff, especially the community service nurses."

F1/R18

"Supervision and mentoring is required."

F1/R21

"To make sure that they are being supported, even in the wards, by operational nurse managers and professional nurses. Management should not allow com servers to work alone as sister in charge of the ward before six months of com serve, even if there is shortage of registered nurses."

F1/R69

"In each ward where a newly qualified professional nurse will be placed, there should be somebody that is designated to guide and mentor them. People should not be thrown in the deep and be told that's the best way to learn."

Respondents suggested mentors who are knowledgeable, patient, not judgemental, not oppressive, and kind. Those willing to guide without being negative, and who can encourage the newly qualified professional nurses to reach their potential.

F1/R1

"Old prof nurses should give their full support for newly qualified prof nurses and not say negative words. Work with them, show them where necessary and encourage them to do to their full potential. If training is necessary, it should be given to new prof nurses."

F1/R26

"To have mentors who will always be there. Not to be oppressed."

F1/R7

"Newly qualified professional nurses still need to be mentored without judgement till independence. More workshops and in-service training is needed as well as more support from old qualified nurse professionals."

F1/R80

"Newly qualified professional nurses should not be allowed to work alone or independently because this exposes our people to risk of negligence and increases lawsuits to the Department of Health. For God's sake, we are dealing with people's lives! No one wants to learn from mistakes when coming to people's lives. This things eat a person's conscience. Please! Management should assign also professional nurses to have meetings/discussions with newly qualified professional nurses to find out what challenges they go through and

help them improve. Also increase the number of workshops and training offered to newly qualified professional nurses. Stop risking with our peoples' life!"

F1/R13

"Always allocate a senior nurse alongside a com server."

Respondents suggested that supervision and support must be given to newly qualified professional nurses to improve their confidence, enhance their competence and to prevent clinical errors. Operational nurse managers and the experienced professional nurses are requested to give guidance and support as well as providing constructive criticism, even praise where due.

F1/R92

"We need a lot of support from our seniors because by the time we start com serve, we feel like we belong to both sides: professional nurse and confused student."

F1/R98

"Monitor and provide positive feedback to com serve nurses."

F1/R8

"Newly qualified professional nurses should have adequate support to increase their self-confidence."

F1/R49

"Newly qualified professional nurses should be allowed to independently make decisions or give ideas and all these should be criticised constructively."

F1/R51

"Newly qualified professional nurses to be supported by seniors and be given a chance to run wards. To be given positive criticism and praises when due. Be given a chance to attend to in-service training and other professional development courses including workshops and conferences."

Respondents suggested that the period of mentoring be three to six months, depending on the mentee's level of competence, and operational nurse managers to be role-models by being hands on in the mentoring of newly qualified professional nurses.

F1/R90

"The mentoring of newly qualified professional nurses should still continue for three months as it makes the person confident and to see their mistakes on the spot and to learn new techniques of nursing as a professional."

F1/R88

"Newly qualified professional nurses need to be supported at least for six months to gain experience in the field they have chosen. They must work at least under supervision of the experienced registered nurse who will be their role model."

F1/R89

"Unit managers should be more hands-on with the new staff and assist in orientating newly qualified professional nurses."

Code 4: A need for formal support guidelines to ensure uniformity in the professional development of newly qualified professional nurses

The respondents suggested that formal guidelines and policies on the support of newly qualified professional nurses be formulated by governing structures and implemented by operational nurse managers. The guidelines should be implemented as part of the professional nurses' key performance areas and be evaluated in the performance management of professional nurses as well as operational nurse managers. Guidelines were proposed to help the operational nurse managers to draw support plans for the newly qualified professional nurses. Without guidelines, support and mentoring was said to be lacking structure, with some operational nurse managers not knowing how to implement the guidance and support. In some public health institutions the support and guidance are not implemented at all, due to the shortage of personnel and lack of formal guidelines.

F1/R5

"The paeds nursing manager was supportive, when she was around I learnt a lot from her. In maternity I was on my own, no support; even in medical ward I was on my own. No in-service training done in all these wards. Monitoring should be done and professional support. There should be community service policies."

F1/R79

"The unit managers don't know what is expected of them to do with the com servers."

F1/ R70

"Newly qualified professional nurses should have continued mentoring and supervision for the duration of the community service year. I have been the manager for the rest of my community service with no supervision. Continued supervision and workshops as well as support guidelines that will be monitored for effectiveness frequently should be made available and compulsory. Managers should not see us as relievers, because mine has been doing administrative work throughout my com serve."

Code 5: A need for mutual respect

Unit managers are expected to role-model professionalism and professional secrecy for others to emulate. Matters should be discussed in relevant platforms and newly qualified professional nurses be kept informed about matters concerning them.

F1/R31

"Com servers must be respected and consulted all the time concerning matters about them and not to hear things from the streets or corridors."

5.5   CONCLUSION

In Chapter 5, the results of the focus groups, interviews and responses from the open-ended questions of the survey questionnaire were described. Chapter 6 will discuss and interpret the results of both quantitative and qualitative data, triangulating the results to show the convergence.

CHAPTER 6

DISCUSSION AND INTERPRETATION OF FINDINGS

6.1   INTRODUCTION

Chapter 5 described the qualitative data analysis. Themes and codes were described, with the participant quotations added to validate the described results. Chapter 6 will integrate and interpret findings from all the qualitative and quantitative data analysed in Chapters 4 and 5.

The interpretation is done to give the overall picture of the outcome/findings. The qualitative and quantitative findings are presented in an integrated manner on a theme and concept basis (Creswell 2013:2142). The demographics of the study findings showed that nursing is still a female-dominated profession. Of the newly qualified professional nurses who participated in the study, 72.3 percent were females and 27.7 percent were males. Those in the age range 21–25 years constituted 33 percent; those aged 26–30, 30 percent; those aged 31–35 constituted 14.3 percent; while the other age ranges were 4.5 percent each. In the study done by Morrow (2009:281), the demographic data showed that in Canada the age of nurses at graduation has increased from 23.2 years to 27.3 years.

Table 6.1:   Themes, sub-themes and codes that emerged

THEMES	SUB-THEMES AND CATEGORIES
6.2 Enhancing induction and professional development support of newly qualified professional nurses during community service	6.2.1 Orientation 6.2.1.1 Orientation programmes 6.2.1.2 Orientation content 6.2.1.3 Orientation challenges 6.2.1.4 Recommendations to overcome orientation challenges 6.2.2 Induction 6.2.2.1 Recommendations to overcome induction challenges 6.2.3 Mentorship 6.2.3.1 Challenges regarding mentorship in public health institutions 6.2.3.2 The impact of the shortage of personnel on the mentorship and supervision of newly qualified professional nurses 6.2.3.3 Recommendations to resolve mentorship challenges 6.2.4 In-service education 6.2.4.1 Challenges experienced in relation to in-service education 6.2.4.2 Recommendations to improve in-service education 6.2.5 Supervision of the novice professional nurses by proficient and expert professional nurses
6.3 Experiences of study participants regarding induction and professional development support	6.3.2 Negative experiences of newly qualified professional nurses and operational nurse managers 6.3.3 Challenges experienced during the support towards professional development
6.4 Recommendations to overcome challenges experienced during the support towards professional development	6.4.1 Nursing education 6.4.1.1 Curriculum changes 6.4.1.2 Theoretical component 6.4.1.3 Clinical component 6.4.2 Nursing management 6.4.3 South African Nursing Council (SANC) 6.4.4 Department Of Health (DOH)

6.2 ENHANCING PROFESSIONAL DEVELOPMENT SUPPORT OF NEWLY QUALIFIED PROFESSIONAL NURSES DURING COMMUNITY SERVICE

Lee et al (2009:1223) describe professional development as: understanding leadership expectations of one's own performance; treating mistakes as learning opportunities; using input to address unit issues; having awareness of professional opportunities to do the job; and having the ability to participate in professional development programmes such as mentorship programmes.

All study participants reported professional development support as being important to enhance the transition from student nurse to professional nurse. The transition period has been defined as "the period of learning and adjustment to the requirements of nursing in which the graduate acquires the skills, knowledge and values (additional to those learned during undergraduate study) required to become an effective member of the nursing workforce" (Hayman-White, Happel & Charleston 2007:186).

This aspect was poorly addressed in the orientation programmes: most programmes (79 percent) did not mention the professional development support to be offered to the newly qualified professional nurses. The professional development support mentioned in the remaining 21 percent of orientation programmes was reported to be given by operational nurse managers and experienced professional nurses of the unit or clinic. It was reported to be in the form of in-service training attended by the newly qualified professional nurses, and departmental case meetings where specific incidents or cases were presented.

Operational nurse managers reported that they were expected to schedule newly qualified professional nurses for in-service training; encourage experienced professional nurses to support them; oversee mentorship in the unit and assess the level of competence of the newly qualified professional nurses to plan its enhancement. They then described the things that they actually did to support the newly qualified professional nurses during the transition period, which were: allocating them to go to in-service training and short courses relevant to the area of allocation; mentoring the newly qualified professional nurses, though informally; clinical teaching to close the clinical skills gap; leadership skills development; professional socialisation and role modelling of professional behaviour. Dyess and Sherman (2011:313) state that support for newly

qualified professional nurses should include novice nurse leadership programmes to develop their leadership skills. They also report that such programmes allay the anxiety and fear of the newly qualified professional nurses by welcoming them and orientating them to the new work environment. Chaperone (2011:23), in an Australian study, confirmed the need for supporting newly qualified professional nurses.

However, only some newly qualified professional nurses who responded to the qualitative questions of the survey reported that they received informal support in some public health institutions; others reported that there was no support in the public health institutions to which they were allocated. Cho, Lee, Mark and Jones (2014:22) state that newly qualified professional nurses migrate from rural public health institutions to urban public health institutions to get support. Operational nurse managers and experienced professional nurses were reported to be mostly supportive in public health institutions that did not have a severe shortage of personnel. DeCicco (2008:20) agrees that newly qualified professional nurses are supported better when there are enough experienced professional nurses to do the mentorship.

Some of the coordinators of community service who participated in the interviews reported that they played a strategic role in the induction and professional development support of the newly qualified professional nurses that they allocated to the public health institutions for community service. They reported that support for the newly qualified professional nurses was minimal, due to factors such as: lack of knowledge of mentoring; severe shortage of personnel and reluctance to support newly qualified professional nurses due to personal reasons. Some studies indicate that young health professionals are more likely to move on if they are not supported in their work (Mooney 2007:79; Leigh et al 2005:508; Stagniti 2010:504). All participants from all data sets agreed on the professional development support to be given to the newly qualified professional nurses as: orientation to the new work environment; induction into the position and role of professional nurse; mentorship; in-service education/short courses relevant to the area of allocation; supervision and guidance.

6.2.1 Orientation

According to the online free dictionary, orientation is defined as a programme introducing a new situation or environment. Hayman-White et al (2007:194) state that

orientation programmes need to enhance the competencies of newly qualified professional nurses' need for safe work environment.

6.2.1.1   Orientation programmes

All data sources reported back about the orientation content. Orientation programmes were reported to be standardised in most of the public health institutions and a few had unit-specific orientation programmes. Survey respondents were of the opinion that orientation should be done upon getting to a new unit. Finnegan, Finnegan, Bates, Ritsperis, McCourt and Thomas (2015:105), after conducting a study on preparing British military nurses for deployment, supported orientation of newly qualified professional nurses, and proposed that orientation should be continuous with every rotation to a new clinical area.

Various institutions rotated the new nurses to other clinical areas differently. In some institutions rotation was not done at all. However, most survey respondents reported that they were rotated to other wards/departments/clinics during the community service; very few stayed in one unit/ward throughout community service. It was suggested that clinical placements/rotations of newly qualified professional nurses be offered as two to three major rotations in a variety of clinical areas.

The sampled public health institutions had orientation programmes. The largely urban provinces had provincial guidelines in addition to the institutional orientation programmes, whereas the largely rural provinces depended only on the institutional orientation programmes for the orientation and induction of the newly qualified professional nurses, when they did offer such programmes.

In largely rural provinces, the orientation programmes of the public health institutions lacked a lot of aspects in both core induction and role-specific phases. Neither province had provincial guidelines. Gatley (1992:85) states that supporting district nurses is not easy, as they do not have enough learning opportunities and have overwhelming workloads.

In largely urban provinces, most of the operational nurse managers of the public health institutions were thoroughly conversant with the provincial guidelines, but they used the

guidelines only during the week of the core induction phase of the orientation. This is the period when the staff development department inducted the newly qualified professional nurses. The nursing personnel used the institutional orientation programme when the newly qualified professional nurses came to the units. Some of the operational nurse managers were not aware of the provincial guidelines. The orientation content was average, although some aspects were still lacking. Hayman-White et al (2007:192), declare that successful transition relies upon the quality of the orientation programme provided by the health institution and the support received during the transition period. Comprehensive orientation programmes upon commencement of community service, and sound and consistent support are essential (Hoffart, Waddell & Young 2011:336).

The provincial guidelines of the largely urban provinces were not incorporated in all the public health institutions' orientation programmes.

The average scores of both largely urban provinces was 48 percent, 7 percent less than the largely rural provinces. The average score for all the four provinces was 52 percent. The findings of this study revealed that the induction/orientation programmes were lacking information and needed to be revised to be more comprehensive, in order to enhance a successful transition from student to professional nurse (Hayman-White et al 2007:192).

The descriptive statistical findings of the study regarding orientation were that the majority of newly qualified professional nurses who participated in the survey received orientation, while others received induction. Very few received both orientation and induction and some received neither orientation nor induction.

Orientation programmes are supported by studies like the one conducted by Phillips, Esterman, Smith and Kenny (2013:1319), who conducted a quantitative descriptive survey to identify predictors of successful transition from undergraduate student to registered nurse. The study found that the three factors for successful transition were: a solid orientation to a new environment, the ability to deal with the clinical challenges of a complex patient and respect from their colleagues.

Survey respondents and focus group participants stated that the time frame for the orientation was too short at most of the public health institutions. Time frames reported were less than a week to one week.

6.2.1.2 *Orientation content*

The orientation programmes collected from public health institutions were assessed against the following content, using a checklist derived from the literature:

Practice orientation

The orientation programmes from all the sampled provinces scored between 70 and 100 percent on the aspects of physical orientation to the practice structure (building and equipment), reporting times for duty, introduction to colleagues, communication channels/hierarchical structure of the public health institution, arrangements for reporting absence, and orientation to the job description. Hayman-White et al (2007:192) report that orientation programmes should include the following aspects: orientation to the nursing procedures; guidance and feedback regarding specific nursing situations; an overview of the hospital administrative procedures; feedback on clinical performance, support from a preceptor and regular supervision.

Legal framework

Legal framework aspects to be taught to the newly qualified professional nurses during orientation should include: relevant acts, regulations, policies, guidelines and protocols applicable to the post at all levels of governance (e.g. SANC, DoH, etc.); emphasis on accountability, handling of client complaints, incidents and client feedback. Fifty percent of the induction programmes did not address the issues of accountability, handling of client complaints, incidents and patient feedback.

Human resources aspects

These were adequately addressed by the orientation programmes at institutions that had an orientation or induction programme that was done at the staff development department and at those that had a district health orientation in addition to the ward or

clinic programme. Halfer, Graf and Sullivan (2008:249) stress the importance of organisational support in the professional development support programmes of the newly qualified professional nurses.

Learning and personal development:

Only 21 percent of the orientation programmes addressed the appraisal system, opportunities for learning and clinical supervision. The newly qualified professional nurses who responded to the survey reported that learning opportunities were inadequate in some public health institutions, while some new nurses were denied the opportunity to attend in-service training or short courses relevant to the clinical department. Jackson (2005:27) states that newly qualified professional nurses also have roles and responsibilities towards their learning and they must initiate the learning if it does not come to the fore.

Clinical practice

This aspect was largely addressed in all the orientation programmes. Programmes included routine tasks, procedures, delegation and health care services specific to the ward or clinic. Kotzee and Couper (2006:2) are of the opinion that institution-specific interventions should be included in support programmes to retain newly qualified health professionals in the rural public health institutions.

Consolidated competencies necessary to be effective in role

The orientation programmes that addressed this aspect were 64 percent *(n=9)*. Some orientation programmes, 14 percent *(n=2)*, even specified the clinical competencies required from the newly qualified professional nurse to be effectively incorporated as a team member.

The checklist included the aspect of supervision of subordinates by newly qualified professional nurses. A few orientation programmes, 21 percent *(n=3)*, addressed this aspect. The operational nurse managers who participated in the focus groups were divided in their opinion; some suggested that there should be no clinical supervision of students by newly qualified professional nurses during community service, while others

were of the opinion that newly qualified professional nurses could supervise student nurses after six months of community service when they were used to the working environment, and had reduced levels of anxiety. They stated that the newly qualified professional nurses could miss out on an important development aspect of nursing leadership if not allowed the opportunity to supervise students.

Mentorship/preceptorship

A few orientation programmes addressed this aspect: 14 percent *(n=2)*. They mentioned that mentorship/preceptorship would be offered to the newly qualified professional nurses, but did not specify whether it would be formal or informal. The period specified in some programmes for the mentorship/preceptorship ranged between two and six months and one year, and the duration of the compulsory community service. McCusker (2013:285) states that the mentoring process should be allowed to go on until the mentor and mentee feel safe to terminate the relationship, which is usually after one year.

Review of the orientation programme

Most orientation programmes did not cover this aspect: 86 percent *(n=12)*. The orientation programmes did not have goals, therefore did not consider whether the orientation programme was effective or not. Only 7 percent *(n=1)* mentioned personal development plans for the newly qualified professional nurses; 14 percent *(n=2)* mentioned that the developmental needs of the newly qualified professional nurses should be determined.

Hayman-White et al (2007:197) state that public health institutions should have measures in place to evaluate the professional development process (orientation, induction, supervision, mentorship, preceptorship, in-service education and provision of learning opportunities for the newly qualified professional nurses). The evaluation should be comprehensive and incorporate the perspectives of relevant key stakeholders to ensure that programmes meet their stated aims and objective. Perspectives of relevant multiple key stakeholders should be explored to develop models of best practice that could assist the ongoing development and monitoring of support programmes for the newly qualified professional nurses (Hayman-White et al 2007:197).

6.2.1.3   Orientation challenges

Inadequate orientation content and time were reported by the survey respondents and focus groups participants as the main challenges. The content was reported to be inadequate in some public health institutions, orientating the newly qualified professional nurses about the new work environment only, not including orientation about the actual work that was going to be carried out. Even those who had orientation content relevant to the work environment were reported to have too short a time frame. Penfold (2011:8) is of the opinion that nursing management places high demands on the newly qualified professional nurses and gives them no support, leading to various challenges while trying to find their feet and at the same time being expected to get off to a 'flying start'.

6.2.1.4   Recommendations to overcome orientation challenges

Participants suggested an increase in the orientation time frame, to be according to the content of orientation, such as two weeks for the public health institutions that rotated the newly qualified professional nurses for a month to three months, depending on the content and the size of the public health institutions.

The participants suggested that operational nurse managers should improve the orientation content, to ensure that orientation programmes are factual and relevant, to serve the purpose of introducing the newly qualified professional nurses to the new work environment (Edwards, Hawker, Carrier & Rees 2011:2216).

