

***Leadership competencies of professional nurses in the
eThekweni health district during the first year of
registration with the South African Nursing Council***

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DECLARATION

I, Nomawonga Corona Solwandle, declare that *"Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council"* is my own work. All sources used or quoted have been indicated or acknowledged by means of complete references.

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DEDICATION

This dissertation is dedicated to: The Lord Almighty, who makes things possible in life.

My late mother Mrs Mildred Ncikazi Mafana (nee Solwandle), mama, you forever reminded me that education is the key, and that with God everything is possible.

My one and only beloved son, Sonwabise Solwandle, and my lovely granddaughters, Chulumanca Solwandle and Linathi Tyopo. My only grandson, Milisuthando Esihle Masondo

My cousin sister, Ntombifuthi Solwandle, for always being there for me, holding the fort, taking care of my home when I could not, thank you Gcwanini. I will forever be grateful to you for the greatest role you have played in my life, you are the sister that I never had.

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ABSTRACT

This qualitative research study was conducted to explore and describe leadership competencies of the newly registered professional (NRP) nurses during the first year of registration with the South African Nursing Council (SANC) in selected provincial hospitals in the eThekweni health district. A qualitative, exploratory, descriptive study methodology was used. Semi-structured interviews were used to collect data; open-ended questions provided participants with an opportunity to provide rich and detailed information about selected experiences as qualified professional nurses.

The main objective of the study was to build on prior work in order to explore and describe selected leadership competencies of the NRP nurses, particularly those related to inability to manage conflict, uncertainty and fear of having to delegate, and observing unethical practice. Benner's model of Novice to Expert nurse was used as the organising framework. The purposive sample comprised eight R425 trained professional nurses in their first year of registration with the SANC, who were working in the selected regional hospitals of eThekweni health district. All participants had completed one year of practice and reported believing that they were at Stage 3: Competent of Benner's Stages of Clinical Competence model – from Novice to Expert. Six themes emerged, namely: support; uncertainty and fear of having to delegate; competence; transition to professional nurse; observed unethical practices; fear of victimisation; and difficult relationships. From the above stated themes fifteen sub-themes emerged.

The results found that nurses are continuing to transition into Benner's Stage 5: which requires continued support and integration as they evolve in their roles as professional nurses.

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LIST OF ACRONYMS AND ABBREVIATIONS

KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
SANC	South African Nursing Council
WHO	World Health Organisation
NRP nurses	Newly registered professional nurses
NGP nurses	Newly graduated professional nurses
R425	SANC regulations for the four-year Comprehensive programme (SANC R425) leading to a qualification in Nursing (General, Psychiatric and Community) and Midwifery
R2598	SANC regulation for scope of practice for registered nurses
US	United States

CHAPTER 1: INTRODUCTION

1.1 Background

South Africa has a four-year comprehensive programme (South African Nursing Council [SANC] R425) leading to a qualification in Nursing (General, Psychiatric and Community) and Midwifery for professional nurses. Nursing students undertake training over four years to attain the skills that will enable them to deliver proficient nursing care to healthcare service users, their families, and communities (Zonke, 2012: 1). In fulfilment of this national requirement of producing skilled and proficient nurses, the South African Nursing Council (SANC) requires that the newly registered professional nurses (from here on referred to as NRP nurses) and midwives have the necessary information, skills, attitudes and values that will empower them to deliver a resourceful specialised nursing service. To ensure excellence in health care, the healthcare system requires skilful and competent NRP nurses. NRP nurses are expected to act independently, make autonomous decisions, and have leadership and management skills that will enable them to deal with the complexities of nursing, such as delegating duties from a leadership position, and managing conflict within the nursing unit. Andrén and Hammami (2011: 10) report that training in leadership skills is required both in theory and in the clinical setting. In order to conceptualise the leadership competencies of professional nurses in their first year post registration with SANC, it is necessary to review the requirements associated with competent leadership.

This chapter outlines the background to the study with respect to newly registered professional nurses' leadership competencies one year after registration with the SANC. It then presents the problem that is being addressed, the problem statement, research question, aim and objectives, as well as significance of the study and the structure of the thesis.

The nursing profession in South Africa is at the core of healthcare, and needs to be nurtured and strengthened if the country is to rise above the many health challenges it faces. The NRP nurses receive very little instruction and training on leadership responsibilities, and are often forced into such positions even though they have not been satisfactorily prepared in their nursing education programmes (Ndaba, 2013:

46). In the study by Roziers, Kyriacos and Ramugondo (2014: 96), it was stated that the NRP nurses experienced fear of being unable to manage conflict, and uncertainty and fear of having to delegate. Enterkin, Robb and McLaren (2013: 207) indicated that leadership should be incorporated in the students' training curricula to enable them to develop and attain the skills that they require for unit leadership. NRP nurses should then be able to manage and lead the nursing unit when they are left on their own in the absence of senior staff, including the unit manager (Enterkin, Robb and McLaren, 2013: 207). According to Parker *et al.* (2014: 151), for a professional nurse to practice independently and autonomously they need to have worked in a unit for at least six months after qualifying, and another six months after that to comprehend the leadership and management competencies. In a study by Feng and Tsai (2012: 2068), the NRP nurses indicated that they needed more experience in a number of areas, including time in a clinical area before qualifying, relating to the doctors during their educational session, and broader experiences in working in a nursing unit setting. In a study by Shezi (2014: 4), the NRP nurses indicated that their nursing unit experiences sometimes conflicted with and contradicted information they had received during training. Teoh, Pua and Chan (2013: 146) stated that although nurses in their study had completed their one year community service placement and were deemed fit for registration as qualified registered nurses, many of them still expressed feelings of being ill-prepared for the reality of nursing practice in the clinical areas, especially with regards to conflict management, witnessing unethical practices and delegating tasks. These skills are vital for effective leadership in the nursing profession.

Kangasniemi *et al.* (2013: 904) indicated that it is the nurses' ethical responsibility to report their errors, as well as the unethical practices that they have identified, in order to ensure patient safety. Roziers, Kyriacos and Ramugondo (2014: 96) found that NRP nurses feel anxious about reporting unethical practices as they fear being victimised by those who have been witnessed committing the acts.

Managing conflict is an important component of leadership. Conflict can arise in the work situation when there is a struggle or contest between people with opposing needs, ideas, beliefs, values, or goals (Müller, Bezuidenhout and Jooste, 2011: 307). Conflict also represents an interactive process occurring within a group which is

characterised by incongruity and disagreement, originating when one party feels negatively affected by another party, resulting in anger, diminished communications, mistrust, disruption, verbal abuse, and intimidating diplomacies (Kaitelidou *et al.*, 2012: 572; Potter, Deshields and Kuhrik, 2010: 157; Johansen, 2012: 50). “Conflict management is the practice of being able to identify and handle conflicts sensibly, fairly, and efficiently” (Johansen, 2012: 50).

Nursing is a team function. Delegation of duties and tasks is an important component that ensures optimal patient care. Delegation “is generally considered to be the process of granting authority to make decisions to employees, thus increasing their decision-making autonomy” (Kærnested and Bragadóttir, 2012: 10). Hasson, McKenna and Keeney (2013: 230), Hansten and Jackson (2010: 285), and Ruff (2011: 17) refer to delegation for a professional nurse as directing other staff to perform nursing tasks and activities that they supervise. Potter, Deshields and Kuhrik (2010: 157), Hansten and Jackson (2010: 285), and Mueller and Vogelsmeier (2013: 20) define delegation as the transferred authority and responsibility of tasks or duties by the registered nurse to the competent subordinates, so as to enrich and develop the subordinates’ decision-making skills, but retaining the accountability and liability of the resumption of that task or duty.

The transition from nurse training into professional practice has been acknowledged as traumatic and fear-provoking to professional nurses (Kamboj, 2013: 8). In the process of role adjustment, the NRP nurses are expected to be competent and proficient in their nursing practice, which can be a reality shock for some (Edwards *et al.*, 2011: 2215). Their experience heightens their levels of emotional stress, such as fear and anxiety, especially during the first year post registration, when they are expected to display their leadership competencies in a nursing unit (Nel, Müller and Colyn, 2011: 2).

In a study by Clark and Springer (2012: e3), the NRP nurses indicated that they experienced frustration at the limited time allocated to obtaining sufficient skills and competencies to manage and lead a nursing unit. These nurses further indicated that they did not receive adequate support in this regard from co-workers and unit managers.

Roziers, Kyriacos and Ramugondo (2014: 95-96) conducted qualitative research with NRP nurses during their first year after graduation. Three themes emerged: a sense of achievement; uncertainty and fear in anticipation of reality; and reality shock. The current research expands on that work with the NRP nurses who have completed one year of practice, and examines the second theme of uncertainty and fear once the participants have experienced the reality of clinical practice. Within that uncertainty theme, eight subthemes were identified and this research explores three of those subthemes, namely: inability to manage conflict; uncertainty and fear of having to delegate; and fear of victimisation after observing unethical practice. Rozier's, Kyriacos and Ramugondo's (2014) research was in the Western Cape with nursing graduates who had started their compulsory year of community service. The current research explored three of the subthemes in a different province of South Africa, specifically eThekweni Health District in KwaZulu-Natal, with nurses who had completed their one year of community service and had been practising as professional nurses for less than one year.

1.2 Problem statement

Following a year of community service in a public health facility, newly registered professional nurses (NRP nurses) are placed in charge of nursing shifts and are expected to be in charge of the nursing units in the absence of the unit manager, despite their limited experience in leadership and management. Ndaba (2013: 46) indicated that the NRP nurses have received very little training for leadership responsibilities and are often forced into leadership positions. They have not been satisfactorily prepared for leadership in their nursing education programmes and are therefore not prepared to function effectively as front-line leaders. The research on which this study expands, found that community service nurses felt they lacked competence when managing conflict, delegating duties or witnessing unethical behaviour. The question remains as to whether these competencies are developed during the year of community service and whether the NRP nurses feel more competent in these areas after their one year of community service in a public health facility.

A number of studies, conducted globally, report a high turnover of the NRP nurses which contributes to the current shortage of professional nursing staff (Msiska, Smith and Fawcett, 2014; Roziers, Kyriacos and Ramugondo, 2014; Mqokozo, 2013; Zonke, 2012; Ndaba, 2013; and Whitehead and Holmes, 2011). This in turn has a direct negative impact on the quality of nursing care and leadership. When unsupported by experienced staff, these nurses become disgruntled and perform poorly, which leads to an increased attrition rate and absenteeism (Mqokozo, 2013: 52-53).

The researcher, in her capacity as a nurse educator, has observed that the NRP nurses are often placed in charge of shifts and expected to be in charge of the nursing units in the absence of the unit manager, in their first year of registration with SANC. The leadership competencies of the first year registered professional nurses in selected public-sector hospitals in the eThekweni Health District in KwaZulu-Natal Province have not been explored.

The experience of fear, anxiety and lack of confidence is aggravated by the reality of community service itself. Community service has not been properly established; for example, there is no system of buddies or role models to support the NRP nurses during their placement. The NRP nurses are placed as unit leaders in hospitals and clinics (both urban and rural) without mentors. A conducive and supportive learning environment for these NRP nurses depends on an adequate placement and support system including supervision, mentorship and preceptorship.

The above statements stimulated the researcher's interest to explore and describe the leadership competencies of the NRP nurses during their first year of registration with SANC. A registered nurse is an individual who is authorised and capable of practicing independently in terms of Section 16 of the Nursing Act No. 33 of 2005, as amended (South Africa, 2005). The research problem highlights the dilemmas and challenges of the NRP nurses which are made worse by the stressors in their working environment. If not properly addressed and resolved, such difficulties and problems are likely to cause a loss to the nursing profession of much-needed personnel and skills.

1.3 The research aim

The aim of this study was to explore the competencies of the NRP nurses in the management of conflict, delegation of duties and the witnessing of unethical behaviour in their first year of registration with the SANC as professional nurses and midwives.

1.4 Objective

The overall objective of the study was to explore the competencies of the NRP nurses in selected concepts within the theme of uncertainty and fear in anticipation of reality. The three concepts chosen to explore were: uncertainty and fear of having to delegate; inability to manage conflict; and fear of victimisation after observing unethical practice.

1.5 Research question

What are the competencies of the NRP nurses in selected leadership concepts in public health hospitals in the eThekweni Health District in KwaZulu-Natal Province as they transition from community service nurses to registered professional nurses?

The objectives of the study are outlined in Table 1.1

Table 1.1: Research objectives

<u>OBJECTIVE</u>	<u>METHOD</u>	<u>OUTCOME</u>
Inability to manage conflict	Interviews	Explored conflict management competencies of NRP nurses
Uncertainty and fear of having to delegate	Interviews	Explore delegation competencies of NRP nurses
Observed unethical practices: fear of victimisation	Interviews	Explored of unethical practices identification competencies of NRP nurses

1.6 Operational definitions

The following terms apply to the study:

1.6.1 Professional nurse

The terms 'registered nurse' and 'professional nurse' are used as synonyms. In this study the term professional nurses refers to professional nurses who have completed their remunerated community service and had registered with the South African Nursing Council in 2015 according to Regulation R425.

1.6.2 Role transition

Hoffart, Waddell and Young (2011: 334) defined the phase of role transition as "the first two years of employment after graduation".

Zagabe (2013: 17) theoretically defines transition as "a period in which the confidence develops and evolves; the process of change from a known area to a new area".

In this research study, role transition is operationally defined as a period during which the NRP nurses develop confidence and competence in the leadership and management of the nursing units.

1.7 Conclusion

South African nurses have to complete a year of community service in a public health facility. Research reveals that they experience a sense of achievement; uncertainty and fear in anticipation of reality; and reality shock when left to manage a nursing unit on their own. Rozier, Kyriacos and Ramugondo (2014: 95-96) reported that the NRP nurses generally lacked leadership competencies in many areas, not least in the delegation of duties, conflict management and identifying unethical issues. Little is known about the NRP nurses' competencies in these leadership concepts following their one year of community service, and whether the one year of community service has helped to develop these competencies. The following chapter presents the literature review that was undertaken.

CHAPTER 2. LITERATURE REVIEW

2.1 Introduction

This chapter presents an overview of leadership competencies, core concepts of leadership as well as problems associated with a lack of leadership competencies. A review of international, national and provincial literature was conducted, to identify the problems encountered by the NRP nurses regarding their leadership competencies, during their first year post registration. A number of databases were searched for English language literature using the search terms 'professional nurses', 'nursing leadership', 'role transition', 'nursing unit', 'delegation', 'ethical issue', 'unethical issue' and 'conflict management'. The databases included EBSCOHost, Google Scholar, ProQuest, SA ePublications, Cinhal and ScienceDirect. Articles from the search that appeared relevant were examined for inclusion in the study. After an initial investigation, resources that were deemed irrelevant were not considered. Articles published before 2001 were included for historical purposes and relevance to the study.

2.1.1 Internationally

Some international studies (Simpson-Cosimano, 2010: 27; Banks *et al.*, 2011: 3568; Calhoun, 2010: 24; Shipman, 2012: 10; Zagabe, 2013: 16; Msiska, Smith and Fawcett, 2014: 101; Makhakhe, 2010: 45; Feng and Tsai, 2012: 2065; Edwards *et al.*, 2011: 2215; Myers *et al.*, 2010: 5; Missen, McKenna and Beauchamp, 2016: 137; Huan, 2013: 137; Rudman *et al.*, 2010: 989) have been conducted on how the NRP nurses cope with the transition from the educational environment to the workplace environment. The aforementioned authors claim that the transition from nurse training to professional practice has been recognised as very stressful and frightening for professional nurses. However, a period of excitement during the transition from student to the NRP nurse can also be a time of immense stress with emotions ranging from nervous tension to extreme anxiety (Simpson-Cosimano, 2010: 27). Purling and King (2012: 3452) state that transition can feel overwhelming and a major role challenge for the NRP nurses. Hoffart, Waddell and Young (2011: 334) defined the phase of role transition as the first two years of employment after

graduation. The above-mentioned authors further state that the stage of transition has been recognised as a challenging time for the NRP nurses. Feng and Tsai (2011: 2065) declare that although the NRP nurses have the competencies that qualify them to be registered professional nurses, most of them still report feeling unprepared for the expectations of their new role. Missen, McKenna and Beauchamp (2016: 137) mention that in the process of transition the NRP nurses are expected to be competent and proficient in their nursing practice. These nurses experience heightened levels of emotional stress such as fear and anxiety, especially during the first year post registration, when they are expected to display their leadership competencies in a nursing unit (Msiska, Smith and Fawcett, 2014: 101).

A study conducted in Lesotho on the transition from student to professional nurse practitioner indicated that newly qualified nursing professionals also found the transition period disturbing and stressful (Makhakhe, 2010: 5).

Edwards *et al.* (2011: 2215), Myers *et al.* (2010: 5), Missen, McKenna and Beauchamp (2016: 137), Huan (2013: 137), and Rudman *et al.* (2010: 989) state that role transition is a stage of role adjustment and is known to be a reality shock.

Studies of the NRP nurses have found that they felt that their education should have better prepared them for their working life by offering more opportunities to enhance skills and critical thinking (Pennbrant, Nilsson, Ohlen & Rudman, 2013:741).

2.1.2 Nationally

A number of studies have been conducted in South Africa (Roziars, Kyriacos and Ramugondo, 2014: 93; Mqokozo, 2013: 62; Zonke, 2012: 49; Ndaba, 2013: 46; Zungu, 2010: 48; Tsotetsi, 2012: 87; Thopola, Kgole and Mamogoba, 2013: 173; Klerk, 2010: 45; Mampunge and Seekoe, 2014: 48; Pillay, 2010: 182) that have explored the transitioning role of the NPR nurses and found that a lack of confidence in this category of nurses is evident. The above-mentioned authors further suggested that these nurses lack the ability to make decisions during the initial exposure to professional roles as their leadership and decision-making skills were still limited. Roziars, Kyriacos and Ramugondo (2014: 93) and Mqokozo (2013: 62) report that the NRP nurses experience feelings of being lost and disorientated and this affects

their capability for effectiveness and their sense of security. Tsotetsi (2012: 64) found that the NRP nurses want better and more supervision. According to Thopola, Kgole and Mamogoba (2013: 169), the absence of back up and feedback often made them feel left out and frightened of consequences that may occur if they did something wrong. The increase in the NRP nurses' expected levels of responsibility and accountability was found to be a major stressor during the transition period (Whitehead and Holmes 2011: 4). Thopola, Kgole and Mamogoba (2013: 178) acknowledge that appropriate orientation and inductions maximise experience, minimise culture shock and contribute to a smooth transition into new professional roles. Hillman and Foster (2011: 52) state that the process of transition is critical to the individual, and that health care leaders should take a second look at the experience of being in transition in a time of many concerns related to nursing orientation cost, retention, and shortage.

2.1.3 Provincially (KwaZulu-Natal)

Research studies conducted in KwaZulu-Natal (Naranjee, 2012: 141; Chiliza, 2014: 75; Masango and Chiliza, 2015: 7; Govender, Brysiewicz and Bhengu, 2015: 5; Shezi, 2014: 62;) have reported that the NRP nurses during the first year post registration get confused when given information that conflicts and contradicts information they have received during training. However, no published studies in the researcher's province (KZN) have addressed the leadership competencies of the NRP nurses. The provincial Department of Health is not cognisant of the experiences of the NRP nurses, so as to be able to provide opportunities for skills development and critical thinking in helping these nurses in their professional development.

2.2 Leadership competencies of newly registered professional nurses

As the NRP nurses enter the workforce, they experience multiple challenges trying to fit into their new professional role (Lee *et al.*, 2012: 790). Pfaff *et al.*, (2013: 2) observes that the professional skills acquired during the NRP nurses' training may not be developed. Hartigan *et al.*, (2010: 292), and Masango and Chiliza (2015: 7) concur with the aforementioned authors when they say that the NRP nurses are not adequately prepared enough to deal with the challenges they face in their practice.

The transition phase from being a student to being a professional nurse is a very stressful phase for NRP nurses. It involves role adjustment and is a stage of reality shock (Caliskan and Ergun, 2012: 1392; Whitehead and Holmes, 2011: 20). The aforementioned authors further explained that during the first year of practice, the majority of the NRP nurses are adjusting to their new roles, and the policies and procedures of the practice background.

2.3 The core concepts of leadership

2.3.1 Competence

The NRP nurses need to be competent in the performance of everyday management tasks such as planning, decision-making and professional maintenance (Nel, Müller and Colyn, 2011: 2). The NRP nurses believed that working in the role of a professional nurse enhanced their clinical skill set and they felt clinically competent (Shipman, 2012: 119).

2.3.2 Inability to manage conflict

Conflict can be seen in a negative way, but it might have positive end results, such as unearthing the root of the problem, and can eventually assist in overcoming resentment and arriving at a common agreement (Brinkert, 2010: 146). Conflict that has not been efficiently resolved or managed can negatively affect the self-worth of the staff. High rates of malingering among the staff can eventually lead to court cases that will adversely affect the organisation as a whole (Johansen, 2012: 50). Most of the registered professional nurses in Zungu's (2010: 48) study mentioned that collaboration was effective in managing conflict, but few mentioned that they avoided conflict. Roziers, Kyriacos and Ramugondo (2014: 98) declared that the NRP nurses in their Western Cape Province study, believed that they had thus far not dealt effectively with conflict and had lost confidence in themselves.

2.3.3 Uncertainty and fear of having to delegate

The purpose of delegation is to gain work proficiency, which can only be achieved when the NRP nurses and the subordinates work together in partnership to manage the changing priorities of care within a patient care assignment (Potter, Deshields

and Kuhrik, 2010: 158). Delegation can develop nurses' leadership skills and improve their involvement in the unit by progressively cultivating their decision-making processes with increasing complexity (Kærnested and Bragadóttir, 2012: 10). The NRP nurses have described problems occurring when they join staff and senior nurses resist delegation. No initiation or completion of the delegated tasks by senior nurses happen (Potter, Deshields and Kuhrik, 2010: 162). The NRP nurses have identified the attitude of senior nurses towards the NRP nurses as a barrier that prevents effective delegation of duties, and that senior nurses underestimate the intelligence of the NRP nurses (Ruff, 2011: 14). The NRP nurses perceived age as a problem as senior nurses are unwilling at times to accept the direction of young, NRP nurses (Potter, Deshields, and Kuhrik, 2010: 162). This can lead the NRP nurses preferring to do tasks rather than delegating them to other staff (Kærnested and Bragadóttir, 2012: 10). The South African Nursing Act (South Africa, 2005) clearly state that equipping the NRP nurses with knowledge and leadership skills in order for them to practice safely and efficiently is the responsibility of the nursing education institution. This also helps in preparing the NRP nurses to delegate duties to their subordinates and to ensure that the subordinates are supervised and monitored.

2.3.4 Observed unethical practice: fear of victimisation

The onus to identify and report hazardous and unethical situations is a professional nurse's ethical and legal responsibility arising out of the NRP nurses' obligation to protect clients from harm, and to sustain the integrity of the nursing profession (Kangasniemi *et al.*, 2013: 909). It is further noted by the aforementioned authors that the role assumed by the NRP nurses in response to hazardous and unethical situations may differ. This can include a series of activities from one-on-one discussions, to formal advocating for system changes to, if necessary, external reporting of apprehensions. Nursing ethics is indispensable to the nursing profession to maintain the nurses' accountability to patient care according to the nursing rules and regulations (Luz *et al.*, 2015: 1188). Ethical problem solving on different levels is a basic part of ethics in nursing leadership. It is the responsibility of the NRP nurses to work towards resolving ethical problems and to be compassionate towards their subordinates' ethical decision-making abilities (Aitamaa *et al.*, 2010: 470). It is a

nurse managers' obligation to work towards reducing ethical problems and give support to subordinates' ethical decision-making ability (Aitamaa *et al.*, 2010: 470).

2.3.5 Support

Support is upholding of a professional nurses right to make a choice to manage a nursing unit and to function as a professional nurse in a nursing institution (Müller, Bezuidenhout and Jooste, 2011: 183). A supportive environment facilitates the post-registration development of nursing practice and assists new professional nurses in practice to improve patient care (Teoh, Pua and Chan, 2013: 144). Roziars, Kyriacos and Ramugondo (2014: 93) found in their study that the NRP nurses defined certain situations as rewarding, such as being well supported by staff, earning a salary, receiving acknowledgement from staff, and attaining positive feedback from supervisors. The NRP nurses have suggested that they would benefit from longer-term support that includes further development of clinical judgement, debriefing opportunities, and skill set enhancement (Enterkin, Robb and McLaren, 2013: 2010). St Clair, 2013: 102) found that the NRP nurses perceived that everyone in their units were extremely helpful and friendships with colleagues were promoted. Some studies have reported that the NRP nurses have perceived that the orientation that they received prepared them adequately for their current position as qualified professional nurses (Meyer, 2014: 96), and that formal orientation programmes have been perceived as helpful, reinforcing and as a refresher course that provides answers to questions that many NRP nurses are too embarrassed to ask (Teufer, 2014: 110; St Clair, 2013: 32). Tsotetsi (2012:51) conducted a study in Gauteng and found that the NRP nurses had difficulty in adapting to the work environment because of limited support, verbal abuse, role conflict and unexpected workloads.

2.3.6 Role transition

While often a period of excitement, the transition from student to the NRP nurse can be a time of immense stress with emotions ranging from nervous tension to extreme anxiety (Simpson-Cosimano, 2010: 27). Purling and King (2012: 3452) stated that the transition can feel overwhelming and is a major role challenge for the NRP nurses. Hoffart, Waddell and Young (2011: 334) define the phase of role transition as the first two years of employment after graduation. Feng and Tsai (2011: 2065)

declare that although the NRP nurses have the competencies that qualify them for registered nurse licensure, most of them still report feeling unprepared for the expectations of their new role. A study on the transition from students to professional nurse practitioner in Lesotho found that newly qualified nursing professionals found the transition period disturbing and stressful (Makhakhe, 2010: 5). Makhakhe then observed that during their community service, the NRP nurses experience a high level of physical and emotional stress, which results in a significant number opting out of the service. A study conducted by Ndaba (2013: 25) found that the majority of the NRP nurses were not ready for independent professional practice at the point of registration, and that there was a lack of practice opportunities in leadership and managerial skills. The aforementioned author indicated that it was only after six months that most of the NRP nurses felt ready for practice. The NRP nurses have little opportunity to practice under supervision in the nursing units during their community service placement, as they are allocated for only three months in each nursing unit. The increase in the NRP nurses' expected levels of responsibility and accountability was found to be the major stressor during the transition period (Whitehead and Holmes, 2011: 4). Dyess and Parker (2012: 619) posited that the period of transition was the turning point for the NRP nurse and has unique characteristics such as increased stress because the new nurse has to adjust to the realities of real clinical practice. According to Dyess and Parker (2012: 619), these changes influence the whole person's quality of life and have an impact on his or her learning abilities. This view is supported by Hillman and Foster (2011: 53) who state that the process of transition is critical to the individual, and that health care leaders should take a second look at the experience of being in transition in a time of many concerns related to nursing orientation cost, retention, and shortage.

2.4 Conceptual framework

Grove, Burns and Gray (2013: 689) define a conceptual framework as "the set of highly abstract, related paradigms that mostly explicates the phenomena of interest, expresses assumptions, and reflects a philosophical stance". Polit and Beck (2014: 135) define a conceptual framework as "interrelated concepts or abstraction assembled together in a rational scheme by virtue of their common theme, and is also called a conceptual model". Polit and Beck (2014: 135) further assert that in a

study that has its origins in a specified conceptual model, the framework may be called the conceptual framework.

The conceptual framework is one that the researcher has established through identifying and defining concepts and proposing relationships between these concepts. By identifying a framework within which ideas are organised, the researcher has been able to show that the proposed study is a rational extension of contemporary knowledge (Brink, van der Walt and van Rensburg, 2012: 26). The concepts that the researcher is referring to are conflict management, delegation of duties and observing unethical practices. The definition, significance and implications of the concepts related to the study are described below. Benner's model of Novice to Expert (Hughes and Quinn, 2013: 395-395) was used to evaluate this study. This theory proposes that the NRP nurses go through five levels of development constructed on their ability to assess and critically think in clinical and management situations (Hughes and Quinn, 2013: 394-395). The five levels of development are Novice, Advanced beginner, Competent, Proficient, and Expert. These levels are illustrated in in Figure 2.1. The first three are explained below.

2.4.1 Benner's model of Novice to Expert

The study was conducted using Benner's model of Novice to Expert, as shown in Figure 2.1. The first three levels of Benner's model of Novice to Expert are explained below.

2.4.1.1 Level 1: The Novice

According to Hughes and Quinn (2013: 394-395), Benner (1984) describes the novice as the NRP nurse who is new to a situation, has no experience of the situation and is therefore unable to draw on past experience in order to make decisions. During this stage, the NRP nurses are mainly influenced by observational and experimental knowledge and workbook concepts learned during undergraduate education. Owing to their comfort level, their focus is often related to completing lists of tasks; therefore, uncertainty is created when asked to move away from these lists (Hughes and Quinn, 2013: 394-395). For the purpose of this research study, the

professional nurses at this level are those who have graduated and are on the first three to six months of their community service.

2.4.1.2 Level 2: The advance beginners

At this level the NRP nurses still operate following rules, but they are able to apply them not only in the exact situations for which they were intended, but also in similar contexts. The once strict rules become more like guidelines; they try out new things, but have difficulty solving problems. Their priority at this stage is on completing tasks. According to Hughes and Quinn (2013: 395), devotion to principles and rules, however, does not help the NRP nurse to decide what is pertinent in a specific nursing situation, and may thus lead to futile performance, so supervision and support is beneficiary. The main objective of the NRP nurse who is at this level is to achieve immediate tasks and they also need clear rules and unambiguous instructions. To improve, the NRP nurses need to get practice dealing with real situations, preferably in controlled situations (Hughes and Quinn, 2013: 395). For the purpose of this research study, the professional nurses at this level have at least finished the first six months of community service.