The provision of temporary substitute professional nurses in the units for the duration of the orientation period was suggested by the focus group participants. They reported that substitute professional nurses would ease the workload and allow the experienced professional nurses some time to orientate and provide other support as applicable to that public health institution.

6.2.2 Induction

Newly qualified professional nurses reported having attended poorly planned induction programmes. The content was reported to be inadequate and/or irrelevant to the work place. The presenters were also reported to be lacking in facilitation skills, having poor knowledge of the subject that they presented. These findings differ from the report written on the induction programmes, and those of the operational nurse managers, who reported that the presenters of the induction programmes were knowledgeable and came from the relevant department about which they were giving information.

6.2.2.1 *Recommendations to overcome induction challenges*

Study participants suggested that the induction time frame should be increased to suit the amount of the content. Formalising the induction programme provincially was also suggested. The newly qualified professional nurses who participated in the survey suggested that the presenters of the induction programme should be knowledgeable about the subject to be presented and prepare adequately. They also suggested that the organisers of the induction programme should plan and provide information booklets for ease of reference when necessary after the induction period. Spiva et al (2013:27) support the notion that the voice of the newly qualified professional nurse should be heard when addressing challenges.

6.2.3 Mentorship

Harrington (2011:168) describes mentoring as a voluntary, intense, committed, extended, dynamic, interactive, supporting, trusting relationship between an experienced person and a newcomer.

Mentoring aspects may include: time management and productivity, managing caseloads of patients, developing clinical skills, overcoming fear and anxiety, dealing with isolation, grasping the business aspects of practice and balancing clinical practice with personal responsibilities (Harrington 2011:172). The participants reported that some public health institutions have informal mentorship relationships, where the operational nurse managers pair mentors and mentees in a team, the experienced professional nurses being mentors and newly qualified professional nurses being

mentees. In other cases the experienced professional nurses were reported to teach the newly qualified professional nurses as they worked with them, due to time constraints and shortage of personnel.

Survey respondents reported mentorship support of about three months at a time in the public health institutions that did not have severe staff shortages. This duration of mentoring is supported by the study by Lee et al (2009:1219), which also found that the participants had mentorship for the duration of three months. Mentorship was reported to be inconsistent, informal, provided by untrained mentors without the support of the public health institutions. Thomas et al (2016:160) emphasise on the importance of organizational support for the success of mentorship relationships.

6.2.3.1   Challenges regarding mentorship in public health institutions

Shortage of personnel, especially professional nurses, was reported in the research findings as having a negative impact on mentoring of newly qualified professional nurses.

The operational nurse managers and experienced professional nurses who were willing to mentor the newly qualified professional nurses reported that they did not get training on mentoring and there was lack of organisational support in their efforts. Lee et al (2009:1219) support training for mentors and list the following aspects to be included in a workshop for training mentors: basic concepts of mentoring; principles of adult learning; defining the mentor role, goals, benefits and barriers for the mentor; supporting and challenging mentees; maintaining professional boundaries; reserving time for mentoring; gender awareness; recognition and reward for mentors; peer mentoring; mentor support; mentor forum to express problems; and programme evaluation.

The research findings reported that mentorship was a non-formal relationship between the experienced professional nurses and newly qualified professional nurses, and that it did not have support from the nursing management and the public health institution. Rhodes (2013:594) states that mentoring needs a culture shift at individual level, at departmental level and at organisational level. Public health institutions should be encouraged to increase the value placed on mentorship and support its benefits, to increase the 'buy-in' from potential mentors by, for instance, offering awards for

excellence in mentoring, and recognising mentoring for performance incentives or promotion.

The operational nurse managers who participated in the focus groups reported that public health institutions had budget constraints and did not have the budget to support programmes like mentorship. According to Gibson and Heartfield (2005:53), a properly resourced mentorship programme should have mentors that are trained, and there should be a budget for supporting newly qualified professional nurses in their transition from student to professional. A properly resourced mentorship programme should have funds and procure relevant resources. There must be a coordinator to administer the programme, provide training workshops, support and encourage contact between participants and resolve emerging difficulties (Gibson & Heartfield 2005:53).

6.2.3.2 The impact of the shortage of personnel on the mentorship and supervision of newly qualified professional nurses

All the data sources of the study have reported that there is a shortage of experienced professional nurses in the public health institutions. The available experienced professional nurses were reported to be mostly reluctant to mentor newly qualified professional nurses, raising concerns of being overworked and wasting their time on nurses who were not permanently employed. They were said to prioritise patient care over supporting the newly qualified professional nurses. The operational nurse managers reported that the experienced professional nurses were reluctant to do both patient care and mentoring, complaining of being overworked. Vance (2002:7) supports the experienced professional nurses, stating that those who are willing to mentor newly qualified professional nurses do not have enough time and energy to do 'anything extra'.

Some of the coordinators of community service and newly qualified professional nurses acknowledged the shortage of personnel and added that the shortage was severe in most of the remote rural public health institutions, where it might be found that the newly qualified professional nurse was the most senior health professional who was in-charge of a clinic, with sub-categories of nurses on the team. In some instances, nurses would have to close down the clinic site in order to travel to other areas for educational sessions (Hanson & Hilde 1989:75). Hanson and Hilde (1989:75) conducted a study on

mentoring of newly qualified professional nurses allocated to remote rural public health institutions. Their findings were that rural mentorship programmes with defined guidelines should be designed to meet the needs of newly qualified professional nurses working at rural clinics. The study is very old, but the findings were found to be still relevant in this era, as demonstrated by the findings from the newly qualified professional nurses, operational nurse managers and coordinators of community service who participated in the current study. Harrington (2011:168) also acknowledges the shortage of professional nurses in rural public health institutions, stating that there is a critical shortage of primary care providers and an ageing population requiring management of chronic medical conditions in rural public health institutions. Hanson and Hilde (1989:76) state that, to strengthen the continuity of a rural nursing mentoring programme, student nurses should be recruited from the rural area so that they will want to return to practise in the rural setting. Such a recruitment strategy is employed by the South African Government, which recruits students to go for medical training, with the agreement that the students will come back as qualified medical doctors to work in the rural areas.

6.2.3.3   *Recommendations to resolve mentorship challenges*

The study participants were of the opinion that support challenges could be addressed by formalising mentorship nationally. The findings also called for regulation of the mentorship support by the SANC and reinforcement by the national DoH. Operational nurse managers and coordinators of community service for nurses who participated in the study believed that national regulation of mentorship could revive the nursing profession through retention of newly qualified professional nurses who had been supported from novice to competence. Block, Claffey, Korow and McCaffrey (2005:135) are of the opinion that operational nurse managers should advocate formalisation of mentorship. "Nursing theorist Patricia Benner proposed the 'novice to expert' theory, which asserts that professional growth occurs in distinct stages and relies on constructive, nurturing relationships akin to mentoring" (Block et al 2005:135).

Operational nurse managers who participated in the study suggested that mentorship should be formal and have specific organisational goals that the mentor and mentee would be obliged to meet. This notion is supported by Harrington (2011:171), who also states that the mentoring programme should have developed specific goals for the

mentee. Brediger (2009:111) adds that there should be a formal contract and agreement that would outline the length of time, schedule of contract, ways that contact would be maintained, and goals and objectives of the mentoring relationship. Acknowledging and defining of mentorship relationships should prevent as many pitfalls as possible (Gibson & Heartfield 2005:51). Hoare, Mills and Francis (2013:90) stress the point that mentors must be willing participants in the mentoring relationship.

The coordinators of community service reported that newly qualified professional nurses did not want to apply for permanent positions in institutions that had not supported them during the transition period. They were reported to be applying to go to more supportive public health institutions (Al-Dossary, Kitsantas & Maddox 2013:3). The public health institutions that disregarded support measures thus could not retain the newly qualified professional nurses on completion of community service. They left to continue serving their bursary obligations in different public health institutions within the same province from which they had obtained the bursary. Harrington (2011:172) states that the outcomes of a well-supported mentorship programme could be: improved quality of care, increased productivity, increased job satisfaction and longevity (greater retention of nurses). Well-designed mentorship programmes could decrease turnover rates and improve professional development (Lee et al 2009:1217).

Some of the operational nurse managers who participated in the focus groups of the study suggested that the community service year should be treated as a form of internship for the newly qualified professional nurses – a year in which they would not be formally counted in the public institution's number of professional nurses. This, however, could not be done because the Department of Health clearly stated that community service was not an internship (South Africa Department of Health 2006:1). Some other countries have nurse residency programmes for the newly qualified professional nurses. Kowalski and Cross (2010:96) report that nurse residency programmes increased the level of clinical competency and professional transition in newly qualified professional nurses and decreased first year turnover rates.

Vance (2002:7) suggests strategies to be used to promote mentoring amidst the shortage of experienced professional nurses. The potential mentors should be encouraged and supported, acknowledging the shortage of staff but also reminding them that newly qualified professional nurses are human, and require the human

relationship of caring, support and encouragement that comes from good mentors. The nursing management should encourage a mentoring mentality that entails collaborating as against competing. The experienced professional nurses will acknowledge that, for the continuity of the profession, they need to nurture their young, not to 'eat them' (Morrow 2009:278; Vance 2002:7). Vance (2002:7) states that mentorship relationships that can thrive in the staff shortage are those that are more inclusive and diverse in age, experience, culture, gender, ethnicity and race. "The relationships will be peer-driven and incorporate the expert-to-novice model" (Vance 2002:7).

In application, after conducting this study, the researcher deduced that in the public health institutions of South Africa, the multiple mentor experience model, as described by Smith et al (2001:101) in Chapter 2, could be applied in two ways if adopted:

The first scenario is one in which, in a unit, the experienced professional nurse becomes a secondary mentor who acts as a preceptor, while the operational nurse manager acts as a primary mentor who presents a total commitment to the mentee (the newly qualified professional nurse). In this scenario, goal clarification will be crucial.

Another scenario of the multiple mentor experience could be one in which the newly qualified professional nurses, as mentees, get exposed to multiple mentors as they rotate in allocation to various units of the public health institution. All the multiple mentors could be trained in all the specific outcomes of the mentorship programme; these specific outcomes could be further narrowed down according to the period of community service: for instance, specific outcomes for the first, second, third or final quarter of the community service year if the rotational period is three monthly. The mentorship relationship would be dictated largely by the period of allocation in a unit. By the end of the community service period, the newly qualified professional nurses, as mentees, would have attained all the specific outcomes and goals of the public health institution's mentorship programme.

The mentoring models described by Harrington (2011:169) could be applied in public health institutions that do not rotate the newly qualified professional nurses during community service. A combination of 1) the primary and secondary multiple mentoring models as described by Smith et al (2001:101), and 2) one of the three mentoring models described by Harrington (2011:169) (the research findings of this study do not

advocate the informal model) could also be adopted by the public health institutions that were reported as not rotating the newly qualified professional nurses.

6.2.4 In-service education

The research findings were that although there were no formal mentorship programmes in public health institutions, there was in-service education in most public health institutions. Staff development departments were responsible for in-service education in public institutions that had them. Operational nurse managers were reported to be responsible for planning and implementing the in-service education in public health institutions that did not have staff development departments.

6.2.4.1 *Challenges experienced in relation to in-service education*

The study findings were that newly qualified professional nurses, like other health professionals, need continuing professional development (CPD) during their compulsory community service period. This can be in the form of in-service training programmes that supplement the basic nursing education, as well as continuous training as a professional to improve patient care (Wilson et al 2009:10).

Challenges were multifaceted. Survey respondents reported that there was no in-service education in some public health institutions. Some reported that it was available but poorly planned. They complained about presenters that did not pitch for presentations, and presentations that were not relevant to enhancing their transition from student to professional nurse. Operational nurse managers were reported as denying newly qualified professional nurses opportunities to attend in-service education programmes, in order to keep on working to allay the shortage of professional nurses in the units. On the other hand, focus group participants among operational nurse managers complained about newly qualified professional nurses who did not avail themselves of the planned in-service education programmes.

6.2.4.2 *Recommendations to improve in-service education:*

The research findings from all the data sources reported that operational nurse managers should plan in-service education programmes and allocate newly qualified

professional nurses to attend the in-service training and workshops. The research participants agreed that the in-service training had to be structured and career oriented. "Newly graduated nurses are eager to be developed so that they can transition into leadership positions in the nursing profession. New nurses who are entering the workforce are already planning their future and need support and mentoring about how to tailor their career trajectory " (Tran 2013:4). Provision of formal, structured training and development relevant to newly qualified professional nurses could assist them in the acquisition and consolidation of many clinical skills, knowledge, and attitudes throughout their transitional year so that they can become competent, confident, accountable and professional (Hayman-White et al 2007:196).

6.2.5 Supervision of the novice professional nurses by proficient and expert professional nurses

The study findings were that operational nurse managers should acknowledge their teaching role and supervise the newly qualified professional nurses with the experienced professional nurses.

Expectations regarding clinical supervision are clearly stated by Hayman-White et al (2007:195), who describe clinical supervision as "a formalised process of meeting between two or more nurses. Its focus is on the professional growth and practice improvement of the supervisee through the examination of the supervisee's clinical work". The same authors state that advantages of clinical supervision are putting emphasis on clinical aspects of a particular area of nursing (e.g. midwifery or mental health nursing); encouraging appreciation of individual clients and their unique social situations; helping with retention and morale; and promoting links between research and clinical practice (Hayman-White et al 2007:195). The study participants reported that clinical supervisors needed formalised support from the public health institution through professional development.

There were reports from the study of inadequate supervision of the newly qualified professional nurses by the operational nurse managers and experienced professional nurses. The suggestion was that public health institutions should re-introduce clinical teaching departments (CTDs) with clinical facilitators to help with clinical supervision;

demonstration of clinical skills where necessary; presentation of in-service programmes and coordination of induction programmes.

6.3   EXPERIENCES OF STUDY PARTICIPANTS REGARDING INDUCTION AND PROFESSIONAL DEVELOPMENT SUPPORT

The knowledge of how newly qualified professional nurses perceive workplace stressors, may bridge barriers to early professional development. This knowledge could assist nursing professional development specialists to develop interventions that support effective and positive transition of newly qualified professional nurses into a new era of professional practice (Mahler & Mancino 2016:E30).

Statistically, the same progress was made by the respondents from novice to competent professional nurse during community service, irrespective of whether induction had been received or not. The survey respondents qualitatively contradicted this. They stated that they felt more competent when supported, gaining independence faster than they would have if there had been no support. The respondents who did not receive support reported that they struggled and had to learn everything by themselves, which led to their taking longer to reach the desired level of competence. "Novice nurses typically require a great deal of support to assist them during the transitional phase" (Hayman-White et al 2007:187). Hayman-White et al (2007:187) add that health care providers who do not provide a working environment that supports the early professional experiences of newly qualified professional nurses run the risk of failing to retain them within the service.

The study respondents reported varying timeframes taken by the newly qualified professional nurses to become competent. The survey respondents (both quantitative and qualitative), and the participants of the focus groups, reported time taken by the newly qualified professional nurses to be competent to be 4–6 months, with a few exceptions of 2 and 12 months respectively. Newly qualified professional nurses were reported to be challenged to successfully transition from student to professional nurse; with the transition stress often manifested as performance anxiety. Hayman-White et al (2007:187) observe that the transition from undergraduate nursing student to professional nurse can be a stressful and difficult time for many newly qualified professional nurses, particularly during the first three to six months.

Tolbert (2012:295) conducted a study to verify the presence and the level of performance anxiety in a sample of newly qualified professional nurses in the US. The study confirmed the presence of performance anxiety and that the level of performance anxiety decreased significantly by the end of the six-month study period.

6.3.1 Positive experiences of newly qualified professional nurses and operational nurse managers

The following positive aspects were reported to have been experienced by some newly qualified professional nurses in relation to induction and professional development support: some received a warm welcome from colleagues in the new unit/department, which had planned professional development support (orientation, induction, mentorship, supervision and guidance; in-service education); felt at ease and became independent; felt growth and development; experienced boosted confidence and enhancement of clinical competence; felt respected as newly qualified professional nurses and as people; had a choice of allocation areas and were happy. The results are confirmed by the findings of a study conducted by Pinchera (2012:18). The study was looking at the challenges particular to newly licensed nurses within their first 18 months of employment and the general implications for improving nursing practice. The results showed that relationships are very important to these nurses; relationships heavily influenced their confidence and development. The study also noted the important role to be played by direct care nurses in assisting their new colleagues to adjust in the nursing profession (Pinchera 2012:18). In a study by McCloughen and O'Brien (2005:279), the new nurse graduates reported a sense of empowerment and self-worth when supported.

Statistically, respondents based in urban or rural areas had the same level of competence when commencing the community service, enjoyed the same support and made the same progress from novice to competent professional nurses. Respondents reported to be competent from four to six months, with a few respondents reporting to be competent from two months or after 12 months. The report is classified as a positive experience because it indicated that there was no discrimination in nursing education or professional development support of newly qualified professional nurses according to being in a rural or urban province of South Africa.

Lima et al (2016:878) conducted a longitudinal study to determine the extent to which competence develops in the first year of nursing practice in newly qualified professional nurses. Gains in competence were statistically significant from commencement to three months and from three months to six months. Gains made between six and twelve months were not statistically significant. The conclusion was that significant gains in competence were achieved in the first six months of transition from nursing students to professional nurses. However, Morrow (2009:280) states that it takes one year to feel confident and competent when practising in acute care.

Some of the operational nurse managers who participated in the focus groups had had positive experiences during the professional development support they provided to newly qualified professional nurses. They reported the following positive aspects about them: the new nurses were eager to learn and respectful and good interpersonal relationships developed (Mensik 2012:22).

6.3.2 Negative experiences of newly qualified professional nurses and operational nurse managers

Experiences of negative attitudes from newly qualified professional nurses were reported in all focus groups. In addition to the negative attitude towards work and colleagues, operational nurse managers who participated in the focus groups accused newly qualified professional nurses of not wanting to learn; they were said to be "hiding behind others", being delinquent and disrespectful. In a quasi-experimental design used by Lee et al (2009:1223) to evaluate a preceptorship programme, the study revealed that a few preceptors expressed disappointment in the learning of the new nurses. Milner and Bossers (2004:104) state that newly qualified professional nurses need to be committed to learning; believe in and respect the guidance provided; appreciate people and resources; appreciate what has been given to them; ask for and be receptive of help when needed. The operational nurse managers and experienced professional nurses, as potential mentors, should be encouraged by the public health institutions to create supportive environments in their own space, where respect, learning, support and sharing will be the expectation (Vance 2002:7).

Operational nurse managers perceived many newly qualified professional nurses as irresponsible and having inexplicable fears. Morrow (2009:279) states that the first few months of nursing can be most challenging and stressful for new graduates; the first year of practice is an important confidence-building phase for nurses. Many newly qualified professional nurses experience a fear of failure, fear of total responsibility and fear of making mistakes (Morrow 2009:279).

Survey respondents had positive and negative experiences during the transition from novice, newly qualified professional nurses to competent professional nurses. The experiences were summed up as, "Transition represents an extended period of adaptation and adjustment and provides a mediated entry into the profession" (Hayman-White et al 2007:190).

Success in enhancing a smooth transition from novice professional nurses to competent professional nurses was reported to differ according to the public health institution to which the respondents were allocated to serve community service. Differences were also according to different units in the same public health institution. Some public health institutions had formal or informal support systems within the institution, while others did not have any institutional support for the newly qualified professional nurses. Wards/units of the same public health institution also differed in the provision of the support.