2.4.1.3 Level 3: Competent practitioner

This stage is characterised by conscious, purposeful planning based upon analysis and careful consideration of a situation. The NRP nurses at this stage are able to identify priorities and manage their own work. They are capable of solving problems. To improve, competent NRP nurses need exposure to a wide variety of typical, real-world 'whole' situations. Benner suggests that the competent NRP nurse can benefit at this stage from learning activities that centre on managing conflict, delegating duties and responding to unethical practices in the nursing unit (Hughes and Quinn, 2013: 395). According to Benner (1984: 27), the competent NRP nurse lacks the speed and flexibility of the skilful nurse and does not have a feeling of complete control and the capability to cope and manage the many possibilities of nursing unit management. Research is more significant at this stage where the NRP nurse is now competent, which is characterised by mindful and cautious planning, based upon careful planning of situations (Hughes and Quinn, 2013: 395). For the purpose of this research the NRP nurses at this stage are regarded as competent and practising as

professional nurses in charge of nursing units. Phillips *et al.*, (2014:108) stated that the NRP nurses believed that their skill acquisition was at a basic level and that their level of competence and proficiency needed to be acknowledged with appropriate patient allocation.

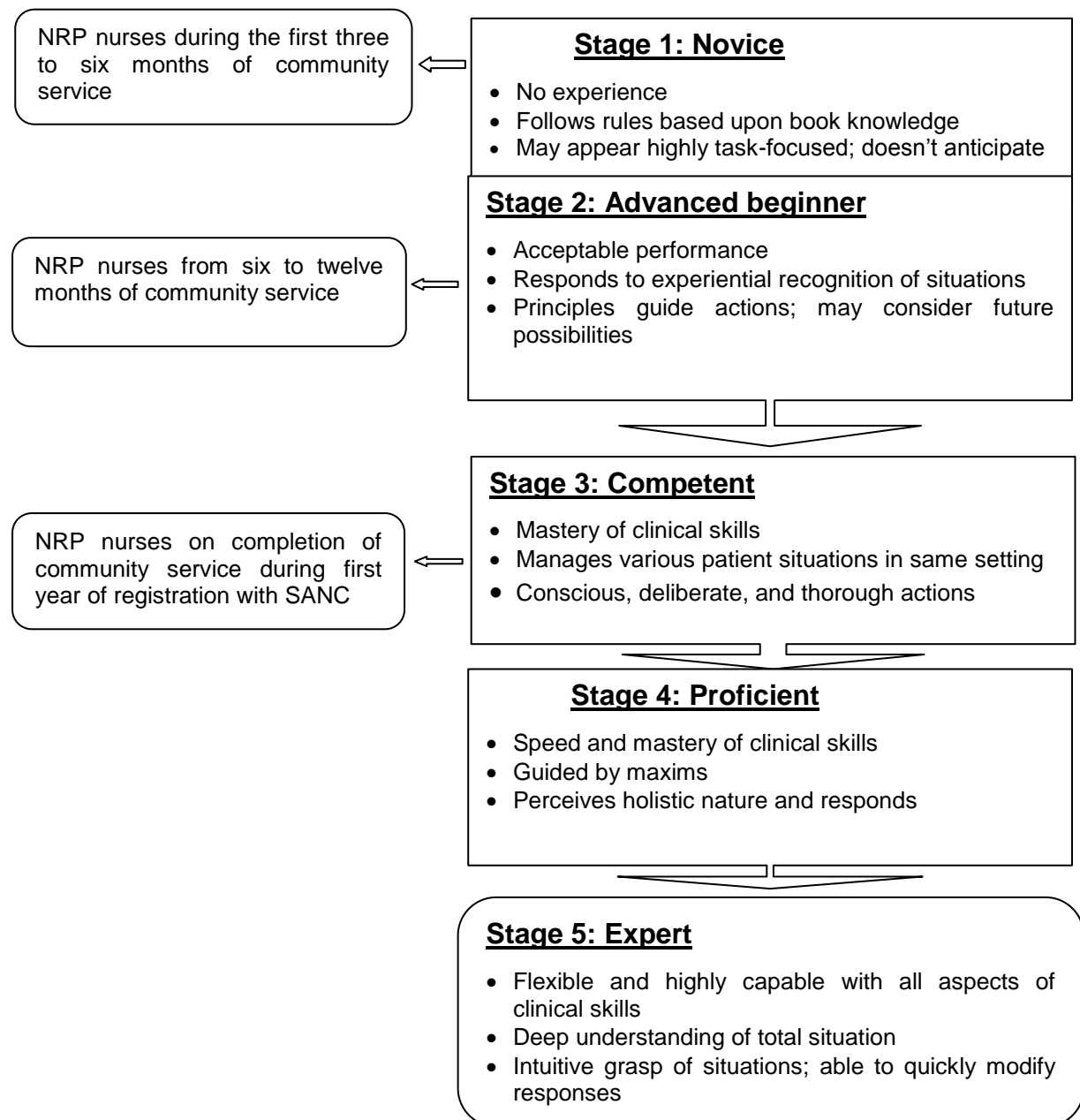


Figure 2.1: The flowchart showing the five levels of the progression of a nurse's development, based on Benner's model of Novice to Expert

Source: Hughes and Quinn (2013: 395)

2.5 Transitioning to being a newly registered professional nurse

The literature suggests that the NRP nurses have feelings of emotional stress, lack self-confidence, display uncertainty about what they know, lack autonomy, lack of support, lack leadership skills, express feelings of disillusionment and feelings of inadequacy (Roziars, Kyriacos and Ramugondo, 2014; Makhakhe, 2010: 36; Naranjee, 2012; Ashton, 2012; Jamieson *et al.*, 2012). Vogelpohl *et al.*, 2013:418 confirm the lack of adequate sources of support for the NRP nurses during their period of transition and the lack of induction and training programmes for them. Vogelpohl *et al.*, (2013:418) emphasized the excessive expectations others have of the NRP nurses that fall beyond their capabilities such as being left in charge of the unit without mentorship as well as the difficult and compressed shifts such as being called in to work during off duty time. Zagabe (2013:16) stated that the period of transition is the turning point for the NRP nurse and has distinctive characteristics such as increased stress because the new nurse has to change to the realities of work life. Zagabe acknowledged that the NRP nurse who is transitioning from community service into acute care settings is in a period that involves changes and innovation. According to Zagabe, these changes influence the whole person's quality of life and have an impact on his or her learning abilities.

2.5.1 Emotional stress

Naranjee (2012: 143) found that the NRP nurses reported that their stress levels were raised when by new situations and when working with new groups of staff, doctors and managers with whom they were not well socialised. Ndaba (2013:59) mentioned that emotional stress can also be experienced as anxiety and fear.

2.5.1.1 Anxiety

The stress inherent in the transition from being a student nurse to becoming a NRP nurse, which includes achieving capability along with working in the difficult environment of current nursing practice, can create considerable levels of anxiety in the NRP nurses (Makhakhe, 2010: 36). Roziars, Kyriacos and Ramugondo (2014: 93) observe that the NRP nurses are anxious, stressed and have self-doubt as they enter the workforce environment as professionals. These authors suggest that

contributory factors to this behaviour are: inadequate communication skills, negative workplace, lack of interpersonal skills, and lack of managerial and organisational skills. Great anxiety is caused by the unit rotation in the first year post registration. Ashton, (2012: 8) found that the NRP nurses reported that anxiety begins as moderate to relentless due to the range of emotional responses that they experience in the work setting. Phillips *et al.*, (2014:108) mentioned that the NRP nurses suggested that they were presented with high levels of acuity, which heightened their anxiety levels. Some of the reports on anxiety by the NRP nurses are linked to their transition from a familiar setting into an unfamiliar setting, where they are expected to perform their duties competently (Watt and Pascoe, 2013: 23). Shezi (2014:51) indicated that the NRP nurses experience anxiety, which is increased by lack of confidence when the nursing unit is busy because there are limited prospects to learn new skills on the job.

2.5.1.2 Fear

The NRP nurses in Pfaff *et al.*'s (2013: 7) study reported that they were not ready for their role as professional nurses and feared making mistakes. The transition from an accustomed educational environment into the unaccustomed workplace setting, where the expectation is to quickly perform as a competent professional nurse, causes stress. This transition can also lead to high anxiety, role adjustment issues and feeling unprepared for the realities of the clinical setting (Casey *et al.*, 2011: 646). In Ashton's (2012: 9) study, the NRP nurses reported that they had a fear of failure while managing nursing units. Tastan, Andsoy and Iyigun (2013: 406) found that although they have self-confidence because of their formal education, the NRP nurses experience fear and uncertainty concerning individual patient cases. Values and practices favoured in colleges and university courses are challenged as the NRP nurses struggle with the realities of practice, striving to understand hospital processes, procedures, and their place in the clinical and organizational requirements (Makhakhe 2010:34). Makhakhe further stated that the NRP nurses lack clear roles and they are afraid of making mistakes, lack confidence and are fearful of new situations.

2.5.2 Lack of confidence

Saccomano and Pinto-Zipp (2011: 522) state that leadership and confidence in delegation are two important illustrative constructs of nursing practice. These authors further state that to be successful in their roles as managers, irrespective of their experience, the NRP nurses need to understand how best to delegate (Saccomano and Pinto-Zipp, 2011: 522). When not adequately prepared for supervisory functions, the NRP nurses frequently do not have the necessary level of confidence to lead and to delegate.

According to Pfaff *et al.* (2013: 7), the NRP nurses reported that their lack of experience in unit leadership led them to self-doubt in spite of their previous experience. Pfaff *et al.* (2013: 7) also observe that the lack of professional confidence that the NRP nurses often feel can be heightened when medical doctors and senior registered nurses use an impatient tone or express disgust. Ashton (2012: 9) mentioned that the NRP nurses reported their lack of confidence in taking on these roles, due to the experiences that they encounter in the nursing units which negatively impact on their confidence. In the study conducted by Makhakhe (2010: 36) the NRP nurses indicated that they lack confidence in the first year post registration. They are overwhelmed, and make mistakes due to their workloads and responsibilities. The NRP nurses often feel vulnerable and exposed leading to a rapid loss of confidence (Jamieson *et al.*, 2012: 36).

Whitehead and Holmes (2011: 22) state that regardless of an evident lack of support, the NRP nurses learn to cope with the change in status from supernumerary student to independent practitioner which results in their confidence levels increasing.

2.5.3 Uncertainty

According to Roziars, Kyriacos and Ramugondo (2014: 95), one of the reasons for the NRP nurses uncertainty and fear related to their perceived inability to manage conflict, the hospital staff expectations about their immediate competency level, concerns about curriculum shortcomings such as how to communicate with “difficult doctors,” nurses’ rights, and legal aspects of nursing. However, they experienced a

sense of achievement in having successfully completed a comprehensive four-year programme before their clinical placement. The duty and accountability of being a NRP nurse conveyed some fears prompted by the uncertainty over their coping competencies, considering the incidence of litigations that are encountered in the nursing fraternity(Ndaba 2013: 57).

2.5.4 Lack of support

Müller, Bezuidenhout and Jooste (2011: 458) define support as “upholding a professional nurse’s right to make a choice to manage a nursing unit and to function as a professional nurse in a nursing institution”. This author further states that support means to assure the professional nurses that they have the right and responsibility to make decisions regarding their managerial skills and reassuring them that they do not have to change their decisions about becoming professional nurses even if senior professional nurses, nurse managers, or any other person raise objections.

Shezi (2014: 62) asserts that despite the four years of academic and clinical training, the NRP nurses need further supervision and guidance, as they cannot function independently.

Mqokozo (2013: 62) and St Clair (2013: 49) mention that the NRP nurses are often given the responsibility of managing the nursing unit without supervision, within the first year of practice. Naranjee (2012: 143) and Whitehead and Holmes (2011: 22) state that the NRP nurses reported lacking support from the more experienced professional nurses resulting in a stressful transition process. Wolff *et al.* (2010: 189) found that the NRP nurses perceived that they were not supported as other staff members were too busy to assist them and they lacked knowledge of the overall functioning of the nursing unit.

2.5.5 Leadership in nursing

Leadership and management, according to Müller, Bezuidenhout and Jooste (2011: 20), must be included throughout students’ training and not just the last semester, so that students can develop the essential skills that they require to lead and manage a

unit. Hasson, McKenna and Keeney (2013: 230), Whitehead and Holmes (2011: 21), and Chandler (2012: 103) found in their studies that the NRP nurses expressed concern about their ability to supervise and delegate nursing personnel. These authors further mentioned that most NRP nurses commented that they were not yet ready to explore conflict management appropriately and professionally. Ashton (2012: 103) noted that the NRP nurses, who were encouraged by their unit supervisors to assume administrative duties and assimilate the role of the registered professional nurse in the nursing unit, were able to do so successfully.

Whitehead and Holmes (2011: 21-22) identified leadership responsibilities for NRP nurses as being challenging. This relates to both self-management and management within a team.

2.5.6 Feelings of inadequacy

In the context of this study, “adequate” refers to the NRP nurses having the competencies according to the outcomes of the R425 nursing programme, to manage a nursing unit (Naranjee, 2012: 12).

Naranjee (2012: 141) reported that the NRP nurses realised their limitations in unit management and their lack of competence in their current practice as the NRP nurses. These authors also noted discrepancies in preparation for management, suggesting that while the theoretical context was satisfactory, the practical aspects such as nursing unit management; prioritising, decision-making and clinical skills were variable. The authors ascribed these inconsistencies to the differences between practice placements offered to the NRP nurses, so varying their individual experiences and abilities.

Jamieson *et al.* (2012: 33) reported that the NRP nurses in the United States (US) experienced a ‘reality shock’ and feelings of being inadequately prepared for their new role. The above statement concurred with the results of the research studies conducted by Caliskan and Ergun (2012: 1392). Makhakhe (2010: 36) comments: “They feel inadequately prepared for the workplace and are very uneasy about interacting with physicians, and feel as if the facility expects too much of them too quickly.”

2.5.7 Feelings of disillusionment

When the NRP nurses realised that nurses are not the caring professional they thought they were, they become disillusioned with the profession they love and believe in (Whitehead and Holmes, 2011: 22 and El-Awaisi *et al.* 2016: 1724). This is when disillusionment sets in, and they feel discouraged. Banks *et al.* (2011: 3568) and St Clair (2013: 109) supported the aforementioned authors by asserting that the NRP nurses have feelings of disillusionment in the first year post registration. These authors also reported that nurses felt frustrated, defenceless, stressed, and disillusioned in the period directly after beginning work.

2.6 Conclusion

This chapter has provided an overview of the current literature on leadership competencies of the NRP nurses regarding conflict management, delegation of duties and observing unethical practices. The conceptual framework of Benner's model was applied from the novice, the advanced beginner and competent practitioner. The problems that were identified in the review of the national and international literature on leadership competencies of professional nurses were as follows: emotional stress, lack of confidence, uncertainty, lack of support, lack of leadership skills, feelings of inadequacy and feelings of disillusionment. In the following chapter the research methodology used for the study will be discussed.

CHAPTER 3. RESEARCH METHODOLOGY

3.1 Introduction

This study focused on leadership competencies of the NRP nurses at selected eThekweni regional hospitals during their first year of registration with the SANC. While recognising the many factors found in the literature that impact on the transition of the NRP nurses to the workplace, conflict management, delegation of duties and identifying unethical practice were the phenomena of interest in this research study.

Epistemology is a branch of philosophy concerned with the nature and forms of knowledge (Polit and Beck, 2012: 12; Creswell 2014: 8). The aforementioned authors further assert that the constructivist paradigm states that awareness is widened when the space between the researcher and the participants is reduced. The expressions and interpretations of study participants are critical to understanding the phenomenon of interest. Subjective interactions are the primary way to access them (Polit and Beck, 2012: 12). Outcomes from a constructivist inquiry are the artefact of the interaction between the researcher and the participants. The construction of reality refers to the idea that reality is assembled through social interaction and interaction with the environment (Msiska, Smith and Fawcett, 2014: 98). This social construction denotes that there are manifold accounts of reality and that reality is diverse (Polit and Beck, 2014: 276).

In terms of epistemology, the study conducted in terms of the constructivism model which views knowledge as socially constructed or socially facilitated. The constructivist epistemology assumes that no objective truth is waiting to be discovered. In this study, the researcher used a constructivist approach as the philosophical foundation of the study. The researcher had to interact with the participants and share their understandings, so as to comprehend and be able to explore their experiences at first-hand level and construe them. Figure 3.1 represents the research process described in this chapter.

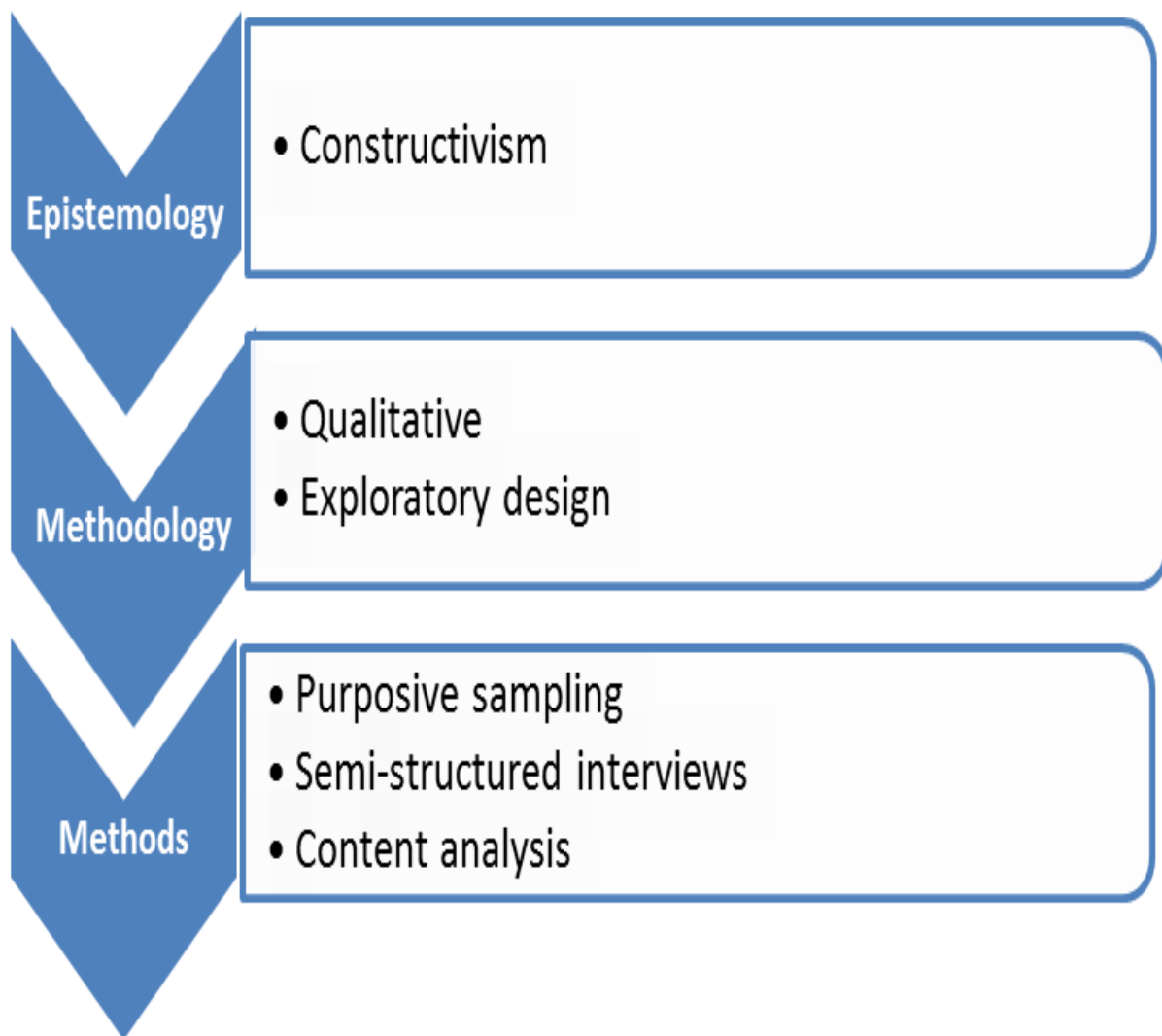


Figure 0.1: represents the three elements of the research process
Source: Crotty (2012: 4)

3.2 Research design

A research design is a blueprint for conducting a study that maximises control over factors that could impede the study's desired result (Grove, Burns and Gray, 2013: 195). The research method is the complete plan of the study which comprises the steps of the research process from problem identification to the actual data collection (Grove, Burns and Gray, 2013: 223). The research method addresses the development, validation and evaluation of research tools and methods to be used to gather and analyse the information obtained during the study (Polit and Beck, 2012: 12).

A qualitative, exploratory, study was undertaken to generate information on NRP nurses' leadership competencies during the first year post registration. An exploratory design was chosen for this study because the researcher wanted to explore the leadership competencies of professional nurses one year after registration with SANC. Through this approach, it was possible for the researcher to gain knowledge and a deeper understanding of the participants' experiences.

The researcher gained knowledge about the leadership competencies of professional nurses based on the experiences of these nurses which might assist the nursing leadership and management of hospitals to develop and improve support systems to meet the NRP nurses' needs. This was qualitative research, which, according to Grove, Burns and Gray (2013: 23) "is a systematic, interactive, subjective approach, used to explore life experiences and to give them meaning". It is also broad and universal and the researcher's views and viewpoints have an impact on the result of the study.

3.2.1 Study setting

The study was conducted in the four (4) eThekweni regional hospitals. The chosen hospitals are categorised as regional hospitals because they are hospitals that provide a variety of general specialist services. Hospitals at this level receive referrals from district hospitals and deliver specialist services to a number of district hospitals. The eight general services that are provided include general surgery, orthopaedics, general medicine, paediatrics, obstetrics and gynaecology, psychiatry, radiology and anaesthetics. All patients in need of these hospital services are attended to with or without medical aid services as these are government hospitals.

3.2.2 Study population

Grove, Burns and Gray (2013: 44) refer to population as the over-all number of units such as individuals, organisations and events from which data can possibly be collected. The study population consisted of all R425 trained professional nurses at the four regional hospitals in the eThekweni health district, who were in their first year of registration with the SANC as a nurse (general, community, psychiatry) and

midwife. NRP nurses are placed in general, surgical, orthopaedics, paediatrics, obstetrics and gynaecological, psychiatric and operating theatre as NRP nurses. They work under the SANC scope of practice for registered nurses (R2598) which states that professional nurses must co-ordinate the health care regimens provided for the patient by other categories of health personnel. These participants completed a four-year comprehensive nursing diploma programme as well as remunerated community service. They then registered with the South African Nursing Council in 2015 according to Regulation R425.

3.2.3 Sampling procedure and sample size

According to Polit and Beck (2012: 521), there is no specific sample size in qualitative research; it depends on the purpose of the research, the quality of the participants and the sampling strategy used. A guiding principle in sample size is “data saturation” which is the point where no new information is forthcoming from the participants. Polit and Beck (2012: 521) state that data saturation is when themes and categories in the data being collected are repetitive and redundant and there is no new information gained by further data collection.

A list of all the NRP nurses who had performed and completed their community service year during 2014-2015 at the four selected public hospitals, and were in their first year of registration with the SANC and who were employed at the study site at the time of the study, was accessed from the hospital administration. Thirteen NRP nurses were eligible to participate in the study. These nurses were contacted telephonically and informed about the research study. Four could not be accessed as they were in mobile clinics and therefore could not participate in the research study. One NRP nurse was booked off sick and could not take part in the research study. A total of eight participants voluntarily agreed to participate in the semi-structured interviews, representing all four selected public hospitals.

3.2.3.1 Study sample

A sampling process is defined as the “selection of a portion of the target population to represent the entire population” (Grove, Burns and Gray, 2013: 42; Polit and Beck, 2012: 567

Sampling of hospitals

Purposive sampling is a judgemental or selective sampling method that involves conscious selection by the researcher of certain subjects or elements to include in a study (Grove, Burns and Gray, 2013: 705). This strategy was used to select the four regional hospitals in eThekweni health district. The regional hospitals were chosen because the R425 trained NRP nurses are placed in these hospitals after they have qualified and completed a year of community service and have full registration as a professional nurse and midwife with the SANC.

Sampling of participants

Participants were selected by means of purposive sampling. This sampling strategy was appropriate as those who were identified as having the information the researcher was interested in were invited to participate (Polit and Beck, 2012: 312). Participants in this study were R425 trained NRP nurses during their first year of registration with SANC. These nurses were placed in general, surgical, orthopaedics, paediatrics, obstetrics and gynaecological, psychiatric and operating theatres. They were working under the SANC scope of practice of registered nurses (R2598) which states that professional nurses must co-ordinate the health care regimens provided for the patient by other categories of health personnel.

Data saturation consists of sampling to the point at which no new information is obtained and redundancy is achieved (Polit and Beck, 2014: 286). The researcher continued to sample until data saturation was achieved and participants were reporting similar experiences.

Inclusion criteria refer to the participants who have specific characteristics of interest to the researcher (Grove *et al.*, 2013: 345; Polit and Beck, 2012: 306).

Inclusion criteria:

- R425 trained NRP nurses in their first year of registration with SANC, working in the selected regional hospitals of eThekweni district.

Exclusion criteria for the study:

- R425 professional nurses who were still on remunerated community service placement.
- R425 professional nurses who were not registered with SANC.
- R425 trained professional nurses in their second year of registration and onwards.
- R683 trained professional nurses.

3.2.4 Data collection methods

Semi-structured interviews were used to collect qualitative data from the study participants. The researcher prepared a list of questions to be discussed with each participant (Annexure J). This technique ensured that the researcher obtained all the information required, and it gave participants the freedom to provide as many illustrations and explanations as they wished (Polit and Beck, 2012: 537). Open-ended questions were used to offer participants the opportunity to provide rich and comprehensive information about their experiences as newly registered professional nurses.

The interview schedule included the following demographic data: age, gender, race, educational background, period of employment, training institution, current institution. Open-ended questions were structured in such a manner that they explored the phenomena of the NRP nurses ability to manage conflict, delegate tasks/duties and identify unethical practices.

3.2.4.1 Data collection process

The researcher met the participants at work where she gave them an information sheet (Annexure H), explained the purpose of the study, and assured participants that participation was voluntary. The researcher obtained contact details for the participants who volunteered to participate in the study, so she could contact them to arrange dates for the interview. The setting for the interview and the date and time was planned with the participants. The rooms that were chosen by participants were private, comfortable and free from disturbances such as telephones. The setting was

arranged so that there were no obstructions between the researcher and the participants during the interview, thus facilitating eye contact and rapport. The researcher honoured the times which were agreed upon between herself and the participants. This resulted in all interviews proceeding according to schedule. The researcher was not wearing her uniform when conducting the interviews so that the participants could feel free and not threatened by the dress code of the researcher. All participants were composed and relaxed during the interview sessions.

On the day and time scheduled for the interviews, the researcher had an information session with the participant during which she (the researcher) introduced herself, explained the topic of the study and briefed the participants about the study. The notion of voluntary participation and the participants' rights were explained. Participants, who agreed to participate, were asked to sign the informed consent form (Annexure I). Data was collected during the participant's spare time, usually when they were off duty. The researcher obtained consent from the participants to use a digital voice recorder to help with data analysis. The interview opened with a grand tour question (Polit and Beck, 2012: 729) which allowed the participants the opportunity to provide rich and detailed information about their leadership competencies as NRP nurses. Interviews lasted between 40 to 45 minutes.

3.2.5 Data analysis

Analysis of the qualitative data entailed categorising, ordering, manipulating and summarising the data and describing it in meaningful terms (Brink, van der Walt and van Rensburg, 2012: 177). After collecting the data, the researcher transcribed the voice recordings verbatim. The collected data was categorised, ordered, manipulated and summarised for interpretation. Figure 3.2 shows the steps undertaken in the data analysis:

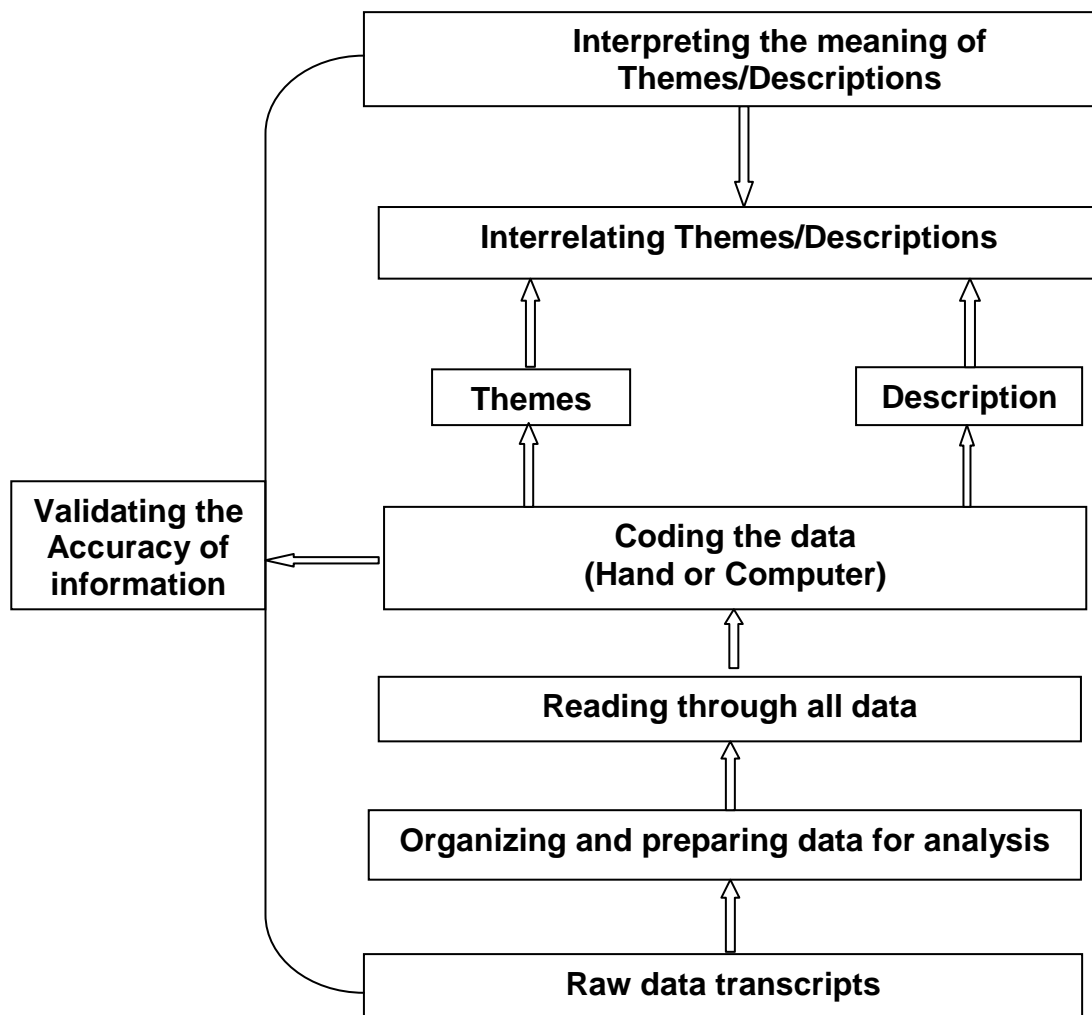


Figure 0.2: Data analysis in qualitative research
Source: Creswell (2014: 197)

The steps recommended by Creswell (2014: 197) were followed for data analyses, namely:

1. Organise and prepare the data for analysis.

The researcher listened to audiotaped interviews then transcribed them verbatim (Annexure L).