Statistically, the level of competence when commencing the community service differed significantly between the degree and diploma holders. The diploma graduates were more competent than the degree graduates upon community service commencement. There was also a significant difference in the support, and progress made from novice to competent professional nurses. The diploma graduates were given less support and the degree graduates progressed faster to competence.

Negative aspects experienced by the newly qualified professional nurses in relation to induction and professional development support were reported as: lack of supervision and other professional development support; and reluctance to supervise and mentor the newly qualified professional nurses.

There were reports of reluctance of the operational nurse managers and experienced professional nurses to supervise and mentor the newly qualified professional nurses. This was reported in the findings of both newly qualified professional nurses, and operational nurse managers. The operational nurse managers reported this about the experienced professional nurses, whereas the newly qualified professional nurses complained about reluctance by both operational nurse managers and experienced professional nurses. In support of the lack of commitment from the experienced professional nurses, Gibson and Heartfield (2005:56) state that the reason for their reluctance to support the mentoring programme could be that they do not foresee any long-term benefits for the unit. Indeed some of the operational nurse managers who participated in the focus groups expressed a concern that they did not have a guarantee that if they supported the newly qualified professional nurses they would be retained in the unit on completion of community service. They felt that they were wasting their time that could have been spent on patient care, by mentoring new nurses every year.

Morrow (2009:282) affirms that all the concerned parties should disclose frustrations and concerns, but newly qualified professional nurses are advised to form a professional bond with the mentor and public health institution, help others, listen and learn. Morrow (2009:282) further argues that newly qualified professional nurses should recognise problems and actively seek solutions and information. Smith et al (2001:103) advise the newly qualified professional nurses as mentees to spend time with the mentors; strive for excellence; trust and accept the mentor's advice; and use all opportunities to consult mentors and other resource people.

Negative feelings experienced by operational nurse managers and newly qualified professional nurses.

Feelings experienced by operational nurse managers during the support period were described as: anxiety – asking themselves if they were doing enough to support the newly qualified professional nurses; ambivalence and anger towards the newly qualified professional nurses who displayed a negative attitude; and guilt – for not being able to provide the expected professional development support to the newly qualified professional nurses.

The newly qualified professional nurses reported feeling as if they had been thrown in the deep end, with very high expectations of them by operational nurse managers. They also felt ridiculed and disrespected by the colleagues that they found in practice, leading to their having low morale and even being denied opportunities for development. The newly qualified professional nurses in a study conducted by McCloughen and O'Brien (2005:279) also reported feeling overwhelmed and extremely vulnerable, and acknowledged the importance of encouragement and guidance during this traumatic and stress-provoking period. In their study, McCloughen and O'Brien (2005:279) state that support during the time of transition has been described as the single biggest factor that helps the individual to develop as a nurse. Vogelpohl, Rice, Edwards, and Bork (2013:414), stated that supporting the newly qualified professional nurses and preventing them from leaving the profession is important.

Some newly qualified professional nurses reported feeling neglected and subjected to unequal treatment by those they found in practice. The degree holders reported that they were discriminated against for commencing with community service late; thus they would not get the orientation and induction that the diploma holders received when they commenced with community service at the beginning of the year. The newly qualified professional nurses felt undervalued and neglected by the experienced professional nurses. They faced unjust criticism, rude and humiliating verbal statements and were distressed by the obvious conflict between other members of the health care team (Morrow 2009:280). The problem of diploma versus the degree was also noted in focus groups of a study by Wolff and Regan (2010:188), where the diploma prepared nurses were deemed to be practice ready compared to the degree prepared nurses. Wolff and Regan reported that "the prevailing perception of some of the focus groups was that diploma prepared nurses were better equipped than baccalaureate-prepared nurses to 'walk into' practice settings and perform competently. Participants attributed this to the perceived differences in clinical education between the two types of education programs (Wolff & Regan 2010:188).

6.3.3 Challenges experienced during the support towards professional development

Challenges that were experienced during the transition period of the newly qualified professional nurses were reported to be mainly organisation-related challenges: lack of

professional development support; shortage of personnel; allocation and scheduling challenges. Morrow (2009:282) explains that the shortage of nursing personnel is compounded by the ageing experienced professional nurses (Baby Boomers, born between 1946 and 1965). There are not enough graduating nurses to replace the projected exodus of experienced professional nurses. The shortage of experienced professional nurses will lead to a shortage of experienced mentors and preceptors (Morrow 2009:282). The retiring generation will take with them their expertise and productivity, critical to the stability of the health care system, and necessary to support and mentor newly qualified professional nurses (Morrow 2009:282).

Newly qualified professional nurses reported that they had no platform through which to lay their grievances. The shortage of personnel was reported to be causing job overload for all professional nurses, including the newly qualified professional nurses. Morrow (2009:282) highlights the fact that the heavy assignments affect the way nurses perceive the quality of their work. There is high role overload, insufficient time to do what is expected, and the workload is too much for one person (Morrow 2009:282).

According to Hayman-White et al (2007:190), the levels of anxiety and stress experienced by newly qualified professional nurses are mostly exacerbated by work overload. They suggest that to reduce work overload problems, public health institutions should clearly articulate the amount of work the newly qualified professional nurse is expected to do by setting objectives, clinical standards and patient outcomes; developing workload measurement systems; clearly defining the roles of all nursing staff and implementing necessary support services.

Challenges related to newly qualified professional nurses were: lack of self-confidence accompanied by fear of the unknown, and poor clinical skills due to lack of clinical exposure and absenteeism (Ndaba & Nkosi 2015:1156). Morrow (2009:280) gives the following reasons for absenteeism in the newly qualified professional nurses: "the newly qualified professional nurses experienced horizontal violence in the form of psychological harassment that included verbal abuse, threats, intimidation, humiliation, excessive criticism, exclusion, denial of access to learning opportunities, disinterest and withholding of information. The cumulative impact leads to high absenteeism, unreported incidences [sic], consideration of leaving the nursing profession and then doing so".

The newly qualified professional nurses who responded to the survey statistically reported that they felt competent upon commencing community service. They claimed to feel confident about the provision of patient care; management of nursing care in the unit; working as a team member; independent decision making; problem solving; integration of knowledge and skills into practice; and professional practice (Clark & Springer 2012:E5). The operational nurse managers who participated in the focus groups reported a different scenario. They reported that the majority of newly qualified professional nurses serving community service were not competent, lacked clinical skills, and did not want to work as part of a team. The extensive criticism of the clinical competence of the newly qualified professional nurses by the operational nurse managers could be due to the fact that "organisations want new staff that can 'hit the ground running'". In fact, newly qualified staff members are simply 'learning to cope' (Hayman-White et al 2007:190; Thomas, McIntosh & Mensik 2016:77).

The coordinators of community service who participated in the interviews reported that the newly qualified professional nurses were still finding their feet and needed guidance and support from experienced colleagues in the nursing profession. Morrow (2009:281) states that once in the practice setting, many newly qualified professional nurses feel not ready for practice though not incompetent; novices work in the present without a full grasp of clinical implications, do not appreciate the nuances and competing risks in clinical situations, and have inherent trust in co-workers (Morrow 2009:281).

Newly qualified professional nurses who were diploma holders were statistically and verbally reported to be more competent than degree holders at the beginning of community service; but the degree holders were reported to progress faster than diploma holders towards being competent. The deduction was that more support was given to the degree holders than the diploma holders, because the latter were used to the work environment. The (diploma) respondents in the survey did mention that the public health institutions in which they served their community service were familiar because they had been allocated to the same institutions as students for clinical practice. They reported that the familiarity reduced the anxiety associated with being newly qualified (Thomas et al 2016:111).

Operational nurse managers reported that newly qualified professional nurses displayed unprofessional behaviour, truancy; an unprofessional dress code, and a lack of compassion, commitment and team spirit. Regarding the unprofessional behaviour, Stichler (2010:159) stated that the nursing profession has long been on a quest to advance the professionalism of its practitioners by creating a culture of professionalism. Experienced professional nurses need to demonstrate maturity by conflict management, such as finding a 'teachable' moment versus talking behind a newly qualified professional nurse's back. Demonstrating maturity would role-model professional behaviour regarding how to deal with uncomfortable situations in the workplace, while respecting the inherent worth of the newly qualified professional nurses (Morrow 2009:284).

Generation-gap related issues were also reported by the operational nurse managers. They complained that the newly qualified professional nurses lacked commitment and team spirit; they saw the operational nurse managers as old and their knowledge as redundant. Implications of the generational gap are that generational characteristics must be considered when addressing issues of personnel (Morrow 2009:282). Morrow (2009:282) states, "Many experienced professional nurses anecdotally complain about the newly qualified professional nurses and have coined a term to say they present with 'grad-itis', which is a term used to describe overconfidence and arrogance".

Vance (2002:7) states that the operational nurse managers, as potential mentors, have to acknowledge that there will always be someone ahead and behind them in professional experience, therefore accept that they could benefit from the richness of generational mentoring.

Coordinators of community service who participated in the individual interviews complained that operational nurse managers reported professional development challenges regarding the newly qualified nurses late or at the end of community service; leaving no room for any remedial action at the strategic level from the province. They also reported that there was poor planning at strategic level, lack of resources at institutional level and attrition of professional nurses upon completion of community service in public health institutions.

Other studies have indicated that the lack of professional development support for the newly qualified professional nurses could lead to poor retention of graduates by the public health sector in all health disciplines in South Africa. Twenty-three percent of newly qualified health professionals were reported to be migrating from South Africa annually after community service, citing poor working conditions in the public sector as a primary reason for leaving (HRH SA 2030, 2011:9). Kruse (2011:1), in a study entitled *Retaining community service nurses in the Western Cape public health sector*, reported that 28 percent of the newly qualified professional nurses considered leaving the public health sector.

6.3.4 Suggested recommendations to overcome challenges experienced during the support towards professional development

Recommendations for professional development support were suggested by the newly qualified professional nurses, operational nurse managers and coordinators of community service for nurses. The recommendations were drawn from the qualitative part of the survey, focus groups and individual interviews. The recommendations have been classified according to the stakeholders whom the participants suggested be roped in to assist with the professional development support of the newly qualified professional nurses.

6.3.4.1 *Nursing education*

Nursing education was stated as one of the important stakeholders in enhancing the transition of newly qualified professional nurses from student to professional. The study participants believed that preparing student nurses adequately for the role of professional nurse could enhance their transition from student to professional (Edwards et al 2011:2215).

The qualitative responses of the survey indicated that the newly qualified professional nurses had different levels of preparation from the different nursing education institutions: some lacked clinical accompaniment, being placed in clinical areas that did not prepare them adequately for the role of professional nurse, and lacking clinical supervision. Hayman-White et al (2007:192) also reported study findings of inadequate clinical and/or theoretical preparation; a lack of confidence in necessary skills; feelings

of conflict; unrealistic organisational demands; and a lack of appropriate and consistent support systems. Awareness of these factors could give health institutions the opportunity to develop and implement strategies that might ameliorate the negative impact often experienced by newly qualified professional nurses during the transition period (Hayman-White et al 2007:192).

6.3.4.1.1   Curriculum changes

All the participants suggested changes in the nursing curriculum regarding the theoretical and clinical component. They suggested that the curriculum should strike a balance between the theory and practice components, with both having equal priority, no one over the other. Implementing curriculum revisions that maximise the didactic and experiential learning of students is essential to prepare competent graduates committed to nursing careers (Hayes & Sexton Scott 2007:28; Neary 2001:2). The operational nurse managers who participated in focus groups complained about the degree holders, saying that they had a lot of theory but fewer clinical skills. They reported that the degree holders needed a lot of support to correlate theory with practice. Another aspect reported was that the diploma graduates were used to the clinical practice areas and had been allocated to actual practice areas as students; whereas the degree holders were allocated less often to/ actual clinical practice areas, relying more on simulation.

6.3.4.1.2   Theoretical component

Nursing education was advised to identify and rectify education/practice gaps in the curriculum during revisions. The recommendations in this regard were that final-year students should be taught theory that prepares them for the professional nurse's role, not "nice-to-know" content. It is suggested that the content and focus of the nursing programme should have less repetition in class, put more emphasis on life science and pharmacology; and include more information on professional issues in the final year (Ross & Clifford 2002:549).

6.3.4.1.3   Clinical component

The coordinators of community service suggested that nursing education should do the competency assessment of students, not delegate that responsibility to the experienced

professional nurses in clinical practice. The experienced professional nurses could help the nursing educators during the competency assessments, if the clinical circumstances allowed them to do so. According to the operational nurse managers, experienced professional nurses were doing both the continuous development, assessing the students formatively and also the final competency assessments in the summative evaluations. All participants were of the opinion that with the current shortage of professional nurses and the high number of student nurses, the summative assessments should be done by the nurse educators for quality purposes. The other point of agreement among the participants was that summative assessments for the final-year students should be held at the clinical practice areas; simulation should be minimal and kept for the lower levels of nurse training.

In the study by Hayman-White et al (2007:190), the strategies suggested to improve the curriculum to enhance clinical competence and transition to professional nurse were: a portfolio that reflected the needs of a final-year student; final-year students being given opportunities to practise the skills necessary to be a professional nurse under supervision; and more specific role clarification for the final-year students. The findings clearly indicate that there should be role clarification between nurse educators, experienced professional nurses and final-year students.

Findings from the study were that students' clinical practice allocation should be modified in the final year of study, to allow more midwifery/medical/surgical clinical placements, not only primary health care as is being done at the moment. Operational nurse managers felt strongly that students should cover deficient/missed clinical hours during their training, to foster discipline and to enhance clinical competence by meeting the clinical objectives for the particular area of allocation. Nurse educators were encouraged to plan and provide clinical experiences and learning opportunities for nursing students that would prepare them for the realities of clinical practice (Hayman-White et al 2007:190).

Operational nurse managers suggested that students should be introduced to working 'shifts' early in their training, to acclimatise them to the practice shifts and to prevent absenteeism when they were professional nurses. They felt that newly qualified professional nurses absented themselves from work because they were not used to working shifts, on weekends and on public holidays.

NEIs were reported by operational nurse managers who participated in the study to be producing quantity, not quality of nurses. They supported the allegation by saying that the number of newly qualified professional nurses was too high, and most of them were not competent in clinical skills. They attributed the high number of newly qualified professional nurses who lacked clinical skills to the high intake of students by the NEIs, due to political pressure, thus compromising on quality for quantity. The operational nurse managers recommended that NEIs should revise their recruitment criteria, to screen potential students for crucial attributes like compassion and commitment. They also suggested that NEIs should be allowed by government to limit the number of students according to the resources available and clinical learning opportunities, to promote quality.

The operational nurse managers and the coordinators of community service suggested that the government should stop the stipend for nursing education, and replace it with bursaries, in order to attract students who really want to study nursing as their first choice, not those attracted to nursing by the stipend.

Newly qualified professional nurses recommended that students should be encouraged to make optimum use of available learning opportunities to prepare for the professional nurse's role. They even suggested that final-year students should be prepared for the transition from student to professional nurse, suggesting methods of preparation like organising a visit from newly qualified professional nurses to give motivational talks about the transition period; and the coordinators of community service to come to NEIs to give information about community service.

6.3.4.2   Nursing management

The operational nurse managers and newly qualified professional nurses who participated in the study recommended the period of rotation to be three-monthly or six-monthly; to allow growth and development of the newly qualified professional nurses. They recommended that regular meetings should be planned by the nursing management, to attend to allocation issues promptly. The rotation of newly qualified professional nurses to various clinical departments was indicated by the inferential statistics to have had a positive effect on the level of competence and the progress

made from novice to competent professional nurses. There was a significant difference between those rotated and those not rotated.

These findings are supported by Hayman-White et al (2007:194), who state that employers tend to favour a greater number of shorter rotations (i.e. one- to three-month rotations); whereas newly qualified professional nurses tend to favour a smaller number of longer rotations (i.e. three- to six-month rotations). Employers and newly qualified professional nurses should have clear role descriptions and expectations available at the beginning of each new rotation, to prevent attitude problems and lack of cooperation from the newly qualified professional nurses.

The newly qualified professional nurses who participated in the survey recommended that the complexity of the work allocated should not exceed their capabilities, to allow them to gain confidence in managing the workload.

The operational nurse managers and coordinators of community service for nurses who participated in the study expressed the need for formal support guidelines to ensure uniformity in the professional development of newly qualified professional nurses. The newly qualified professional nurses who participated in the study expressed the need for mutual respect. Bossers (2004:104) states that mentees need to be committed to learning and they need to believe in and respect the guidance provided by the mentors.

Role modelling of professional behaviour by operational nurse managers and experienced professional nurses was encouraged. The realities of the culture of the workplace are described by Morrow (2009:282) as disappointing. Intergenerational and multigenerational challenges exist when interactions occur between nurses of different generations. Different paradigms may cause different interpretations of the same behaviour, with misunderstandings arising from conflicting generational values and work ethics. The newly qualified professional nurse has to be socialised into the health service organisation's informal rules, formal protocols and procedures, norms and expectations. The transition process as perceived by the newly qualified professional nurses can either be positive or traumatic, depending on the organisation's support and culture (Morrow 2009:282; Anderson, Hair & Todero 2012:207).

Operational nurse managers recommended that they should go all out for the development of the newly qualified professional nurses irrespective of challenges met; even if it meant talking about professional development support of the newly qualified professional nurses in all their meetings. Barnum (2008:17) supports this opinion by stating that nursing managers of area hospitals and other health care facilities should go all out for the support of novice professional nurses, they could even discuss orientation programmes whenever they meet at events.

Coordinators of community service and operational nurse managers suggested that public health institutions should have well-planned, coordinated, implemented and evaluated compulsory professional development support programmes that are comprehensive, to enhance a smooth transition from student to professional and eventually job satisfaction and retention of the newly qualified professional nurses and the experienced professional nurses. North et al (2006:16) affirm that the organisational outcomes of a mentoring programme, which is one of the support programmes, can include increased employee recruitment and retention, decreased novice and expert nurse turnover, cost effectiveness, enhanced career enrichment opportunities and increased job satisfaction.

The findings of the study were that nursing management should support formalisation of professional development support programmes like mentorship; they should also establish staff development departments where these are non-existent. Re-introduction of clinical teaching departments (CTDs) at health institutions could assist with clinical supervision of students and demonstration of clinical procedures for nurses in need. Clinical teaching departments should be fully equipped and adequately staffed by the public health institutions.

6.3.4.3   *South African Nursing Council (SANC)*

The study findings suggested that the nursing education regulation body should provide implementation guidelines for the R765 of 2007, which is the regulation governing the community service for nurses derived from the Nursing Act (Act 33 of 2005). The study participants suggested that the implementation guidelines should include professional development support for newly qualified professional nurses during community service.

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6.3.4.4   *Department of Health (DoH)*

The study participants suggested that the national Department of Health should empower provincial departments of health with relevant resources for the professional development support of newly qualified professional nurses, to enhance their transition from student to professional and to retain them post community service.

A suggestion was made that the DoH should link health institutions in a district, to form health complexes for comprehensive allocations. In such health complexes, such as the ones in Limpopo province, newly qualified professional nurses could experience an allocation at both hospital and primary health care setting within the community service year, with the rotation being six monthly.