2. Read through all the data.

The researcher read and reread through all the transcripts to gain a general sense of the information and reflected on their complete meaning.

3. Begin detailed analysis with a coding process.

Coding is the process of organising the material into segments of text before bringing meaning to the information (Creswell 2014: 197). The researcher

read the transcripts carefully, took text data gathered during data collection, segmented paragraphs into categories, and labelled those categories with a term, often based in the nursing leadership competencies. The researcher picked one interview, which was more interesting and short and on top of the pile, went through this interview, asking herself, "What was it about?" She thought about the primary meaning, writing thoughts in the margin of all transcripts. Once she had completed the task for several participants, she made a list of all topics, clustered similar topics together, took the list back to her data, abbreviated the topics as codes and wrote codes next to the appropriate segments of the text.

4. Generate a description of the themes for analysis.

Description involves a detailed rendering of information about people in a setting. Six themes were generated for this research study. A theme is an abstract entity that brings meaning and identity to a current experience and its variant manifestations (Polit and Beck, 2012: 515). These themes are the ones that appear as major findings in this study, and were used to create headings in the findings section supported by quotations.

5. Making an interpretation or meaning of the data.

Creswell (2014: 197) stated that meaning of data could be the researcher's personal interpretation, inherent in the understanding that the researcher brings to the study from her/his own experience. It could be a meaning derived from a comparison of the findings with information assembled from the literature to confirm past information or diverge from it. In the case of this research study, the interpretation of data emerged from the researcher's personal experience as she herself had trained under the R425 nursing programme.

3.3 Measures to ensure trustworthiness

The researcher enhanced the quality of the research by ensuring trustworthiness of the research. According to Brink, van der Walt and van Rensburg (2012: 171) trustworthiness is described in terms of validity and reliability. Four criteria for developing the trustworthiness of a qualitative inquiry were used: credibility, dependability, confirmability, and transferability (Polit and Beck, 2012: 584).

3.3.1 Credibility/truth value

Credibility refers to confidence in the truth of the data and interpretations of that data (Polit and Beck, 2012: 584; Brink, van der Walt and van Rensburg, 2012: 172). Botma *et al.* (2010: 234) describe credibility as the alternative to validity. The goal of credibility is to ensure that the enquiry is conducted such that the participants are accurately identified and described. Polit and Beck (2012: 277) contend that the researcher should engage in prolonged, persistent observation, triangulation, adequacy, peer debriefing and checks from peers. During the study, the researcher used a voice recorder and semi-structured interviews to ensure the truth value of the study. Prolonged engagement was also involved where the researcher had two visits to the participants as well as spending enough time with them during the interview (Polit and Beck, 2012: 584). The purpose of the first visit was to explain about the important aspects related to the study while the second was on interview.

The researcher was persistent in data collection (probing), read the data repeatedly, provided adequate time for interviews and asked the opinion of an expert (supervisor) regarding the interview guide. Data saturation was reached as eventually, no new information and themes became apparent.

3.3.2 Dependability

Dependability refers to the delivery of evidence such that if it were to be repeated with the same or similar participants in the same or similar context, its findings would be similar (Brink, van der Walt and van Rensburg 2012: 172-173). Dependability is the extent to which similar findings would be obtained through repeated research (Polit and Beck, 2012: 585). It is the alternative to reliability in which the researcher attempts to account for changing conditions in the phenomena being studied. This implies that the researcher should be flexible. In this study dependability was upheld by considering ethical standards, namely quality, respect for participants and functioning within the research protocol.

The exact methods of data gathered (including raw data such as the voices recorded and interviews) and their interpretation was clearly and comprehensively described.

3.3.3 Transferability/applicability

Transferability refers to the capacity to apply the findings in other contexts or to other participants (Brink, van der Walt and van Rensburg, 2012: 173). Transferability refers to the probability that the study findings have meaning to others in similar situations (Polit and Beck, 2012: 197). Purposive sampling was used: participants (newly registered professional nurses) with first-hand experience and who meet the set criteria were used. Thick description of research methods and processes of data was supplied. The fact that data were collected from the NRP nurses strengthened the usefulness of the study to other settings.

3.3.4 Confirmability/neutrality

Confirmability is the traditional concept of objectivity (Polit and Beck, 2012: 585). It is the extent to which the findings are the outcomes and not the biases of the researcher (Polit and Beck, 2012: 585). To enhance confirmability of this study, the researcher wrote constant notes throughout the study as described in data collection. Confirmability is used to guarantee that the findings, conclusions and recommendations are supported by the data. There must also be internal agreement between the investigator's interpretation and the actual evidence. Peer review was implemented to ensure consensus between researcher and the supervisor and co-supervisor regarding the interpretation of data and findings. All three participated in coding the transcribed interviews and consensus was reached on what was important and the meaning thereof. Audio recorded semi-structured interviews, transcribed verbatim and all records are available for audit. Findings were linked to the literature.

3.4 Ethical considerations

The researcher obtained ethical approval from the Durban University of Technology Institutional Research Ethics committee (Annexure A), as well as permission from, the Kwa Zulu Natal Department of Health (Annexure B1), eThekweni district health office (Annexure C) and chief executive officers for the selected regional hospitals (Annexures D1, E1, F1 and G1), to conduct research. Informed consent (Annexure I)

was obtained from the participants. The researcher made contact with the senior nursing manager of the selected regional hospitals where data was collected.

3.4.1 Fundamental ethical principles

According to Brink, van der Walt and van Rensburg (2012: 34-37) and Grove, Burns and Gray (2013: 162), there are three essential ethical principles that guide researchers during the research process. These principles are: respect for persons which involves the right to self-determination, the principle of beneficence where the researcher has to safeguard participants' right to protection from discomfort and harm, and the principle of justice which includes the right to fair selection and treatment and the right to privacy. The researcher adhered to these principles as follows.

3.4.1.1. Principle of respect for persons

This principle includes the right to self-determination and the freedom to participate or not to participate in the research. The principle of self-determination means that the potential participants have the right to decide willingly to participate in the study, without risking any penalty or detrimental treatment. It means that the study participants had the right to question the researcher, to refuse information or to withdraw from the study at any given time if they felt uncomfortable (Brink, van der Walt and van Rensburg, 2012: 36; Polit and Beck, 2012: 172). In this study, participants participated voluntarily and no one decided to withdraw from the research at any stage. Participant confidentiality was ensured through the use of pseudonyms and keeping the consent forms separate from the interview scripts. The researcher respected the autonomy of each participant through their voluntary participation in the study.

3.4.1.2 Principle of justice

The ethical principle of justice involves the participants' right to fair treatment, the right to privacy and the right to confidentiality.

Right to fair treatment means that the researcher must treat people who decline to participate in a study, or who withdraw from the study after agreeing to participate, in a non-prejudicial manner. Participants must have access to the research personnel for any desired clarifications and that participants have to be treated in a gracious and tactful manner at all times (Polit and Beck, 2012: 155; Brink, van der Walt and van Rensburg, 2012: 36). The contact details for the research personnel were written in the information leaflet that was given to the participants. Participants were encouraged to contact the researcher at any time for clarity.

Right to privacy: Semi-structured interviews were conducted in a private room. Participant's views were voice recorded with the permission of each participant. The semi-structured interviews were conducted at the venue chosen in agreement with the participants to assist them to be calm, comfortable, relaxed and to ensure privacy. They were informed that pseudonyms would be used to improve the readability of the results.

Right to confidentiality: The researcher guaranteed that there was no link between the participants' identity and the organisation to the research data that was used in the study. The researcher intends to publish the results of the study, but the researcher informed the participants that personal characteristics would not be revealed in order to maintain confidentiality. Completed interview guides are now locked in a steel cupboard for a period of five years. A password protected, personal computer owned by the researcher was used to store electronic data. After five years this data will be deleted by the researcher.

3.5 Conclusion

The study utilised a qualitative descriptive exploratory design which aimed at exploring and describing the leadership competencies of the NRP nurses one year after registration with the SANC. Data was collected through semi-structured interviews and analysed using Creswell's steps. Trustworthiness was ensured through credibility, dependability, transferability and confirmability. Essential ethical principles that guided this research study were the principle of respect for person

and principle of justice. In the following chapter, the results will be presented and discussed.

CHAPTER 4: RESULTS

4.1 Introduction

This study examined the leadership competencies of NRP nurses working in public hospital nursing units during their first year of registration with the SANC. This chapter will focus on reporting the findings that were realised through the process of data collection and data analysis.

4.2 Demographic profile of the participants

The researcher purposefully sampled eight R425 trained professional nurses, in their first year of registration with the SANC, who worked in the selected regional hospitals of eThekweni health district.

The participants were all female: four African, three Indians and one Coloured ranging in age from 24 to 35 years. They were all employed in teaching hospitals where nursing students are allocated for clinical practice, had earned a four-year comprehensive diploma (R425) in nursing (general, psychiatric and community) and midwifery, and had worked for six to twelve months after their professional registration with the South African Nursing Council (SANC) as a nurse and midwife. All the participants were given pseudonyms throughout the results chapter in order to improve the readability of the chapter.

4.3 Presentation of the research findings

The findings of this qualitative exploratory study describe the leadership competencies of NRP nurses as experienced by them. The analysis of the data, collected during the eight interviews, identified six themes and fifteen sub-themes as illustrated in Table 4.1. Each theme is discussed in detail below, and relevant verbatim quotations from the participants' transcripts are presented.

Table 4.1: Themes and subthemes from the study

THEMES	SUB-THEMES
1. Support	<ul style="list-style-type: none"> • Orientation • Mentoring
2. Uncertainty and fear of having to delegate	<ul style="list-style-type: none"> • Teamwork • Respect • Shortage of staff • Absenteeism
3. Competence	<ul style="list-style-type: none"> • Self-confidence • Assertiveness
4. Transition to professional nurse	<ul style="list-style-type: none"> • Reality shock • Attitude • Trial and error
5. Unethical practices observed: fear of victimisation	<ul style="list-style-type: none"> • Unethical practice by nursing personnel • Unethical practice by medical doctors
6. Difficult relationships	<ul style="list-style-type: none"> • Treatment by nurses • Treatment by doctors

4.3.1 Theme 1: Support

Participants indicated that they did benefit from support from supervisors and other staff members, which made things a bit easier for the smooth running of the units. Participants mentioned that they received support to adjust as professional nurses in charge of the nursing units. The following subthemes were identified: orientation to the hospitals and/or units and mentoring.

4.3.1.1 Subtheme: Orientation

The orientation of personnel to the work environment facilitates the smooth running of the department, promotes time management and the efficient use of equipment designed to monitor patients. Participants mentioned that they were orientated and nursing unit managers were teaching them especially in the nursing units where they were allocated for the first time as professional nurses.

Thobile: *The in charge or the operational unit manager was very open, she was very willing to teach, she was always around regarding supervising and she delegated someone who was able to help and assist with a lot of things that I wasn't familiar with, especially in that unit, with new machinery and what not.*

Participants mentioned that unit managers were willing to teach them and were delegating somebody to assist them as they were new in those units.

Marlene: *The in charge was very open, willing to teach and always around regarding supervision; the structure there was very supportive; they were always ready to show me the road and to guide me.*

Participants acknowledged their orientation which included in-service training on conflict management which made it easy for them when they were working as professional nurses alone in the nursing units.

Jabu: *Sometimes we have in-service where we are taught about how to manage conflict situations, the steps to be followed. They even made examples of such conflicts.*

4.3.1.2 Subtheme: Mentoring

Most of the participants conveyed the need for mentorship from the multiple stakeholders who were involved in assisting them to develop during the transitional period from community service nurse to professional nurse. The researcher learnt that mentoring did not occur in most units, which was contrary to that envisioned for the transition. The expression “*being thrown in the deep end*” was used by all the participants in the study who expressed a lack of support and mentoring from their seniors.

Jabu: *For me it was like you throwing yourself in the deep end because they expect you to do a job of a PN, mhhh ... you have to be responsible, you have to do all the duties of a PN, and being a student we are not exposed that much so to just run the whole ward yourself, so for me eeey ... it was a big change from being a student to professional nurse, because they made me to run a ward.*

The participants were of the view that they were let down and just put into the “deep end” by being left alone to do everything, in order to test their coping abilities and to expose their lack of knowledge.

Thobile: *I learnt to find my feet and know everything even when I literally knew nothing, it was a shaky ground and had to stabilise it yourself because the staff is looking up to you as a sister, regardless of your experiences, to them as long as you are the sister with three bars, then they expect you to know everything.*

One of the participants stated that they were not given mentors unlike other categories of staff who are assigned mentors. They felt that even the unit managers were not advocating for them as NRP nurses.

Celeste: *There's no "this is your mentor, these are the things we are going to do", but it's just "find your way", so you have got nobody to advocate for you as even a nurse in the ward.*

4.3.2 Theme 2: Uncertainty and fear of having to delegate

Some participants reported that the delegation of duties to nursing personnel was manageable, nurses showed respect, and accepted duties delegated to them. The following subthemes were identified: teamwork, respect, shortage of staff and absenteeism.

4.3.2.1 Subtheme: Teamwork

Participants reported that team spirit and unity was displayed by nursing personnel especially with the execution of delegated duties. Nursing care was rendered on time as all nurses were participating; there was no hierarchy among the nursing staff with respect to the delegation of tasks.

Marlene: *In this institution there's more team work, and there's nothing like hierarchy when it comes to working in the unit, everybody is actively involved regardless of the position the people hold in the hierarchy, it only comes in terms of specific nursing care, but even so, if there's no professional nurse, I'm the junior professional nurse, they won't say, no you going to do the medication because you are the sister, we'll all do medication, we'll all do dressings.*

Sandra: *Operational manager always gives everybody an opportunity, it's not like particular person, she was always part of what we were doing, participating, like*

doing the dressing room, it's not like you are the sister so you won't do certain things, like dressing room and it's only staff nurse, we all do things as a family, as a team, there was that team spirit.

Participants stated that allocating work to a team was very helpful as even if one or more nurses were not on duty, nurses accepted the delegated duties with no difficulties.

Meandre: *Usually it helps if it goes in teams, because you get used to same people and the delegation gets easier to do because if this one has done this today, then you know that tomorrow it is someone else. And it helps even when you are short staffed, but you know that if I have so and so, then I know that with medication I am okay.*

4.3.2.2 Subtheme: Respect

Respect from nursing personnel was identified by participants as helpful because it made them to feel that their contribution to patient care was valued and it gave them confidence in their nursing practice. Although a junior professional nurse' opinions and beliefs may not be as mature as a senior professional nurse's, the other nurses respected NRP nurse's decision-making and respected duties delegated to them by professional nurses.

Thobile: *I think it was seven months, and I stayed there, and the feedback I got from staff regarding my own leadership in the unit, I was very respectful, I was able to stay on their level, but when the time came, I was also able to delegate them accordingly and to lead them accordingly, it was easy because of that.*

Meandre: *With delegation we would do it on a paper where people would sign for their delegated staff so as to accept their duties and to take the responsibility for those allocated duties, so with that I had no problem at all at first, even though I was new and younger, but they respected me as a sister, even though they were calling me 'baby sister', but were giving me my place.*

Marlene: *They respect me, they give me my position because they know that regardless of my age, but they know that in the ward I'm a sister, and when I'm*

delegating you, I delegate you according to the level of education and competence; then in the tea lounge I am a baby, you can send me anywhere, but once we are back to the unit I'm the sister and I give orders. The older ones won't give you problems when you delegate them to do something, for example, if the doctor needs the patient's wound exposed, they will not question you because they respect the fact that you are the professional nurse.

Participants emphasised that they were respected by team members in the units where they were allocated; even when they delegated duties to senior enrolled nurses, those duties were carried out without complaints. Participants indicated that respect is essential in leadership as when delegating duties to nurses the respect makes it easier to do.

Thobile: *In the medical units it was not as free flowing, it was a bit tougher, but I found out that as time goes by, staffs respects you if you are working with them, instead of working beyond them, so you have to be on the same level with them, but not on the above level.*

Meandre: *If you respect your staff, they can do anything you ask them to do, and that way there won't be any conflict.*

Marlene: *If you respect people regardless of their level of education, then you are likely to learn a lot because people will like working with you and they get very helpful. You just need to know that respect is a two-way process.*

Deidre: *You learn to respect and appreciate people you work with, because they are senior to you by experience, and they are knowledgeable and you can get a lot of information from them. You must also thank your staff at the end of the day.*

4.3.2.3 Subtheme: Shortage of staff

Participants highlighted that there was a shortage of staff in their allocated units as they did not have any senior professional nurses to support them during their shifts. They also indicated that operational managers came to the nursing units for unit rounds only. They did not assist even if they were aware of the staff shortages.

Meandre: *My experience is that there's not much loyalty among the staff, there's a shortage and a very bad shortage of staff, so as soon as you start, they know you trained in this hospital, you know this hospital, we know you as a student, we know your competence, you do you just swim from orientation you get into the ward and you are a sister, whatever the students, or the ENA or the staff nurse wants, you should be able to answer.*

Deidre: *The operational managers act as if they don't know what is happening in the wards, that there is shortage of staff and they don't even assist.*

As a result of nursing staff shortages, NRP nurses were working through the week without being given any time off and were sometimes summoned from home, to come into work, when they were off duty. Participants also mentioned that the staff shortage was a challenge when delegating duties. Despite the working together of different categories of nurses, when it came to staff shortages some of that collegiality disappeared and people's attitudes hardened.

Thobile: *Most of the wards that I worked in, we did have a lot of challenges like work overload, shortage of staff and equipment for patient care, but not much with conflict.*

Deidre: *Even if you were supposed to be off but you cannot get your day off because one nurse has to be on duty and one has to be off. Sometimes you are called from home to come and work during your off-duty day because there is no professional nurse in the unit to take charge.*

Despite most participants agreeing that there were no issues with delegation, there was a dissenting voice from two participants. They mentioned that even when they delegated duties to senior enrolled nurses, sometimes those duties were not attended to.

Meandre: *That is the only problem I have with regards to delegation of tasks, the staff shortage and being unable to get the right category for certain duties and the other category of staff will start complaining if you allocate them for those duties.*

Sandra: *I think the fact that I am younger than most staff and they are older in age and senior by years of their service, they tend not to listen and won't even execute the duties delegated to them, and the staff nurses has this mentality that they have been there for so long so you can't tell me anything.*

4.3.2.4 Subtheme: Absenteeism

An increase in workload was mentioned by the participants, and was thought to be ascribed to the staff shortages. Not surprisingly, the shortage of staff was said to be directly increasing the rate of absenteeism in some professional nurses, as various participants stated that the delegation of nursing duties was difficult due to the increasing absenteeism.

Meandre: *This leads to staff ending up getting overloaded with work, and the shortage of staff has led to high levels of absenteeism because staff becomes exhausted.*

Professional nurses mentioned that nursing care was affected by absenteeism, as nurses were becoming sick due to excessive workload.

Deidre: *Absenteeism rate is very high and it was a main cause of low morale and poor productivity in nursing staff.*

Meandre: *Then it happens that each professional nurse will then work for maybe three to four days without rest, then will get tired and report off sick, so you end up working without having an off because you are covering for the staff that is not on duty.*

4.3.3 Theme 3: Competence

Participants in this study indicated that they gained competence when they were left alone to be in charge of the nursing units. Self-confidence was promoted by decision-making, independence and problem-solving abilities. The following subthemes were identified: self-confidence and assertiveness.

4.3.3.1 Subtheme: Self-confidence

Participants indicated that despite being left alone to manage and lead the nursing units, they managed to delegate and supervise the work. They mentioned that to be left alone groomed them and it helped them to not forget the skills that they had acquired on the job by “doing.”

Deidre: *Being left alone in unit to find my own way has somewhat groomed and grown me, because you never forget the skill you mastered under difficult circumstances.*

One participant mentioned that working alone encouraged her to work harder with an open mind as she was answerable for the nursing unit. It encouraged her to take responsibility and accountability for her actions.

Sandra: *“The truth is, I can manage on my own, and that’s when I learnt even more, because when I am alone, I have to work with more open mind, knowing that it’s only me and I am in charge and answerable for my acts and omissions.*

Participants mentioned that they gained self-confidence, independence, decision-making and problem-solving abilities. They also mentioned that to be left alone to be in charge of the unit was very helpful and that they grew in confidence.

Deidre: *I gain so much knowledge and developed problem solving skills that enhanced my confidence and strengthened my decision-making.*

Participants mentioned that as they were working in a training hospital, students required information from them as professional nurses which encouraged them to go back to their textbooks to update their knowledge. This in turn enabled them to understand the patient’s conditions which in turn helped to develop self-confidence.

Sandra: *I am also confident about being autonomous now, I think I am competent enough to manage the unit on my own, because you really need to look and learn, not just follow, follow without learning, so I can proudly say that I have learnt a lot, especially with the leadership of the unit.*

Celeste: *You learn to grasp fast and on the go, until you achieve the self-confidence. You also have to go back to your textbooks for knowledge update reasons as students always ask questions from professional nurses.*

4.3.3.2 Sub-theme : Assertiveness

Participants stated that due to the experience they gained from the day of appointment to the present, they developed assertiveness and were able to stand up for themselves. Some participants stated that assertiveness helped them to manage the unit the way they wanted to, with little resistance from the other staff members.

Meandre: *I learnt to speak out and stand firm on what I believe, I have grown to be so confident and say when I do not like what the doctors or even nurses do to the patients, but I approach them in a professional manner, and I still respect them; you need to be firm on your decisions sometimes.*

Deidre: *At first I gain confidence in the ward management, it was not easy for me to come to the fore when I need help. I was less scared, and also it taught me to be assertive and to ask when I do not understand.*

Professional nurses mentioned that assertiveness with respect and a positive attitude helped them to work peacefully with nurses and doctors. Participants indicated that to be firm and treat all nurses as equal as possible, was the key to assertiveness.

Marlene: *I made it clear that in the unit I am in charge and a professional nurse, and I will delegate the staff according to the level of competence, education, and I think positive attitude is the key to smooth running of the unit. Being firm when giving authority and respecting each other regardless of the category is important when working as a team.*

Deidre: *You learn to be assertive but with positive attitude, also learn to respect and appreciate people you work with, because they are senior to you by experience, and they are knowledgeable and you can get a lot of information from them.*

Brook: *You just have to call them aside and you need to be assertive; it's when you know how to assert yourself in the correct manner, and be assertive and not aggressive, you find that it can be easy because your staff can understand "no she is putting me there because she can see that maybe I need help there".*

Participants mentioned that nurses and doctors developed negative attitudes when they are corrected for unethical behaviour. However, the participants mentioned that they had learned to be firm and continued to correct all health personnel, irrespective of their category, when they behaved unethically.

Deidre: *You learn to be assertive to the doctors and tell them to make use of other categories of nursing staff and not necessarily the professional nurse. You have to tell them that I am all by myself, so make use of anybody in the ward that can help you, so as to make our day run smooth.*

Brooke: *You need to be bold and stand your ground firm, but not be aggressive when you tell them about the unethical practices that they do.*

4.3.4 Theme 4: Transition to professional nurse

Participants indicated that there was a lot of frustration and uncertainty when they were expected to be a professional nurse. The following subthemes emerged and are discussed below; reality shock, staff attitude as well as trial and error.

4.3.4.1 Subtheme: Reality shock

The participants experienced was that the transition from being a student nurse to a NRP nurse exposed them to many expectations and challenges that they never encountered while they were student nurses.

Brooke: *It was a very stressful day for me and I was very frustrated as I was new in the profession and did not even know the unit as it was my first day, I did not know what I was doing there, but I learnt from that scary experience because I never forgot.*

Staff shortages led to premature termination of the orientation programme, leaving participants to manage the nursing units on their own. This exacerbated a sense of not being welcome in the nursing unit as well as a measure of distress in the participants. They perceived that senior, experienced nurses were reluctant to acknowledge their new, professional registration status.

Deidre: *I would be scared when I saw the doctors coming into the ward and I would say to myself, 'ahh we mha, I'm alone if doctors what will I do? I was not sure whether to join or not to join the doctors' rounds. You are even scared to be left alone in the ward, and it's not even easy to ask who the doctors are and which team they belong.*

One participant stated that language was a problem in her institution. It was difficult for her as she only speaks and understands English, as in all other institutions, the medium of language is English.

Marlene: *Again the medium language is a problem with the institution, because when I was still new, it came as a shock to me that with some units the report will be handed over in vernacular, instead of English, and if you only stick to English then you are seen as someone who thinks she is better than others.*

4.3.4.2 Subtheme: Attitude

Participants mentioned that having a positive attitude is a two-way process. As professional nurses, they needed to show a positive attitude when dealing with staff, either for conflict management or solving any misunderstandings. Staff members needed to show a positive attitude towards professional nurses when they delegated duties to all nursing personnel.

Meandre: *I learnt that most of the time the attitude is important and approach, and you don't have to give people what they want, but learn to listen to your staff, and also to reason with them.*

Sandra: *You have to deal with the conflict when you are in the right state of mind, and your attitude should be a positive one and again you have to remain neutral and non-judgmental and always follow the protocol for conflict management.*

Participants gave accounts of the negative attitudes they had identified from senior enrolled nurses that they worked with.

Brooke: *You get conflict when you are trying to show someone how the certain procedure is done, but she gets so adamant and starts telling you that I was doing this long before you were even born, and yet what she is doing can adversely affect the patient.*

Thobile: *Very often, in medical wards, it was kind of sadly a much known thing that you are left by yourself, but all the other sections there were lot of sisters there, so it was not the problem with MOPD as well, but medical wards, you were literally left there alone, and there were crickets in the background in your head. I found that it goes with respecting you, but I found that the few sisters had a negative attitude; unfortunately that attitude came mostly from those individuals who bridged into being professional nurses.*

One participant mentioned that some doctors do not work with her as she is new, and other patients do not want to be assisted by a junior professional nurse.

Jabu: *Doctors do not want to do rounds with the junior sisters; they only want senior sisters to do rounds with them. And even the patients they have that negative attitude towards the junior sisters, as if they do not know what they are doing.*

4.3.4.3 Subtheme: Trial and error

NRP nurses themselves identified that they needed the opportunity to practice their skills and apply their knowledge in practice, but this was difficult in a busy environment.

Deidre: *Operational managers won't even organise staff to work with you as someone who is new in the profession, you just have to work through trial and error and through your mistakes.*

One of NRP nurses felt that unit managers who left them alone in the nursing units to be in charge without supervision, expected them to manage the unit like senior professional nurses.

Marlene: *It is like you are just thrown in the deep end and it is either you sink or you learn how to swim, or you drive on against the wall and you make a way around, but you have to try and keep afloat. Because it's either do or die. It's either you can let them swallow you up and eat you whole and then spit you out.*

4.3.5 Theme 5: Observed unethical practices: fear of victimisation

Participants observed some unethical practices by nursing personnel as well as by medical doctors. The following subthemes were identified: unethical practices by nursing personnel and unethical practices by medical doctors:

4.3.5.1 Subtheme: Unethical practice by nursing personnel

Participants reported that basic nursing care such as putting two identity bands on a patient for easy identification was not observed in some of the units. They mentioned that sometimes the wrong procedure was implemented on a patient, even incorrect surgery, because of the wrong identity of a patient.

Thobile: *Simple things that we learn, basic things that we learn, no identification, to a point where the staff member was disciplined for giving the wrong medication to a wrong patient.*

Participants mentioned that the vital signs of a patient are very important for the patient's recovering or to detect any deterioration in their condition, but nurses do not bother to check the vital signs but record them without checking which is very dangerous to the patients' health. Participants also mentioned that observations that are done before meals like blood glucose monitoring are sometimes omitted which put patients at risk of rising blood glucose in their body.

Thobile: *Also, another unethical practice that I identified was in MOPD, it was a community service professional nurse that had come in, and she was asked to give*

an actrapid infusion, gave sixteen or seventeen units; because of the type of insulin syringe that was used, the nurse gave double the prescribed dose. The patient's insulin levels started dropping rapidly, and the patient started getting sweating, very weak, then the doctor ordered to stop the infusion. It was only discovered when the community service sister was now giving another patient the insulin.

Meandre: *Examples of these is when the nurse does not check the blood pressure of the patient who is hypertensive or hypotensive, or when the blood glucose levels of the diabetic patients have not been checked before a meal, and you find out that even the medication has not been given, and nobody reported anything to you as a sister in the ward.*

Marlene: *From when the nurse decides that she is not going to check the blood pressure of the patient but will just take from her head and write the figures down.*

Participants mentioned that nurses are careless when performing certain procedures that they have been allocated according to their level of training, such as the sites to prick when monitoring blood glucose in children. Another noticed unethical problem was with the calculation of doses for medication especially for children and when nurses are corrected they pretend not to know the calculations.

Brooke: *This other patient when she asked the mother why she was back in the ward, the mother told the other patient that she is back because her baby was hurt and the arm is limp, this other patient told her that your baby was hurt by the sister in this ward and not in labour ward, the sister was checking blood sugar levels of the baby, and she did not use the foot of the baby, but she used the arm and she wrapped the arm of the baby and left the baby like that.*

Thobile: *Another unethical practice that I identified was more or less involving was in PRU. A baby was getting pavalex, so the prescription was 350mg, and the pavalex vial is a gram. So I saw the nurse opening three vials I asked, "why are you opening so many vials and yet you only need one vial?", so she said, "no its 3500mg and the vial is 1gm so I have to open three and a half of the fourth vial", but she did not believe me because I was still new.*

4.3.5.2 Subtheme: Unethical practice by medical doctors

Participants mentioned that doctors do not maintain the confidentiality of a patient when it comes to their medical condition, as they talk aloud in the nursing unit about the patient's condition in a way that other patients realise what is wrong with that patient.