McCloughen and O'Brien (2005:279) conducted a study to evaluate the mental health mentorship programme in Australia. The study indicated that the Australian Parliament Senate *Report on the inquiry into nursing* strongly advocated that formal mentoring programmes for newly qualified professional nurses be developed nationally in an effort to support transition from university to practice.

The study participants suggested that there should be formal support from the government, with an elected committee to oversee the support (Gibson & Heartfield 2005:59). McCloughen and O'Brien (2005:279) suggest that the "office of the Chief Nursing Officer be responsible for identifying and prioritising funding initiatives for recruitment and retention of nurses". Mentorship has been recognised as a retention strategy in various studies (Harrington 2011:172; Lee et al 2009:1217).

6.4   CONCLUSION

Chapter 6 discussed the integrated findings of the qualitative and quantitative research data that have been described and analysed in chapters 4 and 5. The results converged to report about the lack of professional development support to the newly qualified professional nurses during community service, when they transit from novice to competence level as professional nurses. The strategies suggested for the professional development support were supported with references to the relevant literature.

Chapter 7 will discuss the development and validation of the guidelines for induction and professional development support.

CHAPTER 7

DEVELOPMENT AND VALIDATION OF THE GUIDELINES ON INDUCTION AND PROFESSIONAL DEVELOPMENT SUPPORT OF NEWLY QUALIFIED PROFESSIONAL NURSES

7.1   INTRODUCTION

In Chapter 6, the researcher discussed the integration and interpretation of the quantitative and qualitative research findings. In Chapter 7 the researcher discusses the development and validation of the guidelines. The research findings, supported by the literature review, were used to develop guidelines on induction and professional development support of the newly qualified professional nurses during community service. The guidelines were validated by nursing experts in the field, in practice and in academia. The guidelines were developed and validated to also meet the last objective of the research objectives:

- *To develop guidelines for induction and professional development support of newly qualified professional nurses*

7.2   DEVELOPMENT OF THE GUIDELINES

Formal guidelines on the induction and professional development support of newly qualified professional nurses are necessary to enhance their transition from student to professional nurse, and in order to enhance their competence and to retain them (Makhakhe 2011:3). According to Edwards, Hawker, Carrier and Rees (2011:2215), professional development support of the newly qualified professional nurses has dual benefits to both the employer and the newly qualified professional nurses. The employer benefits through retention of the nurses, lowered turnover rates, competent nurses and save on recruitment costs. The newly qualified professional nurses benefit from stress and anxiety reduction, job satisfaction, knowledge/skills acquisition, critical thinking and interpersonal skills, confidence and professional socialisation to acquire professional nursing behaviours (Edwards et al 2011:2215).

The researcher used both inductive and deductive reasoning in the process of developing the guidelines. Inferences were drawn from the literature, and the synthesis of the qualitative and quantitative findings of the study. Guidelines were proposed from specific themes and codes of the research findings that strongly indicated the type of support that can be given to the newly qualified professional nurses. The newly qualified professional nurses need to be more skilful and confident with the routines and procedures of the units in the public health institutions (hospitals, community health centres and clinics). This would enhance autonomy and control over practice, leading to job satisfaction and better retention (Hatler et al 2011:91).

7.3 VALIDATION OF THE GUIDELINES

According to Guidelines International Network (G-I-N), guidelines developers should use a rating system to communicate the quality and reliability of the proposed guidelines (Qaseem, Forland, Macbeth, Ollenschlager, Phillips, Van der Wees 2012:531). The Delphi Technique was used to forecast the clarity, comprehensiveness, applicability, adaptability, credibility and validity of the proposed guidelines. Proposed guidelines were sent to nursing experts in guidelines development in academia, and nurse managers in the practice. Hsu and Stanford (2007:3) state that Delphi participants should be highly trained and competent within the specialised area of knowledge related to the target issue. Guideline validators were purposefully selected as professional nurses who were knowledgeable about human resource development in health, knowledgeable about community service for health professionals in South Africa, knowledgeable about the *Strategic plan for nursing education, training and practice 2012/13–2016/17*, and employed as a researcher in nursing education or manager in nursing practice.

The nursing experts were invited to validate the guidelines. An invitation letter explaining the request (Annexure Q) and a validation form (Annexure R), proposed guidelines and a summary of the research findings were sent to nursing experts to validate the guidelines. Twenty-one copies were sent via email (soft copies), and four copies were hand delivered to the experts in hard copy, making a total of 25. Fifteen nursing experts responded to the guideline validation request, which was a 60 percent response rate.

Table 7.1:   Demographic data of the nursing experts (*N*=15)

Descriptor	Frequency
Position	
Head of department	1
Nursing researcher	4
Nursing education manager	4
Nurse manager	6
Total	**15**
Area of employment	
National office (SANC/DoH/HSRC)	4
University	5
Nursing college	2
Health institution	4
Total	**15**
Expertise	
General nursing	15
Community nursing	15
Psychiatric nursing	7
Midwifery	15
Critical care nursing	3
Occupational health	5
Nursing management	14
Nursing education	15
Highest academic qualifications	
Doctoral degree	2
Master's degree	4
Honours degree	7
Basic degree	1
Diploma	1
Total	**15**

7.3.1 Demographic data of the nursing experts

The nursing experts held various positions in nursing departments, relevant to the field of research. They had experience as nursing managers in clinical practice, national offices in the Department of Health and SANC, as nurse educators at nursing education

institutions and researchers in nursing. Their academic qualifications ranged from basic nursing degree to doctoral degree.

7.3.2 Evaluation of the guidelines

The guidelines validation form had the following descriptors to be used when assessing the guidelines. The descriptors were clarity, comprehensiveness, applicability, adaptability, credibility and validity. Table 7.2 depicts the evaluation outcome of the guidelines and comments for each descriptor.

Evaluation criteria used:

1 = Guidelines not acceptable, need major changes

2 = Guidelines acceptable with recommended changes

3 = Guidelines acceptable as described

Table 7.2: Nursing experts' evaluation of the guidelines: Induction and professional development support of newly qualified professional nurses

Descriptors	1	2	3	Comments
Clarity Proposed guidelines are clear, have concrete rationale and precise recommendations	1	2	12	• Guidelines are clear and easy to understand • Well written guidelines • Have precise recommendations
Comprehensiveness Guidelines address all aspects of induction and professional development support	0	3	12	• It is crucial to include aspects pertaining to leadership and ethical practice • All aspects covered but there is also repetition of information in some guidelines
Applicability The guidelines have the potential to be applied in the formulation of induction and professional development support programmes	0	4	11	• Shortage of staff poses a challenge to the implementation of the guidelines, especially in the case of mentors

Descriptors	1	2	3	Comments
Adaptability Guidelines could be applied in different circumstances	0	2	13	• Guidelines could be applied even to other categories of new nurses
Credibility Guidelines are based on the true findings of the research	0	2	13	• The time frame for rotation, cited as 1 to 3 months, is of essence, as it determines exposure and readiness. It also impacts on the monthly/quarterly evaluation done. I thus feel that the guidelines should include the rotation process.
Validity Correct interpretation of the available evidence to support the implementation of the guidelines	0	4	11	• Researcher needs to summarise and come up with one mentorship programme

General comments about the guidelines were as follows: V=Validators R=Researcher

- *V: It would be appreciated that the guidelines also covers community health centres and clinics, as some community service practitioners are placed at district level and at times they are only exposed to community health centres and clinics.*

  R: In the study, public health institutions included all levels: tertiary hospitals, regional hospitals, district hospitals, community health centers and clinics.

- *V: Midwifery is not clearly addressed and it is an area that novice professional nurses must be assisted to master skills and competency in midwifery.*

  R: Guidelines form a basic foundation upon which specific support programmes should be developed. They are general in nature and speciality areas like midwifery, psychiatric nursing and critical care will formulate area specific support programmes.

- *V: Guidelines suggested are feasible and easy to understand. What may be a challenge is a suggestion that operational nurse managers and nursing management should develop their own evaluation tools; perhaps if it can be noted that the process must be preceded by empowering all nurse managers in*

the development of such tools, this will promote a sense of ownership of the tools and contribute to their self-esteem as well. The development of the tools may also be considered in their KPAs.

R: Empowerment of nursing managers and other relevant stakeholders that will partake in the support programmes has been incorporated as suggested. Empowerment may be in a form of training for mentors, workshops on programme development and evaluation, and the like.

- *V: The implementation of the guidelines would greatly enhance the quality of Community Service. A concern, however, is the reality of the work environment, (personnel shortage, poor/lack of resources) etc. Failure to address the basics will compromise the effective implementation of the guidelines.*

  R: Concern acknowledged, but the study could only suggest relevant information to policy makers.

- *V: The number of nurses doing Comm Serv at a time also pose a challenge as it makes it difficult to embrace essential aspects such as mentorship, in-service, adequate supervision and report writing.*

  R: The concern about the high number of student intakes without considering the resources and learning opportunities was also part of the qualitative findings of the study. Relevant recommendations were made by participants in this regard in Chapter 5.

- *V: The guideline reads a bit negative and many of the recommendations seem coerced.*

  R: The suggestion was acknowledged, and guidelines were improved to read in non-coercive statements.

- *V: The managers have many responsibilities but no opportunities for the voices of the newly qualified nurses are provided for. It is important to make sure that the programme is adapted by doing an evaluation of the*

*information provided 3 months after the induction programme. The
participants of the evaluation should be the newly qualified nurses that
have done the induction.*

- *V: The newly qualified nurses must also have the opportunity to evaluate
their mentors so that the mentors´ skills could also be evaluated.*

    R: Evaluation is an integral part of the guidelines. Evaluation specifics will
    be decided upon by the public health institution when they develop the
    support programmes.

- *V: The guidelines should be edited and more scientific language should
be used throughout.*

Validated guidelines were edited as suggested (Annexure S).

7.4   PRESENTATION OF VALIDATED GUIDELINES

Authors from the Guideline International Network (G-I-N), state that a guideline
recommendation should be clearly stated and based on scientific evidence of benefits
(Qaseem et al 2012:530). The researcher used evidence from the study to develop the
guidelines, see Table 7.3 for the themes and categories used. The validated guidelines
emerged as six themes after the incorporation of the suggestions from the nursing
experts. A rationale and recommendations for each guideline are presented. The newly
qualified professional nurse in this context is a person registered with the SANC as a
nurse and midwife; serving the compulsory remunerated community service as
promulgated by the Nursing Act 33 of 2005, through R765 of 2007. Formal guidelines
on the induction and professional development support of newly qualified professional
nurses are necessary to enhance their transition from student to professional nurse
(registered nurse and midwife), in order to enhance their competence and to retain them
(Makhakhe 2011:3).

Table 7.3:   Themes and categories of validated guidelines

Themes	Categories
• Induction to the new work environment	Induction
• Development of a formal mentorship programme	• Mentorship programme • Organisational support • Provision of training for mentors
• Supervision of the newly qualified professional nurses in the clinical areas and leadership development	• Supervision • Reluctance of experienced professional nurses
• Enhancing clinical competence	• Needs assessment • Boosting of confidence and enhancement of clinical competence • Professional development through orientation, attendance of short courses, workshops and in-service training relevant to the place of allocation • Monitoring and evaluation of clinical competence
• Creating a positive work environment to facilitate integration and retention of newly qualified professional nurses	• Integration • Retention
• Establishment of viable communication structures	• Effective communication structures

7.4.1 Theme 1: Induction to the new work environment

This theme comprises information about induction of the newly qualified professional nurses from the quantitative (survey, documents) and qualitative (survey, focus groups and individual interviews) research findings. It took into cognisance the experiences of the newly qualified professional nurses, operational nurse managers, content of orientation programmes, and responses to the quantitative part of the survey. Time frame, challenges and recommendations regarding induction were considered.

7.4.1.1 Guideline 1: Induction of the newly qualified professional nurses to the new work environment

Rationale for the implementation of the guideline (Guideline 1)

Induction will equip the novice professional nurses with knowledge and coping skills *needed to adapt to the new work environment. Knowledge about the new work* environment will also reduce the stress related to unfamiliar surroundings, unexpected practice demands and the high expectations of service placed on the newly qualified professional nurses. Information obtained from the induction will also clarify roles, responsibilities and expectations of both the inductees and the nursing management.

7.4.1.2 Recommendations on the implementation of the guideline (Guideline 1)

- Ideal induction and professional development support programmes should be coordinated from provincial level, down to the health institutions where they should be implemented. The Human Resource (HR) department should provide the human resources for the induction and professional development support programmes that will be implemented after the general induction of the newly qualified professional nurses. This could be in the form of improved recruitment and retention strategies of staff development personnel and revival of clinical teaching departments in the health institutions.
- There should be an induction programme when the newly qualified professional nurses start with employment.
- Planners of the induction programme should ensure that the content is factual, relevant and adequate, but avoid information overload.
- An average of two weeks is suggested for the induction programme; it should not be too short or too long, depending on the size of the health institution and the amount of the induction content.
- Information booklets should be provided for referral at a later stage when necessary, especially for unfamiliar content like that of the Human Resource Department (HR) regulatory matters, protocols and policies.
- Presenters should provide body breaks during induction, to improve participants' concentration.

- Presenters should be well prepared and have knowledge of the subject at hand.

- The induction programme should be repeated at intervals, for instance when another group of newly qualified professional nurses commences with community service. This will prevent discrimination against the groups that commence community service later in the year.

7.4.2 Theme 2: Development of a formal mentorship programme

Information in this theme was derived from the qualitative and quantitative findings; and the literature review. Participants reported a lack of formal mentorship in public health institutions, and recommended strategies for the mentorship programme. The literature provided information about the origins of mentorship, models, reported challenges and suggestions on how to establish mentorship programmes.

7.4.2.1 *Guideline 2: Development of a formal mentorship programme of the health institution that will form part of the operational nurse managers' and experienced professional nurses' key performance areas (KPAs)*

Rationale for the implementation of the guideline (Guideline 2)

The newly qualified professional nurses would be guided to transform from novice professional nurses to competent professional nurses through mentorship by experienced professional nurses and operational nurse managers. They would be able to enhance their clinical skills and learn to be responsible and accountable.

A formal mentorship programme that forms part of the KPAs would encourage compliance, as mentoring would be assessed in the individual's performance appraisal system.

7.4.2.2 *Recommendations on the implementation of the guideline (Guideline 2)*

- Nursing management should develop a mentorship programme and its evaluation tools, which should be implemented by the health institution.

- Nursing managers should be empowered with guidance on programme and tool development before they develop the programmes, to promote a sense of ownership of the programmes they will develop, and to boost their self-esteem.

- Nursing management should have a plan in place to develop experienced professional nurses and operational nurse managers to be mentors as part of their professional development.

- A formal health institution's mentorship programme should be made available to newly qualified professional nurses, with a contract entered into by mentor and mentee. Mentors should give mentees feedback on their progress on a monthly basis in a formal way and write quarterly reports as required by the SANC in the regulation for community service (SANC 2007:4).

- Mentoring should form part of the experienced professional nurses' and operational nurse managers' KPAs and be assessed with their performance appraisal, like other KPAs. This would encourage conformity and reduce the incidence of reluctance to mentor newly qualified professional nurses.

- There should be rotation of the newly qualified professional nurses to other disciplines, but with mentorship being provided throughout.

- The period of mentoring should not be less than six months, depending on the mentee's progress and level of competence.

- Operational nurse managers should act as role models to experienced professional nurses by being hands-on in the mentoring of newly qualified professional nurses.

- Characteristics of mentors as in the mentorship literature should be applied, but over and above those characteristics, mentors should be kind, knowledgeable, patient, and not judgemental or oppressive. They must be willing to guide without negative criticism but with constructive criticism, and encourage the newly qualified professional nurses to reach their potential. They should provide answers to queries and be willing to provide support at all reasonable times. They should role-model professionalism to help mentees to emulate their professional behaviour.

- The nursing management should put programmes in place for monitoring and evaluation of the mentoring of the newly qualified professional nurses. Evaluation programmes should include the evaluation of ethical behaviour and professionalism in the newly qualified professional nurses. Remedial plans should be put in place to discourage unethical or unprofessional behaviour.

- Mentorship should be supported from the provincial level and HR departments and implemented by the public health institutions.

- Mentees should be offered an opportunity to periodically evaluate the mentors and the mentorship process in a formal way, to provide feedback for improvement.

7.4.3 Theme 3: Supervision of the newly qualified professional nurses in the clinical areas and leadership development

Qualitatively, participants voiced the need for supervision and the challenges that they experienced. Recommendations from the concluding statements about supervision were used to develop the guideline. The literature review stressed the importance of supervision.

7.4.3.1 *Guideline 3: Supervision of the newly qualified professional nurses (direct, indirect) in the clinical areas and leadership development*

Rationale for the implementation of the guideline (Guideline 3)

The newly qualified professional nurses might experience growth and development in unit management when the operational nurse managers give them opportunities to manage the units in the various levels of public health institutions (hospitals, CHCs and clinics). Supervision and support will improve their confidence and enhance their competence and might prevent clinical errors.

7.4.3.2 *Recommendations on the implementation of the guideline (Guideline 3)*

- Operational nurse managers should indirectly supervise all the unit activities, including the professional socialisation of the newly qualified professional nurses. The experienced professional nurses should directly and/or indirectly supervise the newly qualified professional nurses, guiding them towards being competent nurse practitioners.
- Operational nurse managers should gradually introduce the newly qualified professional nurses to management activities of the unit under their supervision.
- Newly qualified professional nurses should be given a chance to learn and implement nursing management activities. They should lead teams and be

allowed to take charge of the unit under direct, and later indirect, supervision by the operational nurse managers or experienced professional nurses.

- The operational nurse managers and experienced professional nurses should give guidance and support, as well as providing constructive criticism or even praise where due.

- Operational nurse managers should act as role models to the other professional nurses by being hands-on in supporting the newly qualified professional nurses.

- Interactions between the team members must be professional, and clients must be treated ethically at all times, to enhance professional behaviour.

- The ethos of nursing should be demonstrated by the experienced professional nurses at all times, acting as role models to the newly qualified professional nurses.

- Experienced professional nurses and operational nurse managers should uphold the principles of *Batho Pele* for the newly qualified professional nurses to emulate.

7.4.4 Theme 4: Enhancing clinical competence

The challenges experienced by the focus group participants and survey respondents about inadequate or absent clinical skills, low self-esteem and lack of confidence in the newly qualified professional nurses led to this theme. The research findings also indicated that the newly qualified professional nurses experience fear and anxiety, which limit their competence in the clinical areas. Challenges and strategies to overcome clinical incompetence of some of the newly qualified professional nurses were discussed in Chapter 5.

7.4.4.1 Guideline 4: Enhancing clinical competence of the newly qualified professional nurses

Rationale for the implementation of the guideline

Enhancing clinical competence of the newly qualified professional nurses could help them to transit from novice to competent professional nurses. Competent professional nurses are independent, safe and dependable. This might eventually reduce the

shortage of professional nurses and its adverse effects on the provision of health care in the public health institutions.

7.4.4.2 Recommendations on the implementation of the guideline (Guideline 4)

Needs assessment

- Upon allocation of the newly qualified professional nurses to a clinical area, the operational nurse manager, together with the assigned mentors, should embark on a needs assessment to be able to draw up a support programme for them. Support programmes may be individualised, depending on the assessed needs and level of competence.

- Newly qualified professional nurses should be encouraged to state their learning needs to the mentors, to facilitate the planning process of the necessary support and its implementation.

- The planning of the support programme(s) should include monitoring and evaluation strategies to assess development progress and address challenges promptly.