Meandre: *When the doctors would talk about another patient during the doctors' rounds when dealing with another patient and would even be loud about that.*

Celeste: *Doctors don't talk to the patients during the rounds, but they talk to each other and to the consultants who are standing at the back, instead of talking to the patient who is right in front of them.*

Participants felt that doctors needed to be taught about infection control principles such as wearing of sterile gloves when assessing a woman in labour.

Brooke: *The doctor used the unsterile glove to PV the patient, and I said to him, "are you going to PV the patient?" he said "yeah", and I asked, "with the unsterile gloves?" and he said, "agh, does it make any difference?" and I said, "you know what, what you have just said now makes a difference, would you be happy if your wife is done PV with unsterile gloves?" He said laughing, "ok bring me the sterile gloves then."*

Participants stated that some of the doctors who have a private practice use the government hospital equipment for their private clients without the hospital management being aware of the practice. They mentioned the use of government laboratory services for investigations and sometimes ordering blood for a blood transfusion in a private patient and not for a government patient.

Deidre: *Doctors who have private practices have a tendency of abusing public hospital's equipment for their selfish need, like coming with the specimens from their private practice to the public hospital to be sent to the public pathology department for diagnosis purposes. They also order blood from blood bank and to find out they are not ordering for the patients of this institution but they are ordering the blood for their private practice patients.*

Deidre: *Another thing they steal the equipment from the public hospitals to use it in their private practice, so if the laryngoscopes have been used, you have to make sure that they have been returned and locked because if they get lost and you are the one who was the last one to use them with the doctor, then you can end up writing statements for something done by the doctor.*

4.3.6 Theme 6: Difficult relationships

Difficult relationships with other nurses and doctors appeared to present problems for NRP nurses.

4.3.6.1 Subtheme: Treatment by other nurses

Participants described the conduct of other nurses towards NRP nurses, or observations of the way other nurses treated NRP nurses. Conflict cited by NRP nurses was associated mainly with a wider range of healthcare workers. There was a sense that NRP nurses needed time to gain the confidence of their nursing colleagues in the initial stages after qualification.

Marlene: *She would also choose the people she wanted to work with in the unit, and she would show you if she doesn't like you, she would just single you out. She was acting like a dictator. People use their positions in power to bully the staff around, and mostly these kind of senior professional nurses are doing this because they lack knowledge.*

Senior professional nurses expected NRP nurses to go beyond their expertise as they were only one year after registration. However, senior enrolled nurses and student nurses were not even listening to advice from NRP nurses.

Celeste: *The sisters in the wards who are not R425 trained expect you to do more than you can, especially my experience in the medical ward, where you get acutely psychotic patients, now they don't want to go closer to these patients, they expect you to be the one to go there and handle this patient because you have a psychiatry bar. They always remind you that they are not psychiatric trained. Even with the administrative duties, they will leave you to do things on your own just to spite you.*

Marlene: *Because the students are almost my age and even older, they take advantage of the new professional nurse, especially those still on community service placement. So it's like they querying how come I delegate them, but I always tell them that I'm sister in the ward and I have a right to allocate them by virtue of my position in the profession.*

Thobile: *I said to bridging course student nurse, one day, so and so, listen, if you are not doing this, when you become a qualified professional nurse you are going to come upon a number of problems, because you won't know what you doing, whereas you will be by yourself most of the time and there are not great number of sisters in the medical wards especially, She gave me a look, and she said ... "arg, you say as if you know what I am doing, ok fine", that was it.*

4.3.6.2 Subtheme: Treatment by doctors

Some of the participants commented on their experiences with doctors. To be avoided by the medical professionals or ridiculed by them hampered the ability of NRP nurses to initiate further communication or relationships with providers and could affect the quality of patient care.

Thobile: *I learnt that the understanding between the nurses and the doctors was lacking, because I feel there should be a level where you meet as the healthcare team members. Doctors will not even introduce themselves, they will just walk up into the ward, with no name tag to identify themselves, and they are not even wearing the coats, they do not even say nothing to the nurses, they just walk up to the patient and walk out of the ward without saying nothing to the sister.*

Jabu: *Doctors do not want to do rounds with the junior sisters; they only want senior sisters to do rounds with them.*

Marlene: *The doctors think and feel they know too much and more than a sister and they tend to undermine the nurse's opinion about the patient. For an example you as a nurse, will be augmenting the patient, then the doctor authorises the patient to be taken to theatre now, and you tell the doctor that the patient is still being augmented, and she should at least first p.v. the patient, (in cases of labour ward patients). The doctor will tell you that, "but I have p.ved the patient at 15h00 and she was at 5", but*

the time now is maybe three hours since that 15h00 of the last p.v., they tend to make hasty decisions about the patients without following the necessary steps of decision-making, they will say the patient must be ready for caesarean section but the doctor has not even checked how far the patient's cervical dilation.

Deidre: *I have noticed that most of doctors have a lack of respect towards the nurses in almost all the units and departments, but then lately the nurses have learnt to stand up for themselves and be assertive.*

However other participants did not experience negativism from doctors and found that the doctors were willing to work with them in the unit.

Meandre: *I did not get much negativity from the doctors, I remember my first time in the doctors' rounds, and I was not wearing my epaulettes, so the consultant doctor asked the sister I was with in the rounds, and the sister told them that I was a new sister in the ward, and that was that. Otherwise I really have no bad experiences with the doctors. So as soon as they know you are a sister, they only expect you to work with them and know your work, they do not expect you not to know your work when you were introduced as a sister to them, so you just need to learn fast and stay clued up with your sister's duties, especially the duties concerning the doctors and the patient, you must know your patients.*

Deidre: *The operating theatre doctors they are very professional and they listen to your opinion as a nurse and that makes you feel confident. They make you feel comfortable with them, because as long as you do your work to the best of your ability, they trust your judgement about the patients in recovery room.*

4.4 Conclusion

In this research, six themes emerged: support, uncertainty and fear of having to delegate, competence, transition, unethical issues observed by the participants, and difficult relationships. This study has highlighted the positive experiences, as well as the barriers and difficulties, experienced by NRP nurses as senior professional and enrolled nurses did not show any collaboration in the current workplace environment within training hospitals, as experienced by NRP nurses.

Linking of the different themes and sub-themes with the reviewed literature will occur in Chapter 5, and relevant recommendations will be made.

CHAPTER5: DISCUSSION OF RESULTS AND RECOMMENDATIONS

5.1 Introduction

This study examined the leadership competencies of NRP nurses working in regional hospital units during their first year of professional registration with the SANC in eThekweni district, KwaZulu-Natal province. The overall objective of the study was to explore the competencies of NRP nurses in selected objectives within the theme of uncertainty and fear due to exposure to reality. The three objectives chosen to explore were: uncertainty and fear of having to delegate; inability to manage conflict; and the observation of unethical practice: fear of victimisation.

The results of this study were grounded in interviews with eight nurses who were in their first year of registration with the SANC. The interviews were analysed using qualitative content analysis. The findings illustrate the nurses' transition from "being a novice" to "becoming a competent practitioner" and are in line with the first three stages of Benner's description of nurses' maturation from Novice to Expert (Hughes and Quinn, 2013: 394-395). This research study described the competencies of the three constructs of leadership, namely: uncertainty and fear of having to delegate; inability to manage conflict; and the observation of unethical practice: fear of victimisation in the NRP nurses. During the first stage (Novice nurse) the NRP nurses are guided by rules, have difficulty prioritising, and follow advice without question. During the second stage, (Advanced beginner) the NRP nurses have greater experience and their self-confidence is starting to grow, but they still have difficulty grasping the situation as a whole and need help with setting priorities. During the third stage, (Competent nurse) the NRP nurses can organise their work and deliberately plan for coming events, based on considerable conscious, abstract, and analytical contemplation of the problem (Hughes and Quinn, 2013: 394-395).

5.2 DISCUSSION

In this research, six themes emerged: support, uncertainty and fear of having to delegate, competence, transition, unethical issues observed by the participants, and difficult relationships.

5.2.1 Support

Orientation and mentoring were identified by participants in this study as important concepts in support of NRP nurses. These concepts enabled the NRP nurses to facilitate smooth facilitation of activities, promote time management and efficient use of equipment designed to assess and prevent complications. Participants acknowledged support from supervisors and other staff members which made smooth facilitation of activities a little easier. Participants mentioned that unit managers were willing to teach them and did delegate somebody to assist them with the environment as they were new in the units. The NRP nurses mentioned that unit supervisors encouraged them to successfully assume administrative duties and adapt to the role of the professional nurse in the nursing unit (Ashton, 2012: 103). The NRP nurses indicated that working with experienced professional nurses with a positive attitude automatically allowed them to develop a reciprocal approach as a sign of humanity, thus enhancing the team spirit and the smooth execution of duties in the nursing unit (Geyer, 2013:226).

Mentoring is acknowledged as being the best way to create a supportive environment for socialisation into the nursing profession (Chiliza, 2014: 75). Mentors should guide and support NRP nurses as this will enhance improvement in their competence (Lekhuleni *et al.*, 2012: 58). Zagabe (2013:19) supported the idea that mentoring was beneficial when a long-term relationship was formed between a NRP nurses and a knowledgeable nurse who supported the maturation of the novice. Furthermore, Zagabe attested that nurses were responsible for their professional development and knowledge advancement to enable them to provide competent and safe care for patients and their families.

However, the researcher learnt that mentoring, although acknowledged as an important aspect of support in nursing, did not occur in most units, which was contrary to that envisioned transition. The expression "*being thrown in the deep end*" was used by the participants who expressed lack of support and mentoring from their seniors. Most of the participants conveyed the need for mentorship from the multiple stakeholders who are involved in assisting them to develop during the transitional period. Lack of support and caring on the part of management is common in the

nursing environment where the majority of the NRP nurses did not receive enough support and caring from their nurse managers (Makhakhe, 2010: 45). The NRP nurses had difficulty in adapting to the work environment because of limited support, verbal abuse, role conflict and unexpected workloads (Tsotetsi, 2012: 87). The NRP nurses are prematurely expected to take on an increased level of responsibility, seemingly without the back-up, guidance and support of a mentor or supervisor (Makhakhe 2010:34). Phillips *et al.*, (2014:109) cited that the NRP nurses reported being so shocked and distressed by the inadequate support, unprofessional workplace behaviour, and isolating experiences encountered, that they sometimes questioned their vocation.

Orientation of personnel to the work environment facilitates smooth running of the department, promotes time management and efficient use of equipment designed to assess and prevent complications (Walker *et al.*, 2013: 509). The NRP nurses indicated that they were adequately orientated in some units, which enhanced the smooth running of the units. Formal comprehensive and individualised orientation programmes are integral to the transition of NRP nurses from community service nurses to professional nurses (Teoh, Pua and Chan, 2013: 144; Govender, Brysiewicz and Bhengu 2015: 5). NRP nurses stated that they were warmly welcomed and adequately orientated by their seniors (Ndaba 2013: 46). NRP nurses should be welcomed into the unit and proper orientation and supervision ensured so as to strengthen retention of staff (Chiliza, 2014: 77).

However, the study also revealed that the orientation varied in different institutions and units. Some participants stated that they were made to work as professional nurses in charge of the units from the commencement day of their employment as professional nurses, without being orientated. This finding concurs with Du Plessis and Seekoe (2013: 9) who reported that participants in their study felt that the hospital and unit leaders did not co-ordinate their functions or orientate them. The current study also showed that some of the NRP nurses commenced work even before the organised orientation programme, and would only join the programme later when they had learned on their own, on the job. The NRP nurses require orientation related to their appointment, in order to be effective in their new position and to cope with the challenges of the new position (Bruce, Klopper and Mellish,

2011: 338). Lack of sufficient orientation was also revealed as one of the contributory factors to a lack of confidence affecting the NRP nurses (Thopola, Kgole and Mamogoba, 2013: 173). Some participants, who experienced insufficient orientation to the new workplace, felt lost and disorientated which affected their capability, effectiveness and sense of security (Andrén and Hammami, 2011: 12). Ebrahimi *et al.*, (2016:157) mentioned that some experienced nurses lack the patience to work with the NRP nurses, reasons given included high levels of expectation, their lack of trust in the NRP nurses' work, the lack of time to properly guide them, perceptions around laziness, and general disinterest in teamwork.

5.2.2 Uncertainty and fear of having to delegate

Uncertainty and fear of having to delegate consisted of four subthemes. These were teamwork, respect, shortage of staff and absenteeism. Delegation of duties emerged as a theme in the current study and is an important aspect of professional nurses' daily activities. Delegation of duties is done by professional nurses in order that patients receive the care and attention they need. Delegation of duties is promoted by teamwork and respect among nursing personnel. Participants reported that team spirit and unity was displayed by nursing personnel especially with the execution of delegated duties. Nursing care was rendered in time as all nurses were partaking. There was no hierarchy and the NRP nurses were accepted by nursing personnel as part of the team, which was different from their experiences in nursing school (Shipman, 2012:128). Participants emphasised that they were respected by team members in the units where they were allocated. This gave value and confidence to all members of the team and their contribution to patient care. Participants stated that although the NRP nurses' opinions and beliefs may not be as mature as those of the senior staff members, respect added to the richness of the experience and the complexity of the team. The NRP nurses were satisfied with the team as respect was ensured, and they perceived respectful interactions with other healthcare professionals (Pfaff *et al.*, 2013: 7).

Nevertheless, delegations of duties were hindered by a shortage of staff and staff absenteeism. The researcher found that the shortage of staff was a problem for all

participants, which resulted in a lack of practice to improve their skills and to apply knowledge in practice, due to a busy environment where suitable role models were not available. As a result of nursing staff shortages, the participants were left with heavier workloads. The workload was considered to be a frequent stressor as evidenced by how frequently this appeared in statements by the participants, obviously causing them concern (Suresh, Matthews and Coyne, 2013: 773). The NRP nurses expressed that they felt guilty when handing over incomplete tasks and did so with expressions that have apologetic connotations leaving their uncompleted work for the other nurse, it meant intentionally increasing the other's workload or not helping the other (Sonmez and Yildirim 2015:107).

Some participants reported that shortage of staff directly increased absenteeism in other nurses and it impacted negatively on the delegation of duties. The NRP nurses were confronted with a shortage of staff and rapid staff turnover rates which altered the nurse's ability to provide quality patient care (Klerk, 2010: 45). Not surprisingly, participants stated that the delegation of nursing duties was difficult due to the increasing absenteeism which was the result of staff shortages.