Boosting of confidence and enhancement of clinical competence

- The experienced professional nurses should support and encourage the newly qualified professional nurses to practise their clinical skills. Confidence will be boosted when their nursing skills are improved by the support that they receive from the experienced professional nurses. Support may be in the form of demonstration of clinical procedures upon request, and supervision during a clinical procedure when the newly qualified professional nurse performs such procedure for the first time or feels insecure and not yet confident. Support might enable them to gain skills, develop positive self-esteem and boost their confidence.

- Enhancing of clinical competence should be done by experienced professional nurses, operational nurse managers and clinical nurse educators from the clinical teaching department of the health institution.

Professional development through orientation, attendance of short courses, workshops and in-service training relevant to the place of allocation

- The operational nurse managers should oversee the development of a comprehensive, unit-specific orientation programme to ease the transition from student to professional nurse. Orientation offers a sense of being welcomed and accepted into a unit. It enhances group cohesion among team members and boosts team spirit in a unit. The orientation programme should be comprehensive and specific to the unit's speciality (e.g. maternity, intensive care, medical, surgical or paediatrics) and the level of public health institution (hospital, CHC or clinic).

- Newly qualified professional nurses should attend short courses relevant to the clinical area of allocation; the short courses should be those provided by the district health or provincial department of health to develop personnel. This will help them to improve their nursing care.

- The operational nurse managers should provide learning opportunities and allow and encourage them to attend relevant professional development programmes.

- Health institutions should reintroduce clinical teaching departments with the necessary personnel and equipment, for the professional development of newly qualified professional nurses, as well as students.

Monitoring and evaluation of clinical competence

- Nursing management should monitor the professional development support of the newly qualified professional nurses, while the operational nurse managers and mentors should monitor the progress in their clinical competence.

- Evaluation tools should be put in place to be used at agreed-upon time frames. Mentors could evaluate mentees monthly, using a formal generic tool that could be developed in the form of a tick sheet, with a space for comments, to save time and improve compliance. Evaluation tools can be developed formally by the nurse managers. Operational nurse managers can develop their own tool to evaluate the mentor and mentee's progress monthly, reporting on the mentorship process. The nursing management should receive quarterly reports from operational nurse managers about the progress of the newly qualified

professional nurses. The quarterly evaluation report should be comprehensive and report on the professional development support given and the progress made by the newly qualified professional nurse in moving from novice to competent professional nurse. Challenges reported should be accompanied by suggested strategies for the way forward. The quarterly evaluation reports will assist the nursing management to comply with the SANC regulatory requirements in the community service regulation (SANC 2007).

- Mentorship and clinical supervision of newly qualified professional nurses should be a permanent item on the agenda in nursing management meetings, to monitor the progress of their implementation. Nursing managers should give feedback on this item on a departmental basis (e.g. medical or surgical department).

7.4.5 Theme 5: Creating a positive work environment to facilitate integration and retention

According to the research findings, the transition period is a stressful period for the newly qualified professional nurses. It emerged that smooth transition from student to professional depends largely on the support that they receive from the new work environment, type of welcoming, integration into teams and respect for the new nurse as a person. Strategies suggested from both quantitative and qualitative findings were incorporated to form the guideline.

7.4.5.1 Guideline 5: Creating a positive work environment to facilitate integration and retention of newly qualified professional nurses

Rationale for the implementation of the guideline

A positive work environment allays anxiety and fear of the unknown and should prevent a negative attitude on the part of the newly qualified professional nurses. It enhances their integration into the workplace and gives a feeling of belonging. It will make them feel welcome as valuable members of the nursing profession and multidisciplinary health team. It fosters professionalism and might encourage them to perform to the best of their potential.

7.4.5.2 Recommendations on the implementation of the guideline

- Nursing management should create supportive practice environments that facilitate newly qualified professional nurses' integration into the public health institutions.

- Newly qualified professional nurses should be welcomed warmly at the public health institutions to make them feel appreciated as valuable health professionals.

- Public health institutions should strive to make them feel at ease and the allocated mentors ensure that they fit well into the areas of allocation.

- Gradually working independently as professional nurses will give them a sense of responsibility and accountability. They might even welcome the responsibility as they are guided to have confidence in what they are doing.

- Clinical competence expectations of the newly qualified professional nurses by the nurse managers must be realistic. This will relieve the pressure that comes with being a newly qualified professional nurse.

- Nursing management should encourage all nurses to treat one another in a humane way. Respect for the newly qualified professional nurses as people in the health institutions will ease their fear of the unknown and help them feel proud to be part of the nursing profession. Workplace bullying should be prevented or dealt with promptly and effectively when it occurs.

- Newly qualified professional nurses should learn to communicate and work as good team members and strive to be competent, independent and dependable nurse practitioners with good communication skills.

- Experienced professional nurses should interact professionally, with a positive attitude, in their teams for the professional socialisation of the newly qualified professional nurses. They should treat patients with dignity and respect to encourage the newly qualified professional nurses to emulate the caring ethos. They should instil a sense of accountability and responsibility in the newly qualified professional nurses.

- Nursing management should afford the newly qualified professional nurses the opportunity to choose their allocation areas as much as is possible. When consulted about their allocation, they will feel happy that their opinions have been taken into consideration. Being happy about the area of allocation might enhance

their morale and competence when they work in clinical departments that they are interested in. This might increase their retention upon completion of community service.

- The operational nurse managers and mentors should introduce responsibilities gradually. Too much responsibility too quickly may overwhelm the newly qualified professional nurses and make them feel as if they are being thrown in at the deep end. Supervision and guidance should be maintained while they are not yet confident. They are transitioning from student nurse to professional nurse; thus support and guidance are necessary to enhance their clinical competence.

- Nurse managers should avoid instilling feelings of being discriminated against and subjected to unequal treatment. University and college graduates should be treated in the same way, without negative criticism. They should all be inducted and orientated to the new work environment, irrespective of their time of commencement at the health institution. The induction programme should be planned adequately to meet the needs of all the newly qualified professional nurses, irrespective of the date of commencement. Adequate resources for the induction should be mobilised timeously to cater for the envisaged number of newly qualified professional nurses.

7.4.6 Theme 6: Need for viable communication structures

Both quantitative and qualitative research findings reported that communication structures were ineffective or non-existent in most of the public health institutions. Newly qualified professional nurses did not have a formal platform on which to raise concerns and there was poor communication about matters that concerned their community service. Strategies suggested were put together to form this guideline, in order to improve or establish viable communication structures at public health institutions.

7.4.6.1 *Guideline 6: Establishment of viable communication structures*

Rationale for the implementation of the guideline

Availability of viable communication structures and formal grievance procedures will ensure that communication throughout the health system is open and clear. Newly qualified professional nurses will know the chains of command, how to communicate

with relevant stakeholders and communicate their challenges timeously, and they will be kept informed on all matters that concern them.

7.4.6.2 *Recommendations on the implementation of the guideline*

- Nursing management should create communication structures such as meetings, suggestion boxes, newly qualified professional nurses' forums and email facilities to report positive and negative incidents. Nursing management must monitor the communication structures and implement necessary interventions promptly when a negative incident is reported.

- There should be a professional person delegated by the nursing management to be in charge of monitoring the communication structures put in place. This person could serve as the starting point for the newly qualified professional nurses to have a platform on which to lay grievances and complaints.

- Operational nurse managers should role-model professionalism and professional confidentiality for others to emulate. Matters should be discussed in the relevant platforms and newly qualified professional nurses kept informed about matters that concern them.

- Emphasis should be placed on the importance of mutual respect, development of good communication skills and acknowledgement of one another's achievements.

- Staff should use available communication structures effectively and report broken chains of communication to the relevant authorities to ensure continuity.

- Nursing management should monitor and evaluate the use and efficacy of the available communication structures, using agreed-upon mechanisms put in place.

7.5   CONCLUSION

Chapter 7 discussed the development and validation of the guidelines for the induction and professional development support of newly qualified professional nurses during community service. The guidelines were developed from the quantitative and qualitative research findings supported by the literature. The guidelines are recommended for
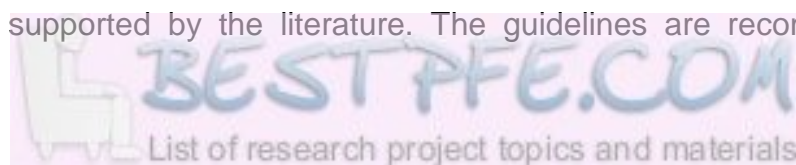
implementation by nursing management at all levels of public health institutions, with the support of the national and provincial departments of health.

Relevant stakeholders can be called upon to empower nurse managers with skills and knowledge for the development of induction and professional development support programmes for the newly qualified professional nurses, derived from the above guidelines. The nursing directorate at provincial departments of health is expected to support and monitor the implementation of the guidelines if they are accepted by the relevant policy-making structures at the Department of Health.

Chapter 8 discusses the study conclusions, limitations and recommendations for further research.

CHAPTER 8

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1   INTRODUCTION

Chapter 7 discussed the development and validation of guidelines. In Chapter 8, the researcher discusses the key findings from all the data sources, the conclusions about the study, the limitations of the study and recommendations for further research on the professional development support of newly qualified professional nurses.

8.2   PURPOSE OF THE STUDY

The purpose of this concurrent, convergent mixed-methods research was to determine the induction and professional development support given to, and that which is required by, newly qualified professional nurses to enhance their transition from novice professional nurses to competent professional nurses. The information obtained was used to develop induction and professional development support guidelines for newly qualified professional nurses in SA.

8.3   RESEARCH DESIGN AND METHODS

This study was a mixed-methods design of concurrent triangulation approach that employed quantitative and qualitative research methods to comprehensively study the professional development support of newly qualified professional nurses during community service in South Africa. The mixed-methods design was chosen for the purpose of triangulation of research methods and results, and complementarity, in that the research methods compensated for the others' flaws, thus capitalising on their strengths and providing significance enhancement for the development and evaluation of the guidelines. The quantitative phase was the survey and documents, while the qualitative phase was descriptive phenomenology.

The research paradigm is pragmatism, which is explained by the authors Polit and Beck (2012:604) as being practical. It enabled the researcher to use the advantages of the

quantitative and qualitative methods to explore the phenomenon of professional development support of the newly qualified professional nurses during community service. Benner's (1984) Novice to Expert Model was used as a theoretical framework underpinning the study.

The newly qualified professional nurses underwent the first three levels of development in the model while serving community service. They were novices upon commencement of community service, and progressed from advanced beginners from the second month of community service to competent after the sixth month of community service. They were supported by proficient and expert professional nurses during their transition from novice newly qualified professional nurses to competent professional nurses.

8.3.1 Quantitative phase

Orientation and induction programmes were collected from provincial district health offices and public health institutions for content analysis using a self-designed checklist.

8.3.1.1   The survey

A systematic probability sampling method was used to sample the 350 newly qualified professional nurses from the list obtained from the SANC, for participation in the survey. The survey was used to quantitatively and qualitatively describe their experience of the induction and professional development support given to the newly qualified professional nurses during community service in the designated public health institutions of South Africa. The questionnaires were posted to all nine provinces of South Africa. The 112 newly qualified professional nurses who responded to the survey were from eight of the nine provinces of South Africa; there were no responses from the Northern Cape province. The newly qualified professional nurses responded to a survey questionnaire that had both quantitative and qualitative questions. Analysis of the quantitative responses was statistical, using SPSS version 23.

8.3.1.2   Documents

A total of 14 orientation and induction programmes were collected from the public health institutions that were sampled for conducting focus groups. A self-developed checklist

rooted in the literature was used to analyse the orientation programmes for compliance (see Annexure T).

8.3.2 Qualitative phase

8.3.2.1 Survey

Qualitative content analysis was done for the open-ended questions of the mixed questionnaire. Each of the three open-ended questions of the survey questionnaire had 112 responses. The analysis yielded two themes, four sub-themes and 17 codes (see Table 5.5).

8.3.2.2 Focus groups and interviews

Non-probability, purposive, criterion-based and homogeneous sampling was used to sample the operational nurse managers and the coordinators of community service for nurses. Operational nurse managers participated in 12 focus groups, and four coordinators of community service for nurses participated in individual interviews. Analyses were phenomenological, following the Coliazzi method as modified by Creswell. Comprehensive data were collected and analysed to answer the research question: *How are the newly qualified professional nurses supported in terms of induction and professional development during community service in South Africa?* The focus groups data yielded two themes, nine sub-themes and 43 codes (see Table 5.2).

8.3.3 Development and validation of guidelines

The research findings were integrated in Chapter 6, to form concluding statements that were used to develop the guidelines. The suggested guidelines were sent for validation to nursing experts in academia as researchers, and to nurse managers as experts in practice. The Delphi technique was used to validate the guidelines. The feedback from the validation process was analysed, and the researcher incorporated the suggested changes to finalise the guidelines (see Chapter 7 and Annexure S). Table 8.1 depicts the summary of the validated guidelines. This section met the last two objectives, namely: *to develop guidelines for induction and professional development support of*

newly qualified professional nurses; and to validate the guidelines through nursing experts.

Table 8.1: Summary of validated guidelines

Validated guidelines: Induction and professional development support of newly qualified professional nurses during community service

Guidelines	Rationale for the implementation of the guidelines
1 Induction of the newly qualified professional nurses to the new work environment	Induction will equip the novice professional nurses with knowledge and coping skills needed to adapt to the new work environment. Knowledge about the new work environment will also reduce the stress related to unfamiliar surroundings, unexpected practice demands and the high expectations of the service upon the newly qualified professional nurses. Information obtained from the induction will also clarify roles, responsibilities and expectations of both the inductees and the nursing management.
2 Development of a formal mentorship programme of the health institution that will form part of the operational nurse managers' and experienced professional nurses' key performance areas (KPAs)	The newly qualified professional nurses will be guided to transform from novice professional nurses to competent professional nurses through mentorship by the experienced professional nurses and operational nurse managers. They will enhance their clinical skills and learn to be responsible and accountable. A formal mentorship programme that forms part of the individual's KPAs will encourage compliance, as mentoring will be assessed in the individual's performance appraisal system.
3 Supervision of the newly qualified professional nurses (direct, indirect) in the clinical areas and leadership development	The newly qualified professional nurses might experience growth and development in unit management when the operational nurse managers give them opportunities to manage the wards. Supervision and support will improve their confidence, enhance their competence and might prevent clinical errors.
4 Enhancing clinical competence of the newly qualified professional nurses	Enhancing clinical competence of the newly qualified professional nurses could help them to transit from novice to competent professional nurses. Competent professional nurses are independent, safe and dependable, and this step might eventually reduce the shortage of professional nurses and its consequences in public health institutions.

Guidelines	Rationale for the implementation of the guidelines
5 Creating a positive work environment to facilitate integration and retention of newly qualified professional nurses	A positive work environment allays anxiety and fear of the unknown and might prevent a negative attitude in the newly qualified professional nurses. It enhances their integration into the workplace and gives a feeling of belonging. It will make them feel welcome as valuable members of the nursing profession and multidisciplinary health team. It fosters professionalism and might encourage them to perform to the best of their potential.
6 Establishment of viable communication structures within the health institution	Availability of viable communication structures and formal grievance procedures will ensure that communication throughout the health system is open and clear. Newly qualified professional nurses will know the chains of command, how to communicate with relevant stakeholders and communicate their problems timeously, and they will be kept informed on all matters that concern them.

8.4   CONCLUSIONS

8.4.1 Conclusions on quantitative phase

8.4.1.1   The survey

The newly qualified professional nurses who responded to the survey indicated that the level of support differed according to the public health institution in the various provinces. The support differed from province to province, institution to institution and sometimes even in the units of the same public health institution, though they were all newly qualified professional nurses who had undergone the same nursing education and training.

Newly qualified professional nurses indicated quantitatively that they received orientation, induction and in-service training in some of the public health institutions during community service. There were those that indicated that they did not receive any form of professional development support from the public health institutions to which they were allocated for community service.

There were no differences in the level of competence among the newly qualified professional nurses when starting community service when they were compared by

race, gender and province. There were significant differences when they were compared by qualification. The diploma holders were statistically found to be more competent than the degree holders when starting community service, but both groups progressed to be fully competent around the sixth month of community service.

8.4.1.2 Documents

The content of the orientation and induction programmes was inadequate. The programmes were not comprehensive. None of the orientation or induction programmes addressed all of the general aspects, core induction phase or the role specific phase of the checklist criteria.

Sections 8.4.1.1 and 8.4.1.2 met the objective: *To explore the induction and professional development support given to newly qualified professional nurses during community service in the designated public health institutions.*

8.4.2 Conclusions on qualitative phase

8.4.2.1 The qualitative part of the survey

The newly qualified professional nurses aired their views qualitatively by responding narratively to the open-ended questions of the questionnaire. They unanimously reported a shortage of personnel that indirectly resulted in: the lack of professional development support; reluctance of operational nurse managers and experienced professional nurses to supervise them; inadequate induction and orientation periods; poor communication structures and informal professional development support provided at the public health institutions. The allocation to clinical areas and timeframes for rotation were also reported to be problematic.

8.4.2.2 Experiences of the newly qualified professional nurses in terms of induction and professional development support

They reported negative and positive experiences. Positive experiences reported by some newly qualified professional nurses were a warm welcome; induction; orientation; being given an opportunity to choose clinical areas of allocation; informal mentorship;

reciprocated respect; supervision, and being integrated as team members by other members of the team in the unit of allocated clinical areas. The support received eased the anxiety and fear associated with being newly qualified, and enhanced their transition from students to professionals.

Negative experiences reported by some newly qualified professional nurses were: being shouted at; being disrespected; not being integrated as team members; their views not being considered; being called "students"; not being inducted; not being orientated; being denied opportunities to attend in-service training; having no supervision and no mentoring.

This section met the objective: *To describe the experiences of the newly qualified professional nurses regarding their induction and professional development support during community service.*

8.4.2.3   *Focus groups*

Operational nurse managers of the public health institutions from four provinces of South Africa participated in the focus group discussions. Data saturation was reached after 12 focus group discussions. Operational nurse managers described the professional development support given to the newly qualified professional nurses during community service to enhance their clinical competence. They reported that induction was given for a period of a week on average at some of the public health institutions in the largely urban provinces. The induction was organised by the human resource development, and was implemented by the staff development department of the public health institutions. In one of the largely rural provinces, induction was organised and implemented by the human resource department of the district health office. Newly qualified professional nurses from the community health centres and clinics converged at the district health office for a one-week induction period. The hospitals in the same province did not have an induction programme for the newly qualified professional nurses. They received orientation in the clinical areas where they were allocated for community service.

The operational nurse managers of some public health institutions reported that they provided informal mentoring, in-service education, used teachable moments and the

pairing system to support the newly qualified professional nurses. They also supervised the newly qualified professional nurses directly and indirectly as they progressed from novice to competence.

8.4.2.4 The experiences of the operational nurse managers regarding professional development support

Operational nurse managers who participated in the focus group discussions reported positive and negative experiences regarding the professional development support of the newly qualified professional nurses. Positive experiences were reported as getting newly qualified professional nurses who acted professionally; had respect for team members; had good interpersonal relations and a positive attitude towards the new work environment. They also reported having had the opportunity to supervise newly qualified professional nurses who were eager to learn.

Negative experiences reported by operational nurse managers were the shortage of professional nurses; heavy workloads; poor clinical skills of newly qualified professional nurses; experienced professional nurses who were reluctant to supervise newly qualified professional nurses; negative attitudes displayed by some of the newly qualified professional nurses; lack of guidelines and institutional support towards initiatives on the professional development support of the newly qualified professional nurses.

The operational nurse managers reported challenges that they experienced in this area. Some of the challenges reported by the operational nurse managers concerning the experienced professional nurses and newly qualified professional nurses were mostly related to the intergenerational gap. They mainly related to misunderstandings about generational characteristics between the three groups of Baby Boomers, Generation X-es and the Millennial Generation. For example, the operational nurse managers and newly qualified professional nurses complained about each other's attitudes, level of education, age-related aspects, and lack of commitment. Factors that both groups acknowledged as having contributed to the exacerbation of the challenges were: work overload, shortage of professional nurses and lack of formal support of professional development programmes from the public health institutions.

This section met the objective: *To explore the experiences of the operational nurse managers regarding induction and professional development support of the newly qualified professional nurses during community service.*

8.4.2.5 The role of the coordinators of community service for nurses in induction and professional development support

Coordinators of community service were interviewed individually. Some of the coordinators of community service for nurses were professional nurses by qualification. They reported that they had a strategic role to play in the induction and professional development support of the newly qualified professional nurses. They developed provincial guidelines for the induction and development support, and also supported the public health institutions in the implementation process. Some of the coordinators were not nurses but were coordinating all community service for health professionals within the province; they did not take part in the professional development support of the newly qualified professional nurses. This section answered the objective: *To determine the role of the coordinators of community service for nurses regarding the induction and professional development support of the newly qualified professional nurses during community service.*

Table 8.2 depicts the summary of the research findings.

Table 8.2:   Summary of research findings

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
The role that the nurse managers can play to realise the suggestions in order to support the newly qualified professional nurses most effectively.	–	Supervision and mentorship required.	Operational nurse managers to be role models in supervision and mentorship of newly qualified professional nurses. Encourage experienced professional nurses to supervise and mentor newly qualified professional nurses. Advocate formalisation of mentorship	Operational nurse managers to acknowledge their teaching role. Advocate formalisation of mentorship. Request agency professional nurses for the duration of the orientation period. Going all out for the development of the newly qualified professional nurses	Operational nurse managers to oversee that supervision and mentorship are done. Coordinators of community service have a strategic role to play. They allocate the newly qualified professional nurses to health institutions. Provide guidance and support to health institutions by giving them guidelines on the professional development support of the newly qualified professional nurses.

Table 8.2:   Summary of research findings (continued)

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
Role modelling of professionalism.	–	–	Some professional nurses were role models.	The ethos of nursing and professional socialisation were included as part of the nursing culture during the orientation process. The core values of the nursing profession were explained to instil professionalism.	–

Table 8.2:   Summary of research findings (continued)

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
Support given to the newly qualified professional nurses in terms of induction and professional development.	Induction, but duration not specified. Orientation time frame one week to one month. Standardised orientation programmes for the hospital, wards add their specifics. Time frame of rotation in allocation reported to be one to three months.	Orientation and/or induction. Informal mentorship. In-service within health institution. Short courses relevant to place of allocation in some health institutions.	Formal induction and standardised orientation programmes for some health institutions. Induction time frame reported to be an average of one week. Time frame of rotation in allocation reported to be ranging from one to three months. In-service training offered by some health institutions.	Formal induction and standardised orientation programmes for some health institutions. Induction time frame reported to be an average of one week. Time frame of rotation in allocation reported to be ranging from one to three months. In-service training offered by some health institutions. Team allocation and on-the-spot teaching used as support.	Give information about community service to final year students and newly qualified professional nurses. Give health institutions guidelines or framework for professional development support (urban provinces). Monitor professional development support through quarterly reports.

Table 8.2:   Summary of research findings (continued)

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
Stakeholders that can be roped in and the role they should play to enhance the transition of the newly qualified professional nurse from student to professional	–	–	Nursing education Nursing management	Nursing education Nursing management South African Nursing Council (SANC) Department of Health (DoH)	Nursing management South African Nursing Council (SANC) Department of Health (DoH)
Average time taken by newly qualified professional nurses to become competent	–	4−6 months	4−6 months	4−6 months	–

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Table 8.2:   Summary of research findings (continued)

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
The ideal but practical induction and professional development support that can be given to the newly qualified professional nurses.	Core induction phase (1st week–2nd month) Practice orientation. Legal framework. Occupational health aspects. Human resources aspects. Learning and personal development.	_	Set sustainable communication structures to improve communication. Nursing management to have formal meetings with newly qualified professional nurses to address problems, complaints and to communicate matters relevant to community service.	Increase orientation and induction time. Improve the orientation content. Formalise the induction programme provincially. Institute supervision and guidance of the newly qualified professional nurses where non-existent and reinforce it where it is minimal. Formalise mentorship.	Coordinators of community service for nurses should be nurses employed under the directorate of nursing. Allocation of newly qualified professional nurses for community service should be comprehensive. Regulation of the mentorship support by the South African Nursing Council (SANC)

Table 8.2:   Summary of research findings (continued)

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
The ideal but practical induction and professional development support that can be given to the newly qualified professional nurses	Role-specific phase (2–6 months) Clinical practice. Consolidate competencies necessary to be effective in role. Provide professional development support. Supervise newly qualified professional nurses. Mentorship.	_	_	Nursing management and operational nurse managers to oversee mentorship programme. Role modelling of professional behaviour. Allocation for community service should be comprehensive Regulation of the mentorship support by the South African Nursing Council (SANC). No clinical supervision of	Formalisation of mentorship. Re-introduction of clinical teaching departments (CTDs). The DoH to formalise and to support mentorship programmes from provincial level. Professional development support programmes to be coordinated and monitored from provincial level Writing of quarterly reports as regulated by SANC in the community service

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
	Review of the programme.			students by newly qualified professional nurses during community service. Re-introduction of clinical teaching departments (CTDs). Operational nurse managers to encourage experienced professional nurses to supervise the newly qualified professional nurses.	Regulation R765. Nursing management to institute supervision and guidance of the newly qualified professional nurses where non-existent and reinforce it where it is minimal. Formal guidelines that are from the national department.

Table 8.2:   Summary of research findings (continued)

Common themes across data sets	Documents (Induction/ orientation programmes)	Questionnaires – responses from newly qualified professional nurses	Newly qualified professional nurses (narratives – open-ended questions 44–46)	Operational nurse managers (focus groups)	Coordinators of community service (interviews)
Challenges in relation to induction and professional development support of the newly qualified professional nurses	No induction, no professional development support in most health institutions. Only 21 percent of induction programmes dealt with the issue of supervision. Other public health institutions did not mention whether they do supervise the newly qualified professional nurses or not.	No induction. No in-service training. No supervision.	Not given preferred allocation. No mentorship. No induction; where available, induction content not relevant, or duration too short. Not listened to. Not respected, shouted at. No supervision. Shortage of professional nurses for supervision and mentorship	Shortage of personnel. Inadequate orientation content and time. Lack of self-confidence among newly qualified professional nurses, accompanied by fear of the unknown. Allocation and scheduling challenges. Negative attitude of newly qualified professional nurses. Hiding behind others Poor clinical skills.	Lack of information about community service to newly qualified professional nurses. Allocation problems Lack of clinical skills. Substance abuse. Absenteeism. Operational nurse managers do not write quarterly reports as regulated by SANC.

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8.5   LIMITATIONS OF THE STUDY

The study did not include the human resource managers and staff development managers in the interviews. They could have given information about their role in the professional development support of the newly qualified professional nurses.

The study was comprehensive and complex, but there were limited current relevant publications for literature review and to support the findings. Professional development support of newly qualified professional nurses is a topic that has not yet been studied comprehensively, especially in South Africa.

There was a poor response to the posted survey questionnaires, which delayed the quantitative data collection. There was a prolonged post office strike after the questionnaires were posted, lasting for several months, resulting in the poor responses from the respondents. A survey monkey could not be used because the majority of the newly qualified professional nurses on the list from the SANC did not have valid email addresses. The researcher had to resort to personal delivery of questionnaires.

Regardless of the limitations, the study succeeded in exploring the induction and professional development support of the newly qualified professional nurses during community service. All the research objectives of the study were met, and guidelines regarding the induction and professional development support of the newly qualified professional nurses during community service were developed and validated. The guidelines were developed to serve as a professional development support strategy to enhance the transition of newly qualified professional nurses from students to professionals, and to retain them in the public health institutions upon completion of community service.

8.6   RECOMMENDATIONS

This section met the objectives: To determine the support needed by newly qualified professional nurses in terms of induction and professional development. The coordinators of community service for nurses, operational nurse managers and newly qualified professional nurses who participated in this study recommended the following

strategies that could be implemented to enhance the induction and professional development support of the newly qualified professional nurses:

8.6.1 Recommendations regarding nursing practice

Nursing management

- Public health institutions should have well planned, coordinated, implemented and evaluated compulsory professional development support programmes that are comprehensive, to enhance a smooth transition from student to professional.
- Rotation of newly qualified professional nurses to other clinical departments should be three monthly or six monthly, to facilitate learning, growth and development.
- Newly qualified professional nurses should have a choice in the allocation of clinical areas; the findings of this study indicated that when personal interests in the allocation of clinical areas are considered, clinical competence becomes enhanced. Anxiety and fear related to being newly qualified are reduced.
- Allocation to the same clinical department should not be repeated, to prevent burnout and to allow newly qualified professional nurses to rotate to other clinical areas and learn.
- Clinical teaching departments in public health institutions should be reintroduced, for supervision of students, presentation of in-service education and demonstration of clinical procedures to students and newly qualified professional nurses, where necessary.

8.6.2 Policy recommendation

8.6.2.1 South African Nursing Council (SANC)

The recommendations to the national regulator of nursing education and practice were as follows:

- The South African Nursing Council should regulate professional development of the newly qualified professional nurses during community service. The

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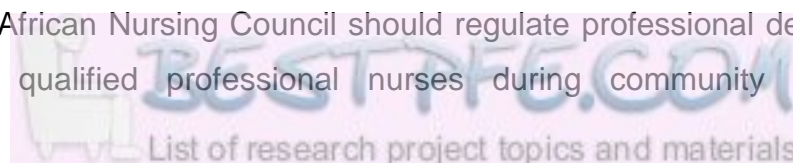
recommendation could be implemented by developing implementation guidelines for the regulation of community service (SANC 2007); the implementation guidelines to include professional development support of the newly qualified professional nurses during community service.

- The SANC should validate professional development support of newly qualified professional nurses during its validation visits to clinical areas.

8.6.2.2   *National Department of Health (DoH)*

- The national Department of Health should provide formal support guidelines to ensure uniformity in the professional development of newly qualified professional nurses during community service.

- The national Department of Health should empower provincial departments of health with relevant resources for the professional development support of newly qualified professional nurses, to enhance their transition from students to professional nurses and to retain them post community service.

- Provincial departments of health should link public health institutions in a district, to form health complexes for comprehensive allocations of newly qualified professional nurses during community service.

- The provincial departments of health should empower public health institutions and strategically monitor the implementation of the national guidelines on induction and professional development support of the newly qualified professional nurses during community service.

8.6.2 Recommendations regarding nursing education

- Theoretical and clinical curriculum changes were suggested to strike a balance between theory and practice.

- Nursing education institutions should revise the recruitment criteria to screen potential students for crucial attributes like compassion and commitment.

- Students should be introduced to working 'shifts' and public holidays early in their training, to acclimatise them to the practice shifts and to prevent absenteeism when they are professional nurses.

8.6.3 Recommendations for implementation of the guidelines

The guidelines were developed as a strategy that the national Department of Health could use to enhance the transition of the newly qualified professional nurses from students to professional nurses and to retain them in the public health institutions after community service. Hatler et al (2011:88) point out that the first 3 to 12 months of employment are stressful and the experiences of this period profoundly influence the careers of the newly qualified professional nurses; thus the need for professional development support to create positive transition experiences in order to retain them. The following recommendations should be considered during the implementation of the guidelines:

The South African Nursing Council, the National Department of Health, nursing education and nursing practice should:

- Consider the adoption and implementation of the guidelines applicable to them.
- Develop a plan to implement and monitor the outcomes of the guidelines.
- Identify relevant key stakeholders that would support the implementation of the guidelines, such as nursing associations, nursing education bodies, nursing management, newly qualified professional nurses, experienced professional nurses, nurse managers, human resource managers, and other relevant community structures for each of the disciplines to which the guidelines are relevant.
- Establish support structures that could determine and plan implementation strategies for the guidelines.

8.6.4 Recommendations for further research

This research study found professional development support of newly qualified professional nurses during community service to be a complex, multifaceted phenomenon. The following areas need to be researched further:

- The study survey could be extended to the Northern Cape and the South African Military Health Services to get their input, since there were no responses from

these areas. The questionnaires could be given to the newly qualified professional nurses to fill in and be handed back to the researcher to increase the response rate.

- Newly qualified Indian professional nurses could be interviewed to get their views on induction and professional development support of newly qualified professional nurses. Newly qualified professional nurses from this race group did not respond to the survey questionnaire posted to them.

- A professional development support programme derived from the guidelines developed in this study could be piloted.

- The perceptions of experienced professional nurses regarding the professional development support of newly qualified professional nurses during community service could be determined.

- Mentoring of newly qualified professional nurses during community service could be further explored.

8.7   CONTRIBUTION OF THE STUDY

Theoretically this study falls within the human resource development for health.

Specifically, it falls within the current concerns regarding increasing shortage of professional nurses in the public health institutions.

The findings of this study have provided useful insights into induction and professional development support of newly qualified professional nurses during community service in South Africa; particularly challenges regarding induction, orientation, mentoring, in-service education and supervision, and recommendations to resolve these challenges. To the researcher's knowledge, this is the first such comprehensive study on this topic. The study used a robust methodology, employing qualitative and quantitative approaches to determine the induction and professional development support given to the newly qualified professional nurse during community service in South Africa; and the actual professional development support needed by the newly qualified professional nurses, to enhance their transition from novice to competent professional nurses. It is, therefore, envisaged that this study has contributed to the emerging body of knowledge on newly qualified professional nurses' professional development in South Africa; and also contributed to the existing global body of knowledge on the subject.

As a result of the findings of this study, the researcher has proposed recommendations for induction and professional development support of the newly qualified professional nurses during community service. Induction and professional development support guidelines have been developed to guide all relevant stakeholders in the professional development of newly qualified professional nurses during community service. If these recommendations are adopted and implemented, it is hoped that they will greatly improve the socialisation of newly qualified professional nurses to the new work environment and effectively enhance their transition from novices to professional nurses.

8.8   CONCLUSION

The question of how the newly qualified professional nurses are supported in terms of induction and professional development during community service in South Africa was effectively addressed with evidence produced by the research findings. The study found that there was no formally laid down or adequate professional development support for the newly qualified professional nurses. Any support that was given was mainly from the public health institutions, without the support of the Department of Health or the SANC.

Public health institutions did not have programmes in place to support operational nurse managers and experienced professional nurses who were providing the informal support to the newly qualified professional nurses on community service. This aspect was evidenced by the limited formal support structures for the induction and professional development support of the newly qualified professional nurses within the public health institutions, provincially or nationally. Support for the operational nurse managers and experienced professional nurses as mentors could have been built into the development of the support programmes for the induction and professional development support of the newly qualified professional nurses, as suggested by the developed guidelines of this study.

Other aspects found to be hindering the development of support structures were the shortage of experienced professional nurses in the public health institutions, leading to work overload on the remaining few, thus leaving no room for an unstructured, informal

and non-incentivised professional development support of the newly qualified professional nurses.

All the objectives of the study were achieved, culminating in an addition to the scientific body of knowledge in nursing by the development and validation of the guidelines for induction and professional development support of newly qualified professional nurses during community service.

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ANNEXURES

ANNEXURE A

Research Clearance Certificate

UNISA | university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/199/2013

Date:	1 August 2013	Student No: 5327-334-6

Project Title: Induction and professional development support of newly qualified professional nurses during community service in South Africa.

Researcher: Memme girly Makua

Degree: D Litt et Phil   Code: DPCHS04

Supervisor: Prof ZZ Nkosi
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√]   **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B

EASTERN CAPE APPROVAL

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	040 608 0830
Date:	21st January 2014	Fax No.	043 642 1409
e-mail address:	zonwabele.merile@impilo.ecprov.gov.za		

Dear Mrs MG Makua

Re: Induction and professional development support of newly qualified professional nurses during community service

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

ANNEXURE C

GAUTENG PROVINCE APPROVAL

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (Principal investigator)	Ms. Mamme Girly Makua
Organization / Institution	UNISA
Research Title	Induction and Professional Development Support of Newly Qualified Professional Nurse during Community Service in South Africa
Protocol number	P011013
Date submitted	09/10/2013
Date reviewed	06/03/2014
Outcome	APPROVED
Date resubmitted	N/A
Date of second review	N/A
Final outcome	N/A

It is a pleasure to inform that the Gauteng Health Department has approved your research on "Induction and Professional Development Support of Newly Qualified Professional Nurse during Community Service in South Africa".

The Provincial Protocol Review Committee kindly requests that you to submit a report after completion of your study and present your findings to the Gauteng Health Department.

Approves / not approves

Dr Bridget Ikalafeng
Provincial Protocol Review Committee, Chairperson
Date_____

ANNEXURE D

MPUMALANGA APPROVAL

MPUMALANGA PROVINCIAL GOVERNMENT

Building No.3
No. 7 Government Boulevard
Riverside Park Extension 2
Nelspruit
1200
Republic of South Africa

Private Bag X 11285
Nelspruit, 1200
Tel: 013 766 3429
int: +27 13 766 3429
Fax: 013 766 3458
int: +27 13 766 3458

Department of Health

Litiko Letemphilo	Umnyango WezaMaphilo	Departement van Gesondheid

Enquiries: Themba Mulungo (013) 766 3511

07 July 2014

Ms. Girly Makau
989 Sysie Street Silverton
PRETORIA
0184

Dear Ms. Girly Makau

APPLICATION FOR RESEARCH & ETHICS APPROVAL: INDUCTION AND PROFESSIONAL DEVELOPMENT SUPPORT OF NEWLY QUALIFIED PROFESSIONAL NURSES DURING COMMUNITY SERVICE IN SOUTH AFRICA

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent.

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

07/07/2014
DATE

MR. MOLEFE MACHABA
RESEARCH AND EPIDEMIOLOGY

We care   Do you?

Open Rubric

MPUMALANGA
A Pioneering Spirit

ANNEXURE E

Western Cape DOH approval

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
Tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP048/2014
ENQUIRIES: Ms Charlene Roderick

989 Sysie Street
Silverton
Pretoria
0184

For attention: **Mrs M G Makua**

Re: Induction and professional development support of newly qualified professional nurses during community service in South Africa

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

New Somerset Hospital	Dr D Stokes	Contact No. 021 402 6992/6408
Karl Bremer Hospital	Dr L Naude	Contact No. 021 918 1222
Bellville CHC	Sr M Rerreira	Contact No. 021 951 2326
Reed Street CHC	Sr N Lewin	Contact No. 021 946 3790

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

ANNEXURE F

CONSENT TO PARTICIPATE IN A SURVEY OF THE STUDY

I ---the undersigned, declare that I am an adult who is above 18 years. I have read the information leaflet accompanying this consent form for the study titled: **Induction and Professional Development Support of Newly Qualified Professional Nurses during Community Service.** The researcher explained to me that filling in the questionnaire will take about ten minutes. I understand that the response has to be sent back to the researcher for analysis. I am aware that participation is voluntary and I may withdraw from the study at any time without any consequences to me. The researcher explained that data will be kept confidential at all times and I will remain anonymous. It was also explained that data will be used to formulate guidelines, write a thesis document to be kept at the UNISA library, to write articles for publication and presentation at conferences. I have the right to get the results upon request.

I am aware that there is no compensation for participation in this study. I understand the purpose of the study as well as information contained in this consent form. All my questions concerning the study have been clarified. I agree / do not agree to participate in the focus group. (delete whichever is not applicable to you).

Signature of the participant ---------------------------------- Date----------------------

Witness (name in block letters) -- Signature---------------

ANNEXURE G

CONSENT TO PARTICIPATE IN AN INTERVIEW OF THE STUDY

I ---the undersigned, declare that I am an adult who is above 18 years. I have read the information leaflet accompanying this consent form for the study titled: **Induction and Professional Development Support of Newly Qualified Professional Nurses During Community Service.** The researcher explained to me that the focus interview will take thirty minutes. I understand that the interview will be tape recorded. I am aware that participation is voluntary and I may withdraw from the study at any time without any consequences to me. The researcher explained that data will be kept confidential at all times and I will remain anonymous. It was also explained that data will be used to formulate guidelines, write a thesis document to be kept at the UNISA library, to write articles for publication and presentation at conferences. I have the right to get the results upon request.

I am aware that there is no compensation for participation in this study. I understand the purpose of the study as well as information contained in this consent form. All my questions concerning the study have been clarified. I agree / do not agree to participate in the focus group. (delete whichever is not applicable to you).

Signature of the participant ---------------------------------   Date----------------------

Witness (name in block letters) --- Signature---------------

ANNEXURE H

FOCUS GROUP GUIDE

OPERATIONAL NURSE MANAGERS

1   What are your experiences of the induction and professional development support given to the newly qualified professional nurses during community service?

1.1   How are the newly qualified professional nurses supported in terms of induction and professional development during community service?

1.2   What role do nurse managers play in induction and professional development support of these nurses?

1.3   What are the challenges in relation to their induction and professional development support?

2   According to you, what is the required induction and professional development support for these nurses during community service to enhance their competence?

2.1   What is the ideal but practical induction and professional development support that can be given to the newly qualified professional nurses during community service to ease their role transition from student nurse to professional nurse as well as for them to work safely and independently in the clinical environment?

2.2   What role can the nurse managers play to realise the suggestions in order to support the newly qualified professional nurses most effectively?

2.3   Which stakeholders can be roped in and what role should they play? (e.g education / management)

ANNEXURE I

INDUCTION AND PROFESSIONAL DEVELOPMENT SUPPORT OF NEWLY QUALIFIED PROFESSIONAL NURSES DURING COMMUNITY SERVICE

Thank you for participating in this survey. The questionnaire will take a maximum of 10 minutes to complete. Please answer all the questions and return the responses as soon as possible to the researcher.

Section A is the demographic data. This information is necessary for statistical purposes. Do not write your name or any self-identifying information since the responses should remain anonymous and confidential. Section B comprises questions where you are given options to respond according to your experiences during community service. Section C is narrative questions. This section gives you the opportunity to air your views on the topics, which is very important.

Please note* 1   Put the completed questionnaire and filled consent form in the provided box

Thank you once again for taking part in this survey.

Researcher: Mrs M G Makua (makuamg@unisa.ac.za) 012 429 6524 / 0723726573
Supervisor: Prof Z Z Nkosi (nkosizz@unisa.ac.za) 012 429 6758
Institution: University of South Africa (UNISA)

RESPONSE 1

QUESTIONNAIRE

SECTION A DEMOGRAPHIC DATA

Fill in / choose the relevant information in the provided boxes as applicable to you

1   Your age in years

23

2   Gender

M	F
	x

3   Race (for statistical purposes only)

Black	Coloured	Indian	White	Other (specify)
x				

4   Qualification

Diploma	Degree
	x

5   Province from which qualification was obtained

ECAPE	FSTATE	GP	KZN	LIMPOPO	MPUMAL	NCAPE	NWEST	WCAPE
		x						

6   Province of community service

ECAPE	FSTATE	GP	KZN	LIMPOPO	MPUMAL	NCAPE	NWEST	WCAPE
		x						

7   Month and year of community service completion

03	2015

8   Duration of community service

1 year x		More than a year (specify)	

9   Community service institution (choose applicable)

8 hour clinic	
24 hour clinic	
District hospital	
Regional hospital	
Tertiary hospital	

10   Was rotated to other wards / departments / clinics during community service

yes	no

SECTION B

CHOOSE THE OPTION THAT BEST REPRESENT YOUR EXPERIENCES DURING COMMUNITY SERVICE

Answer yes, unsure or no. The following were applicable to you as a newly qualified professional nurse during community service:

		yes	unsure	no
11	Received orientation			
12	Received induction			

Mark the response relevant to your level of competence when you **commenced** community service for each of the areas of clinical practice below

		Not competent	Not applicable	Competent
13	Provision of patient care			
14	Management of nursing care in the unit			
15	Working as a team member			
16	Independent decision making			
17	Problem solving			
18	Integration of knowledge and skills into practice			
19	Professional practice			

During community service, when did you perceive yourself as:

		never	1-2 months	3-4 months	5-6 months	After 6 months
20	learning your new role as a professional nurse					
21	growing and maturing in new role as a professional nurse					
22	taking charge of the ward / clinic					
23	confident nurse practitioner					
24	competent nurse practitioner					
25	independent nurse practitioner					
26	safe nurse practitioner					
27	well socialized into the nursing profession					

Use the below scale to rate how were the following statements applicable to you as a newly qualified professional nurse during community service.

SA = Strongly Agree

A= Agree

DK= Don't Know

D= Disagree

SD= Strongly Disagree

		SA	A	DK	D	SD
28	you had to be in-charge of the ward / clinic within the first week of community service					
29	you felt adequately prepared for managerial responsibility of a ward / clinic within the first week					

30	you had formal support which made the transition process from student nurse to professional nurse less stressful					
31	you felt proficient in the technical aspects of patient care					
32	you felt that you have acquired the essential clinical skills to enable you to function as a qualified professional nurse					
33	your community service institution had a formal induction program to support newly qualified professional nurses					
34	the induction program of the health institution was uniform for all doing community service					
35	you were allocated a formal mentor / preceptor to support you as a newly qualified professional nurse					
36	you worked under the supervision of an experienced professional nurse for the first three months of community service					
37	your personal and professional development was given a high priority					
38	you worked as part of a team					
39	your opinion was respected as a team member					
40	constructive criticism was given					
41	you were given an opportunity to develop your skills in nursing assessment and management of patients					
42	you attended nursing workshops / conferences **within** the institution where you served community service					
43	you attended nursing workshops / conferences **outside** the institution where you served community service					

SECTION C: BRIEFLY AIR YOUR VIEWS

44   State the **positive** aspects experienced as a newly qualified professional nurse during community service in relation to induction and professional development support

_____

_____

_____

45   State the **negative** aspects experienced as a newly qualified professional nurse during community service in relation to induction and professional development support

_____

_____

_____

46   State your suggestions to improve the induction and professional development support for the following:

46.1   **Nursing Education** (suggestions to prepare final year nursing students for professional   nurse   role)

_____

_____

_____

_____

46.2   **Nursing Management** (suggestions for induction and professional development support for newly qualified professional nurses)_____

_____

_____

_____

_____

THANK YOU!

ANNEXURE J

Cronnbach's test

Reliability

Scale: ALL VARIABLES IN Section B

Case Processing Summary

		N	%
Cases	Valid	11	100.0
	Excluded[a]	0	.0
	Total	11	100.0

a. List wise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.756	33

ANNEXURE K

INTERVIEW SCHEDULE

OPERATIONAL NURSE MANAGERS

1   What are your experiences of the induction and professional development support given to the newly qualified professional nurses during community service?

1.1   How are the newly qualified professional nurses supported in terms of induction and professional development during community service?

1.2   What role do nurse managers play in induction and professional development support of these nurses?

1.3   What are the challenges in relation to their induction and professional development support?

2   According to you, what is the required induction and professional development support for these nurses during community service to enhance their competence?

2.1   What is the ideal but practical induction and professional development support that can be given to the newly qualified professional nurses during community service to ease their role transition from student nurse to professional nurse as well as for them to work safely and independently in the clinical environment?

2.2   What role can the nurse managers play to realise the suggestions in order to support the newly qualified professional nurses most effectively?

2.3   Which stakeholders can be roped in and what role should they play? (e.g education / management)

ANNEXURE L

INTERVIEW SCHEDULE COORDINATORS

PROVINCIAL COMMUNITY SERVICE COORDINATORS

1.   According to your experience, how are the newly qualified professional nurses supported in terms of induction and professional development during community service?

    1.1   What role do provincial coordinators play in induction and professional development support of these nurses?

    1.2   What is the current induction and professional development support for these nurses?

    1.3   What are the challenges in relation to their induction and professional development support?

2.   According to you, what is the required induction and professional development support for these nurses during community service to enhance their competence?

    2.1   What is the ideal but practical induction and professional development support that can be given to the newly qualified professional nurses during community service to ease their role transition from student nurse to professional nurse as well as for them to work safely and independently in the clinical environment?

    2.2   What role can the provincial coordinators play to realise the suggestions in order to support the newly qualified professional nurses most effectively?

    2.3   Which stakeholders can be roped in and what role should they play? (e.g education / management)

ANNEXURE M

PRELIMINARY CODED FOCUS GROUP TRANSCRIPT

Researcher: **What are the challenges in relation to their induction and professional development support?**

F3/R5: sometimes is about the off duties. They say that we should allocate the NQPN to do office hours in the first month of com serve. But when she comes to the ward, the NQPN prefers to work normal hours worked by all in the ward, seven sevens included.

F3/R8: the general challenge here is that they are currently allocated for one month in a ward. The time becomes too little for her to learn. When she tarts to adjust to the ward, she is taken away to start in another ward.

F3/R4: we have a terrible shortage of staff. You find that it is you, the operational nurse manager and the NQPN on duty, you have to support her, you can't leave her alone after four.

F3/R5: the shortage of professional nurses also affect them, you find that the professional nurse is there but she has to attend to other ward duties, and thus cannot support her.

Researcher: but patient care will always be there and in some institutions the p/ns will comprise of the operational nurse manager, the experienced p/n and the NQPN. So in that case do you imply that the NQPN will not be guided and supported due to shortage of personnel?

F3/R9: yes, patient care takes top priority, we really do not have time to attend to the NQPN adequately. That's why sometimes you find that even the ward admin takes the back seat. The overall ward admin is not up to standard, mh mh! (shaking head)

F3/R2: the other challenge is about the NQPNs themselves, during their training, there is something that they miss. When they are students they do not expose themselves to other clinical learning experiences, they concerntrate more on what is written than the actual patient care. They forget that after the four years they have to do the actual practicals in the wards. They need to be supported in doing basic staff when they come in as NQPN, things that they should have mastered as students. So instead of us taking them to the next level of being a professional nurse, we end up teaching them basic procedures. There is a shortage of basic clinical skills, maybe the clinical exposure was inadequate, but that's what we find in most cases.

All: MH, MH! (nodding heads)

F3/R3: the other thing is that there is a difference between the university students and college students when they are NQPNs. We observe the more theory but shortage of skills in the university students. Most of them are blank when coming to procedures. They depend more on the professional nurses when they come in as

ANNEXURE N

Question 1.3: **FINAL CODES QUOTATIONS AND FOLDERS (Data handling)**

Codes	Quotations	Comments
Shortage of personnel	…a challenge is that, when we are short staffed, they don't get this proper mentoring. You find that you have to take her from this team, to give her to another team. In that case you find that she gets confused, because we want her to get used to that group to build a better working relationship and trust.	F1/P5 (folder/ Participant)
	Sometimes we become short staffed with the professional nurses, so the operational nurse managers will take them up to do the ward administration with them. I orientate them on the ward admin as well.	F1/P4
	…actually we do find challenges in ensuring that the newly qualified professional nurses find their feet in the service. One of the challenges is staff shortage that I alluded to earlier. That is our main, main challenge in	F2/P2
	We have a terrible shortage of staff. You find that it is you, the operational nurse manager and the NQPN on duty, you have to support	F3/P4
	We encounter a problem of shortage of personnel. We have to leave the com serve sisters alone after four in the afternoon and some of them cannot manage. We leave them alone during the second month. We do overtime during the first month when they are	F5/P2 Time frame nqpn expected to be competent due
	It is unfair to the com server who now have to take charge of thirty six to forty patients. And sometimes that com server has to cover two wards when there is absenteeism and the other nurse for the other ward did not come. She will now have to take charge for seventy plus patients! Which is absolutely disastrous	F6/P5

ANNEXURE O

PART OF A FOCUS GROUP TRANSCRIPT

Sister Z: but sometimes we knock off at seven depending on the demand in the ward.

Researcher: **What are the challenges in relation to their induction and professional development support?**

Sister Z: sometimes is about the off duties. They say that we should allocate the NQPN to do office hours in the first month of com serve. But when she comes to the ward, the NQPN prefers to work normal hours worked by all in the ward, seven sevens included.

Sister N: the general challenge here is that they are currently allocated for one month in a ward. The time becomes too little for her to learn. When she tarts to adjust to the ward, she is taken away to start in another ward.

Sister P: we have a terrible shortage of staff. You find that it is you, the operational nurse manager and the NQPN on duty, you have to support her, you can't leave her alone after four.

Sister Z: the shortage of professional nurses also affect them, you find that the professional nurse is there but she has to attend to other ward duties, and thus cannot support her.

Researcher: but patient care will always be there and in some institutions the p/ns will comprise of the operational nurse manager, the experienced p/n and the NQPN. So in that case do you imply that the NQPN will not be guided and supported due to shortage of personnel?

Sister K: yes, patient care takes top priority, we really do not have time to attend to the NQPN adequately. That's why sometimes you find that even the ward admin takes the back seat. The overall ward admin is not up to standard, mh mh! (shaking head)

Sister June: the other challenge is about the NQPNs themselves, during their training, there is something that they miss. When they are students they do not expose themselves to other clinical learning experiences, they concerntrate more on what is written than the actual patient care. They forget that after the four years they have to do the actual practicals in the wards. They need to be supported in doing basic staff when they come in as NQPN, things that they should have mastered as students. So instead of us taking them to the next level of being a professional
nurse, we end up teaching them basic procedures. There is a shortage of basic clinical skills, maybe the clinical exposure was inadequate, but that's what we find in most cases.

All: MH, MH! (nodding heads)

ANNEXURE P

INFORMATION LEAFLET

INDUCTION AND PROFESSIONAL DEVELOPMENT SUPPORT OF NEWLY QUALIFIED PROFESSIONAL NURSES DURING COMMUNITY SERVICE

The title is for a research study of a Doctoral Degree in Nursing (PhD) and the researcher is a student at the University of South Africa (UNISA). The aim of this research is to find out what induction and professional development support do the newly qualified professional nurses get during community service; and what is the envisaged support that these nurses would like to get to ease their transition from the role of the student nurse to that of a professional nurse who can effectively function as a competent, safe, independent nurse practitioner.

The survey is a part directed at Professional Nurses who have recently completed community service because the researcher believes that these nurses will be in the position to give a comprehensive report of how they were supported during the community service period.

The focus group interviews are directed at nurse managers who supervised the newly qualified professional nurses during community service. The one to one interviews are directed to the provincial coordinators of community service who oversee community service placements at provincial level.

The proposal for this research was given ethical clearance by the Higher Degrees Committee of UNISA and permission to conduct the study was obtained from the Provincial Departments of Health. Information will be kept confidential. The respondents' privacy will be maintained. The information will be kept confidential and will not be used for other things other than writing a report, drawing guidelines, disseminating results in a form of articles as well as presentations in conferences. Participation is voluntary and you may withdraw from the study at any time without consequences. The researcher does not foresee any harm to the participants.

Your input is highly valued. The input will be further utilised in the formulationn of guidelines that will be presented to the national policy makers suggesting a uniform structured induction and professional development support that can be used nationally.

You are requested to fill in the accompanying consent form to indicate that you will or will not participate in this research.

THANK YOU

Researcher: Mrs M G Makua (makuamg@unisa.ac.za) 012 429 6524 / 0723726573

Supervisor: Prof Z Z Nkosi (nkosizz@unisa.ac.za) 012 429 6758
Institution: University of South Africa (UNISA)

ANNEXURE Q

INVITATION TO NURSING EXPERTS

Good day,

I am Memme Girly Makua, a doctoral student at the University of South Africa (UNISA). I have conducted a research study titled: ***Induction and professional development support of newly qualified professional nurses during community service in South Africa (SA).*** The purpose of the research was to determine the induction and professional development support given to, and that which is required by newly qualified professional nurses to enhance their transition from novice professional nurses to competent professional nurses.

The objectives of the study were:

1   To determine the induction and professional development support given to newly qualified professional nurses during community service in the designated public health institutions.

2   To describe the experiences of the newly qualified professional nurses regarding their induction and professional development support during community service.

3   To explore the experiences of the operational nurse managers regarding the induction and professional development support of the newly qualified professional nurses during community service

4   To explore the role of the coordinators of community service for nurses regarding the induction and professional development support of the newly qualified professional nurses during community service.

5   To determine the support needed by newly qualified professional nurses in terms of induction and professional development.

6   To develop guidelines for induction and professional development support of newly qualified professional nurses during community service.

6   To validate the guidelines through nursing experts.

The researcher used a mixed methods design of concurrent triangulation approach to collect qualitative and quantitative data. Quantitative data were collected from newly qualified professional nurses who have recently completed community service using a questionnaire; induction / orientation programs obtained from twelve health institutions of four provinces, and provincial guidelines of two provinces. The qualitative data were collected from twelve focus groups with operational nurse managers of health institutions in four provinces; interviews with coordinators of community service for nurses and written narratives from newly qualified professional nurses who have recently completed community service.

You are invited as a nursing expert to evaluate the enclosed guidelines to assist with the validation process. The guidelines were developed through a process of logical reasoning, drawing conclusions deductively and inductively from the research findings and literature.

Enclosed are the following documents:

1. Proposed guidelines for induction and professional development support of newly qualified professional nurses (summary in page 10 -12)
2. validation form
3. Summary of the research findings

The researcher will make a follow up to collect **the evaluation form** within **two weeks**. Do not hesitate to call or email for any clarification needed.

<u>Contact details</u>

Researcher: Mrs M G Makua 0723726573 <u>makuamg@unisa.ac.za</u>

Promoter: Prof Z Z Nkosi 012 429 6758 <u>nkosizz@unisa.ac.za</u>

Thank you!!!

ANNEXURE R

EXPERTS' OPINION ON THE GUIDELINES: INDUCTION AND PROFESSIONAL DEVELOPMENT SUPPORT OF NEWLY QUALIFIED PROFESSIONAL NURSES

Demographic Data of the experts

Kindly complete the following information about yourself

Position	
Employer	
Field of expertise	
Academic qualifications	
Professional qualifications (e.g SANC registrations if you are a nurse etc)	
Province of employment	
Any relevant information to note about you	

Guidelines Validation Form

Proposed guidelines: Induction and Professional Development Support of Newly Qualified Professional Nurses

Evaluation criteria:

1= Guidelines not acceptable, need major changes

2= Guidelines acceptable with recommended changes

3= Guidelines acceptable as described

Kindly use the provided criteria to rate the proposed guidelines and use the last column for comments

Descriptors	1	2	3	Comments
Clarity Proposed guidelines are clear, have concrete rationale and precise recommendations				
Comprehensiveness Guidelines address all aspects of induction and professional development support				
Applicability The guidelines have the potential to be applied in the formulation of induction and professional development support programs.				

Adaptability Guidelines could be applied in different circumstances				
Credibility Guidelines are based on the true findings of the research				
Validity Correct interpretation of the available evidence to support the implementation of the guidelines				
Other (specify)				

Additional comments or recommendations:

_____

_____

_____

_____

_____

Thank you for the valuable contribution.

M. G Makua 0723726573

makuamg@unisa.ac.za

Promoter details:

Prof Z. Z. Nkosi 012 429 6758

nkosizz@unisa.ac.za

ANNEXURE S

VALIDATED GUIDELINES FOR INDUCTION AND PROFESSIONAL DEVELOPMENT SUPPORT OF NEWLY QUALIFIED PROFESSIONAL NURSES

Introduction

Formal guidelines on the induction and professional development support of newly qualified professional nurses are necessary to enhance their transition from student nurse to professional nurse, in order to enhance their competence and to retain them (Makhakhe 2011:3). The newly qualified professional nurses need to be more skilful and confident with unit routines as well as procedures. This will enhance autonomy and control over practice, leading to job satisfaction as well as retention (Hatler, Stoffers, Kelly, Redding & Carr 2011:91).

Background

Compulsory remunerated community service in South Africa was introduced in 1998, starting with medical doctors and other health professionals were called to join as the years went by (DoH 2006:1). Nurses commenced with community service in 2008 after the nursing bill was promulgated into the Nursing Act, Act 33 of 2005 (SANC R765:1). The objectives of community service were to curb the shortage of health professionals in public health institutions and for professional development of the health professionals serving community service (DoH 2006:1).

Dr Percy Mahlathi, the Deputy Director General for Human Resources for the Department of Health in 2006, stated that community service provides the young professionals with an opportunity to develop skills, acquire knowledge, behavior patterns and critical thinking that will help them in their professional development (DoH 2006:1). The National Department of Health (NDoH) issued generic guidelines for community service for all health professionals and the South African Nursing Council (SANC), through R765 of 2007, developed regulatory guidelines for newly qualified professional nurses commencing with community service. The guidelines

from NDoH and SANC are both silent about professional development support of the newly qualified professional nurses commencing community service.

Formal national guidelines for induction and professional development support of newly qualified professional nurses will ensure uniformity of support systems across the provinces. Effective support systems help to ensure that newly qualified professional nurses are prepared and supported in their professional role (O'Shea & Kelly 2009:1534). One of the research findings was that nursing management should facilitate the development of support programs derived from the guidelines; and the support programs should be implemented as part of the key performance areas and be evaluated in the performance management of professional nurses as well as operational nurse managers to ensure compliance.

Without guidelines, support including mentoring, will be lacking structure with some operational nurse managers not knowing how to implement the required guidance and support (Paterson 2012:33). According to the research findings, in some health care institutions, induction and professional development support are not implemented at all due to the shortage of personnel and lack of formal guidelines.

The following guidelines were developed through a process of logical reasoning. Logical reasoning is a process of drawing conclusions (Nickerson 2010:2), both deductively and inductively, using evidence from the literature and research findings. The guidelines were formulated using information obtained from the qualitative and quantitative research findings, as well as the literature. The research data was obtained from newly qualified professional nurses who have recently completed community service, the operational nurse managers in the clinical areas, co-ordinators of community service for nurses as well as induction and orientation programs from various health institutions of the four provinces that took part in the research.

Guideline 1   Induction of the newly qualified professional nurses to the new work environment

Rationale for the implementation of the guideline

Induction will equip the novice professional nurses with knowledge and coping skills needed to adapt to the new work environment. Knowledge about the new work environment will also reduce the stress related to unfamiliar surroundings, unexpected practice demands and the high expectations of the service upon the newly qualified professional nurses. Information obtained from the induction will also clarify roles, responsibilities and expectations from both the inductees and the nursing management.

Recommendations on the implementation of the guideline

- Ideal induction and professional development support programs should be coordinated from provincial level, down to the health institutions where they should be implemented. The HR department should provide the human resources for the induction and professional development support programs that will be done after the general induction of the newly qualified professional nurses. This can be in a form of improved recruitment and retention strategies of staff development personnel and revival of clinical teaching departments in the health institutions.
- There should be an induction program when the newly qualified professional nurses start with employment.
- Planners of the induction program to ensure that the content is factual, relevant and adequate. Avoid information overload.
- An average of two weeks suggested for the induction program, for it not to be short or long, depending on the size of the health institution and the amount of the induction content.
- Provide information booklets for referral at a later stage when necessary, especially for unfamiliar content like that of the Human Resource Department (HR), regulatory matters, protocols and policies.
- Provide body breaks to improve participant's concentration.
- Presenters to be well prepared and to have knowledge of the subject at hand
- Induction program to be repeated at intervals e.g when another group of newly qualified professional nurses commence with community service. This will prevent discrimination against the groups that commence community service later in the year.

Guideline 2   Nursing management to formulate a formal mentorship program of the health institution that will form part of the operational nurse managers' and experienced professional nurses' key performance areas (KPA)

Rationale for the implementation of the guideline

The newly qualified professional nurses will be guided to transform from novice professional nurses to competent professional nurses through mentorship by the experienced professional nurses and operational nurse managers. They will enhance their clinical skills, be able to learn to be responsible and accountable.

A formal mentorship program that forms part of the individual's KPAs will encourage compliance as mentoring will be assessed in the individual's performance appraisal system.

Recommendations on the implementation of the guideline

- Nursing management should have a plan in place to develop experienced professional nurses and operational nurse managers to be mentors as part of their professional development.
- A formal health institution's mentorship program to be made available to newly qualified professional nurses with a contract entered into by mentor and mentee. Mentors to give mentees feedback on their progress on a monthly basis in a formal way and to write quarterly reports as required by SANC in the regulation for community service (SANC 2007, R765).
- Mentoring should form part of the experienced professional nurses as well as operational nurse managers' key performance areas (KPA) and be assessed with their performance appraisal like other KPAs. This will encourage conformity and reduce the incidences of reluctance to mentor newly qualified professional nurses.
- There should be rotation of the newly qualified professional nurses to other disciplines but with mentorship being provided throughout.
- The period of mentoring should not be less than six months, depending on the mentee's progress and level of competence
- Operational nurse managers to be role models to experienced professional nurses by being hands on in the mentoring of newly qualified professional nurses.
- Characteristics of mentors as in the mentorship literature should be applied, but over and above those characteristics, mentors should be knowledgeable,

patient, non-judgemental, not oppressive and kind. They must be willing to guide without negative criticism but constructive criticism and encourage the newly qualified professional nurses to reach their potential. They should provide answers to queries and be willing to provide support at all reasonable periods. They should role model professionalism for mentees to emulate their professional behaviour.

- The nursing management should put programs in place for monitoring and evaluation of the mentoring of the newly qualified professional nurses.
- Mentorship to be supported from the provincial level, HR departments and implemented by the health institutions.

Guideline 3   Supervision of the newly qualified professional nurses (direct, indirect) in the clinical areas and leadership development

Rationale for the implementation of the guideline
The newly qualified professional nurses might experience growth and development in unit management when the operational nurse mangers give them opportunities to manage the wards.

Supervision and support will improve their confidence, enhance their competence and might prevent clinical errors.

Recommendations on the implementation of the guideline

- Operational nurse managers should gradually introduce the newly qualified professional nurses to management activities of the ward under their supervision.
- Newly qualified professional nurses should be given a chance in learning and implementing nursing management activities. They should lead teams and be allowed to take charge of the ward under direct and later indirect supervision of the operational nurse managers or experienced professional nurses.
- Operational nurse managers and the experienced professional nurses should give the guidance and support as well as to provide constructive criticism, even praise where due.

- Operational nurse managers should be role models to the other professional nurses by being hands on in supporting the newly qualified professional nurses.

Guideline 4   Enhancing clinical competence of the newly qualified professional nurses

Rationale for the implementation of the guideline
Enhancing clinical competence of the newly qualified professional nurses could help them to transit from novice to competent professional nurses. Competent professional nurses are independent, safe and dependable, which might eventually reduce the shortage of professional nurses and its consequences in health institutions.
Recommendations on the implementation of the guideline

Needs assessment

- Upon allocation of the newly qualified professional nurses in a clinical area, the operational nurse manager together with the assigned mentors should embark on needs assessment to be able to draw a support program for them. Support programs may be individualised depending on the assessed needs and level of competence.
- Encourage newly qualified professional nurses to state their learning needs to the mentors, to facilitate the planning process of the necessary support and its implementation.
- The planning of the support program(s) should include monitoring and evaluation strategies to assess development progress or to be able to attend to hiccups promptly.

Boosting of confidence and enhancement of clinical competence

- **T**he experienced professional nurses should support and encourage the newly qualified professional nurses to polish their clinical skills. Confidence will be boosted when their nursing skills are improved by the support that they received from the experienced professional nurses. Support may be in a form of demonstration of clinical procedures upon request, supervision during a clinical procedure when the newly qualified professional nurse performs such procedure for the first time or feels insecure or not yet confident. Support might make them to be able to gain skills, develop positive self-esteem and boost their confidence.

- Enhancing clinical competence should be done by experienced profess professional nurses, operational nurse managers and clinical nurse educators from the clinical teaching department of the health institution.

Attendance of short courses, workshops and in-service training relevant to place of allocation

- Newly qualified professional
- nurses should attended short courses relevant to the clinical area of allocation; this will help them to improve their nursing care.
- The operational nurse managers should provide learning opportunities, allow and encourage them to attend relevant professional development programs.

Monitoring and evaluation of clinical competence

- Nursing management should monitor the professional development support of the newly qualified professional nurses while the operational nurse managers and mentors should monitor the progress in their clinical competence.
- Evaluation tools should be put in place to be used at agreed upon time frames. Mentors can evaluate mentees monthly, using a formal generic tool that can be developed in a form of a tick sheet with a space for comments, to save time and improve compliance. Operational nurse managers can develop their own tool to evaluate the mentor and mentee's progress monthly, reporting on the mentorship process. The nursing management can receive quarterly reports from operational nurse managers about the progress of the newly qualified professional nurses. The quarterly evaluation report should be comprehensive and report about the professional development support given and the progress made by the newly qualified professional nurse in moving from novice to competent professional nurse. Hurdles reported should be accompanied by suggested way forward. The quarterly evaluation reports will assist the nursing management to comply with the SANC regulatory requirements in the community service regulation (SANC 2007, R765).
- Mentorship and clinical supervision of newly qualified professional nurses should be a permanent agenda in nursing management meetings, to monitor the progress of their implementation. Nursing managers should give feedback on this item on a departmental basis e.g medical or surgical department etc.

Guideline 5   Creating a positive work environment to facilitate integration and retention of newly qualified professional nurses

Rationale for the implementation of the guideline

Positive work environment allays anxiety, fear of the unknown and might prevent negative attitude in the newly qualified professional nurses. It enhances their integration into the work place and a feeling of belonging. It will make them feel welcome and as valuable members of the nursing profession and multidisciplinary health team. It fosters professionalism and might encourage them to perform to the best of their potential.

Recommendations on the implementation of the guideline

- Nursing management should create supportive practice environments that facilitate newly qualified professional nurses' integration into the health institutions
- Newly qualified professional nurses should be welcomed warmly at the health institutions to make them feel appreciated as valuable health professionals.
- Health institutions should strive to make them to feel at ease and the allocated mentors to ensure that they fit well into the areas of allocation.
- Gradually working independently as professional nurses will give them a sense of responsibility and accountability. They might even welcome the responsibility as they are guided to have confidence in what they are doing.
- Clinical competence expectations from the nurse managers should not be very high upon the newly qualified professional nurses as they are still finding their feet in the profession. Realistic expectations upon them will relieve the pressure that comes with being a newly qualified professional nurse.
- Nursing management should encourage all nurses to treat each other in a humane way. Respect for the newly qualified professional nurses as people in the health institutions will ease their fear for the unknown and might make them to feel proud to be part of the nursing profession. Work place bullying should be prevented or dealt with promptly and accordingly when it occurs.
- Nursing management should afford the newly qualified professional nurses the opportunity to choose their allocation areas as much as is possible. When consulted about their allocation, they will feel happy that their opinions were taken into consideration. Being happy about the area of allocation might enhance their morale and competence when they work in clinical departments that they are interested in. This might increase their retention upon completion of community service.

- The operational nurse managers and mentors should introduce responsibilities gradually. Too much responsibility too quickly may overwhelm the newly qualified professional nurses and make them feel like being thrown at the deep end. Supervision and guidance should be maintained while they are not yet confident. They have met the minimum SANC requirements for registration as professional nurses after being found competent by the nursing education institutions that trained them, but they are still inexperienced as professional nurses. They are transitioning from student nurse to professional nurse, thus support and guidance are necessary to enhance their clinical competence.

- Nurse managers should avoid instilling feelings of being neglected and subjected to unequal treatment. University and college graduates should be treated the same way without negative criticism. They should all be inducted and orientated to the new work environment, irrespective of time of commencement at the health institution. The induction program should be planned adequately, to cater for those who commence with their employment at the beginning and during the year. Adequate resources for the induction should be mobilised timeously to cater for the envisaged number of newly qualified professional nurses.

Guideline 6   Establishment of viable communication structures

Rationale for the implementation of the guideline

Availability of viable communication structures and formal grievance procedures ensure that communication throughout the health system is open and clear. Newly qualified professional nurses will know the chains of command, how to communicate with relevant stakeholders, communicate their problems timeously and they will be kept informed with all matters that concern them.

Recommendations on the implementation of the guideline

- Nursing management should create communication structures such as meetings, suggestion boxes, newly qualified professional nurses' forums and email facilities to report positive and negative incidences. Nursing management to monitor the communication structures and to implement necessary interventions promptly when a negative incidence is reported.

- There should be a professional person delegated by the nursing management to be in charge of monitoring the communicating structures put in place. This person could serve as the starting point for the newly qualified professional nurses to have a platform to lay grievances and complaints.

- Operational nurse managers should role model professionalism and professional secrecy for others to emulate. Matters should be discussed in relevant platforms and newly qualified professional nurses to be kept informed about matters concerning them.
- Emphasis should be put on the importance of mutual respect, development of good communication skills and to acknowledge each other's achievements.
- Newly qualified professional nurses should learn to communicate and work as good team members, strive to be competent, independent as well as dependable nurse practitioners.
- They should use available communication structures effectively and report broken chains of communication to the relevant authorities to ensure continuity.
- Nursing management should monitor and evaluate the use as well as the efficacy of the available communication structures, using agreed upon mechanisms put in place.

Conclusion

The guidelines are recommended for implementation by nursing management at health care institutions. Relevant stakeholders can be roped in to assist in the development of induction and professional development support programs for the newly qualified professional nurses derived from the guidelines. The nursing directorate at provincial departments of health are expected to support and monitor the implementation of the guidelines.

Information that was deduced from the research findings is that: formal structured induction and professional development support for newly qualified professional nurses doing community service across the provinces of South Africa (SA) can be a positive professional socialization experience that can lead to confident, competent, independent as well as safe nurse practitioners.

SUMMARY

Guidelines: Induction and professional development support of newly qualified professional nurses

Guidelines	Rationale for the implementation of the guidelines
1 Induction of the newly qualified professional nurses to the new work environment	Induction will equip the novice professional nurses with knowledge and coping skills needed to adapt to the new work environment. Knowledge about the new work environment will also reduce the stress related to unfamiliar surroundings, unexpected practice demands and the high expectations of the service upon the newly qualified professional nurses. Information obtained from the induction will also clarify roles, responsibilities and expectations from both the inductees and the nursing management.
2 Nursing management to formulate a formal mentorship program of the health institution that will form part of the operational nurse managers and experienced professional nurses' key performance areas (KPA)	The newly qualified professional nurses will be guided to transform from novice professional nurses to competent professional nurses through mentorship by the experienced professional nurses and operational nurse managers. They will enhance their clinical skills, be able to learn to be responsible and accountable. A formal mentorship program that forms part of the individual's KPAs will encourage compliance as mentoring will be assessed in the individual's performance appraisal system.
Guidelines	**Rationale for the implementation of the guidelines**
3 Supervision of the newly qualified professional nurses (direct, indirect) in the clinical	The newly qualified professional nurses might experience growth and development in unit management when the operational

areas and leadership development	nurse mangers give them opportunities to manage the wards. Supervision and support will improve their confidence, enhance their competence and might prevent clinical errors.
4 Enhancing clinical competence of the newly qualified professional nurses	Enhancing clinical competence of the newly qualified professional nurses could help them to transit from novice to competent professional nurses. Competent professional nurses are independent, safe and dependable, which might eventually reduce the shortage of professional nurses and its consequences in health institutions.
5 Creating a positive work environment to facilitate integration and retention of newly qualified professional nurses	Positive work environment allays anxiety, fear of the unknown and might prevent negative attitude in the newly qualified professional nurses. It enhances their integration into the work place and a feeling of belonging. It will make them feel welcome and as valuable members of the nursing profession and multidisciplinary health team. It fosters professionalism and might encourage them to perform to the best of their potential.
Guideline	**Rationale for the implementation of the guideline**
6 Establishment of viable communication structures within the health institution	Availability of viable communication structures and formal grievance procedures ensure that communication throughout the health system is open and clear. Newly qualified professional nurses will know the chains of command, how to communicate with relevant stakeholders, communicate their problems timeously and they will be kept informed with all matters that concern them.

ANNEXURE T

CHECKLIST FOR CONTENT: INDUCTION/ORIENTATION PROGRAMME

Level of designated public health establishment: ----------------------------------

Province: _____

Area classification: Rural / or Urban _____

CONTENT	YES	NO	COMMENTS
Goal of program			
Contact person/details			
Phase 1 – Core Induction (1ˢᵗ week – 2 Months) Practice orientation - Physical orientation to practice structure (building / equipments) - Reporting times for duty - Management arrangements (HR) - Meeting colleagues - Communication channels/ hierarchical structure - Absence reporting arrangements (sick / delayed) - Orientation to the job description			
Legal framework - Relevant acts, regulations, policies, guidelines and protocols applicable to post at all levels of governance - Accountability - Handling of client complaints, incidences and patient feedback			
Occupational health aspects - Own practice responsibilities - Occupational health policies applicable			
Human resource aspects - Remuneration and benefits - Grievance procedure - Appointment letter			
Learning and personal development - Appraisal system - Opportunities for learning - Clinical supervision			
Phase 2 Role Specific Phase - 2- 6 Months			
Clinical practice			
Consolidated competencies necessary to be effective in role			
Professional support			
Supervision of subordinates			
Mentorship / preceptorship			
Reviewal of programme - Goals met - Outstanding developmental needs - Personal development plan			