Despite of the above findings, studies across reviewed many NRP nurses described feelings of stress, uncertainty, and inadequacy in the first months of work (Walker 2017:510). Ndaba (2013:57) stated that stress levels were compounded by intimidation, and lack of respect from the lower categories of nurses who have been in the profession for a long time did not want to be delegated by the NRP nurses. Shezi (2014:63) stated that the failure of experienced professional nurses to acknowledge that other categories such as enrolled nurses and enrolled nurse auxiliaries refused to accept tasks delegated to them by the NRP nurses resulted in intimidation and undermining of the authority of the NRP nurses. Studies show that the NRP nurses have difficulties in managing the staff they work with (Sonmez and Yildirim (2015:108). Similarly, literature includes reports of staff not responding to questions from, not assisting, and not completing tasks assigned by the NRP nurses (Sonmez and Yildirim (2015:108).

5.2.3 Competence

This theme consisted of two subthemes: self-confidence and assertiveness. According to SANC (2005) a competent nurse carries professional qualities such as knowledge, skills, attitudes, judgement, beliefs, values and technical abilities to a relevant and new situation in order to exact safe, effective care. The NRP nurses at this stage are able to identify priorities, capable of solving problems and able to accomplish their own work. Participants expressed overall satisfaction with the training they received during their preparation to becoming professional nurses.

Pfaff *et al.* (2013:7) specified that NRP nurses need to be competent in the performance of everyday management tasks, such as planning, decision-making and professional maintenance. Participants indicated that they gained leadership competence when they were alone to be in charge of the units. Self-confidence was promoted by decision-making, independence and problem-solving abilities. The NRP nurses reported that working in the professional nurse's role enhanced their clinical skill and they felt clinically competent (Shipman, 2012: 119). Participants indicated that they were left alone to manage the unit, but they coped with delegation and supervising the work. They mentioned that to be left alone groomed them and it helped them to remember the competencies that they had recently acquired. NRP nurses experienced increased confidence, particularly after successfully managing a nursing unit on their own (Roziars, Kyriacos and Ramugondo, 2014: 93). These nurses felt confident in their roles, making decisions, and interacting with other professionals (Shipman, 2012: 117).

The researcher identified that assertiveness promoted competence among participants as they reported that due to the experience they gained from the date of appointment up to the present, they developed assertiveness and were able to stand up for themselves. Participants indicated that to be firm and treating all nurses as equally as possible was the key to assertiveness. These nurses had found their identity and no longer focused mainly on their own behaviour, but they were now able to shift their standpoint and attention onto patients' needs (Andersson and Edberg, 2010: 188). The findings of this study indicated that participants felt more competent during their first year post registration; although a lack of human and

material resources hindered their progress. The support of experienced professional nurses was critical in this regard. Ortiz (2016:23) stated that acting independently without the support from the experienced staff was an experience that dramatically increased professional confidence for the NRP nurses. Shezi (2014:50) stated that working alone without supervision could be empowering because it taught the NRP nurses to work independently and boosted their self-confidence and resilience. Even though the NRP nurses shared that working alone was perceived as one of their biggest challenges during their first year post SANC registration, they gained confidence through working independently (Shezi 2014:50).

5.2.4 Transition to the professional nurse

This theme consisted of three subthemes: reality shock, attitude and trial and error.

Transition in nursing begins when the student nurse qualifies as a professional nurse and starts to work as an NRP nurse. At this novice stage the nurse has little experience of managing a unit independently. Participants stated that initially they experienced uncertainty when they were asked to do doctors rounds, but realising this would not change, they had to move away from being uncertain and do the task expected of them. NRP nurses felt inadequately prepared for the workplace and were very apprehensive about interacting with physicians and felt as if the facility expects too much of them too quickly (Makhakhe, 2010: 36). Participants indicated that initially there was a lot of frustration and uncertainty when they were expected to be a professional nurse in charge of the units, but eventually they adapted to the role and adjusted. The competent NRP nurse can benefit at this stage from learning activities that centre on managing conflict and delegating the duties. They also learnt how to cope when observing unethical practices in the nursing unit. Participants found that the transition from being a student nurse to an NRP nurse exposed them to many expectations and challenges that were never encountered while they were still students. The NRP nurses experienced the transition from being a student nurse to a professional nurse exposed them to many expectations and challenges that were never encountered while they were still students (Roziars, Kyriacos and Ramugondo, 2014: 97). Reality shock was identified in the transition period as participants mentioned that they were shocked by the levels of accountability and

expectations in respect of the conditions under which they worked in the clinical areas. These nurses experienced a 'reality shock' and feelings of being inadequately prepared for their new role (Jamieson *et al.*, 2012: 33). The transition from student to professional nurse has long been recognised as a difficult time and nursing was the only profession which expected a completely finished product at the end of pre-registration (St Clair, 2013: 49-50).

However, the researcher identified that negative attitudes of colleagues hindered the transition period for the participants. The researcher reported that participants experienced negative attitudes which were displayed by some members of the staff through poor communication with the NRP nurses. Participants stated that they were expected to know everything because they were fresh from college. Criticism ensued by staff as sometimes the term "three bars" (meaning that within four years a person qualified for midwifery, community and psychiatry) would come up, which made them feel insecure as the NRP nurses were practicing under mentorship yet qualified and registered with SANC as professional nurses. The NRP nurses recalled incidents that had occurred in clinical placement areas after their completion of training, when hospital staff showed a negative attitude towards them and withheld information that they needed to function effectively. This created conflict (Roziers, Kyriacos and Ramugondo, 2014). Negative experiences could lead to NRP nurses refraining from seeking help and consequently trying to solve problems on their own (Purling and King, 2012: 3461). Participants mentioned that some doctors do not work with them as they are new. Some patients do not want to be assisted by a junior professional nurse.

5.2.5 Observed unethical practices: fear of victimisation

This theme consisted of two subthemes: unethical practice by nursing personnel and unethical practice by medical doctors.

The researcher found that participants identified unethical practices in different units and or hospitals where they were employed. Ulrich *et al.*, (2010: 7) mentioned that without sufficient staffing, it is difficult to meet the ethical standards of professional practice which can impede nurses from meeting many of their primary

responsibilities, including protecting the rights of individual patients and families, alleviation of suffering, and preserving their own integrity. Participants reported that basic nursing care such as putting two identity bands on a patient for easy identification was not observed in some of the units. Hence wrong procedures were implemented on patients, even surgery, because of the incorrect identity. The NRP nurses reported that when senior professional nurses are challenged by the new professional nurses about their deviation from care standards, they get irritated (Fenwick *et al.*, 2012: 2056). Sonmez and Yildirim (2015:108) reported that the NRP nurses experienced difficulties in calculating drug dosage for paediatric patients in the absence of experienced professional nurse.

The nurses are ethically responsible, not only for reporting and documenting their own errors, but also for ensuring patient safety in team work (Kangasniemi *et al.*, 2013: 904). Sometimes nurses working on night duty would discuss as if it's a good thing, that when they want to have a peaceful night duty shift they would just minimise all the flow rates for intravenous infusions, so that they should last throughout the night up to the morning (Msiska, Smith and Fawcett, 2014: 101). The NRP nurses believed that if they are not competent to practice safely, it is unethical to accept responsibility for providing patient care (Kangasniemi *et al.*, 2013: 909). Participants mentioned that doctors do not maintain confidentiality when it comes to patients' conditions, as they talk loudly in the nursing unit about the patients' diagnoses in such a way that other patients can find out what is wrong with fellow patients. The nurses in hospitals reported that they experienced frequent ethical problems related to patient confidentiality or privacy issues, as well as staffing pattern issues (Parker, 2014: 153).

5.2.6 Difficult relationships

This theme consisted of two subthemes, namely, treatment by other nurses and treatment by doctors.

Difficult relationships with other nurses and doctors appeared to present problems for the NRP nurses. Although both nurses and physicians have common goals of providing quality health care and comfort to the patients, the traditional relationship between them has been that of physician dominance and of the NRP nurse

deference (Ajeigbe 2012:135). It has been reported that due to lack of confidence, the NRP nurses form hierarchical relationships with experienced nurses and physicians rather than colleague relationships (Sönmez and Yıldırım 2015:107). Conflict cited by participants was associated with a wider range of healthcare workers, not just nurses. The researcher identified that participants commented on their experiences with doctors who were not willing to do rounds with them, as they were newly qualified. The NRP nurses reported having difficulties in communications with physicians and patients' relatives due to their lack of knowledge and experiencing fear of being unable to answer questions (Sonmez and Yıldırım 2015:108). It has been reported that due to lack of confidence, the NRP nurses form hierarchical relationships with experienced nurses and physicians rather than colleague relationships.

Poor communication experiences between the NRP nurses and doctors decreased their lack of professional confidence, but ultimately, propelled the NRP nurses forward on the professional confidence continuum (Ortiz, 2014: 116). Participants felt that they needed time to gain confidence from their nursing colleagues in the initial stages after qualification. Fenwick *et al.* (2012: 2058) agreed with the findings as they confirmed that senior professional nurses mentioned that there was no need for support programmes and the NRP nurses should have already learnt what they required at the university or should try to learn now by themselves, or even being thrown in at the deep end so that they are forced to learn. This concurs with Ortiz (2014: 115) who reported that 100% of the NRP nurses agreed that making mistakes and poor communication experiences with colleagues further decreased their lack of professional confidence. Lee *et al.* (2012: 794) also confirmed that in this situation, the NRP nurses perceived themselves as being utterly alone in their role as NRP nurses and that unreasonable treatment by senior nurses does occur in the nursing profession. Doctors sometimes refuse to explain patients' conditions to them, and order scheduled medications such as anti-depressants for them without their consent. If nurses intervene it creates animosity between nurses and doctors (Dihn, 2012: 36). The nurses lacked autonomy in collaborating with doctors in their daily work. Doctors due to their education level and position-related respect, scored more highly in work autonomy with clinical decision-making and treatment care plans design than nurses (Huan, 2013: 90). Nurses and doctors should work in

collaboration to provide high quality, patient-centred care and ultimately increase patient care outcomes (Linebarger, 2014: 19). Nurses mentioned that doctors dominated in clinical practice and nurses have no say in patient care (Baiyekusi, 2010: 34). Some professional nurses have reported that doctors use coercive tactics in their methods of persuading patients in favour of surgery, such as a C-section, against the patients' wishes (Murata, 2014: 39). Huan (2014:90) found significant differences in attitudes and perceptions of collaboration between nurses and doctors. Nurses show a higher willingness to collaborate compared with their medical colleagues in both general and specialist hospital and scored higher work related skills.

5.3 Benefits of the study

The findings of this study may contribute to developing leadership guidelines for undergraduate nurses to prepare them for their responsibilities upon registration and employment. It may also provide information for developing opportunities for professional development post qualification, thereby contributing to the quality of health care. The findings could also assist nurse educators to address issues through the curriculum and nurse managers to address issues through placement, orientation, mentorship and delegation of duties.

5.4 Recommendations

The following recommendations are made with a view to overcoming the challenges experienced by the NRP nurses. These recommendations are based on the findings of the study, and some of the recommendations were highlighted by the participants during data collection. These recommendations are thematically focused on two areas: the nursing institutions, and further research.

5.4.1 The nursing institutions

- Orientation programmes in the units should be conducted for all staff members in order that the staff become acquainted with all the activities, protocols, procedures and policies of the units in order to render positive outcomes for patient care. The NRP nurses would profit from continuing support

that includes a revised orientation programme, interview prospects, meetings aiming at the development of clinical judgement and service improvement.

- Rotation of the NRP nurses through different areas during their first year post SANC registration, in order to gain experience. Implementation of strategies such as clinical rotation through different nursing unit settings provides an opportunity to practise skills and consolidate professional nurse's practice.
- Mentoring of the NRP nurses by experienced professional nurses, to socialise them into the profession and to help them to reflect on their experiences.
- Continuous in-service education and effective development programmes, in order to equip professional nurses with all the necessary information and skills to be effective and efficient.
- Observe the teaching role of the experienced professional nurses (information sharing) in the unit for support, in order that the NRP nurses also acquire knowledge from the experienced professional nurses.
- In-service education on communication skills, this will also address attitudes in the work place as this will promote professionalism and increase morale of the staff.
- Experienced nurses should recognise the value of their own expertise and clinical judgement, and learn ways of transferring that experiential knowledge to the NRP nurses.
- To develop a strategic points with a suggestion box through which the NRP nurses can contribute with concrete inputs and their grievances.

.The KwaZulu-Natal Department of Health must consider the provision of adequate staffing in relation to the number of patients.

5.4.2 Nursing education institutions

- Introduction of a clinical teaching model that will allow sufficient time for preceptors to accompany students in order to correlate theory to practice and to develop cognitive and psychomotor competencies.
- Lecturers, clinical lecturers need to visit the clinical field often, specifically with their student nurses to ensure that they obtain the clinical skills necessary to be ready for the nursing field.

- Follow-up programmes with the NRP nurses should be implemented to enhance support.
- Students should be placed in specialised units such as maternity unit during their final year of the course, so that they are not challenged by midwifery practices when they qualify, as they are expected to provide mother and child care on registration.

5.4.3 Research

- A national study should be conducted when R425 professional nurses finish community service.
- A mixed-method research approach may be used to compare the research findings about the needs of the NRP nurses with regard to mentorship in the different public health-care facilities of KwaZulu-Natal so that the research results can be generalised.
- Involvement of all other experienced nursing categories to explore and describe their attitudes/traits, qualities and skills with respect to the NRP nurses during their first year post registration with SANC.
- Further research on the benefits experienced by the NRP nurses during their first year post registration with SANC.
- Further research on the challenges experienced by the NRP nurses during their first year post registration with SANC.

5.5 Limitations

- The study was only conducted in public hospitals, focusing on professional nurses who had studied for the Diploma in Nursing (General, Psychiatric and Community) and Midwifery, R425. Private hospitals were excluded.
- Only female participants were interviewed in the study. The absence of male participants at that time, due to their placement elsewhere, has the potential to render this study gender biased.

5.6 Conclusion

This study found that the development of the NRP nurses' leadership competence is a dynamic process that occurs throughout the first year of practice. In order to achieve professional confidence, the NRP nurses must experience both positive and negative circumstances even if it is uncomfortable or frightening.

The NRP nurses who participated in this study faced complex, ambiguous situations during the first year post registration with SANC. While being acutely aware of their novice status and perceived lack of knowledge, the NRP nurses encountered human resource challenges, lack of support, poor mentoring, negative attitudes and a lack of continuous development strategies. Some of the challenges experienced were viewed as opportunities to learn, while other challenges demoralised some of the participants. Despite these constraints, many of them verbalised their personal and professional growth and development during this period. A properly structured, mentored service experience can have a positive impact on NRP nurses and can provide benefits to the communities they serve. The researcher also found that the participants were not independent and competent soon after being placed in their clinical areas at registration, and experienced little or no support from the experienced professional nurses. The NRP nurses need intellectual, practical, and emotional support and appropriate feedback to relieve them of concerns they may have over their performance of tasks, their ethical distress, fear, insecurity and anxiety.

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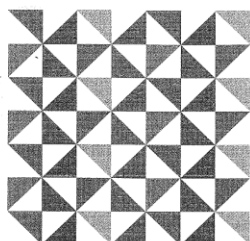
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ANNEXURES

ANNEXURE A Ethical clearance/permission from Higher Degrees Research Committee/Institutional Research and Ethics Committee at Durban University of Technology



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

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900

Fax: 031 373 2407

Email: lavishad@dut.ac.za

http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

26 March 2015

IREC Reference Number: **REC 19/15**

Ms N C Solwandle
Flat 2611
John Ross House
22/36 Victoria Embankment
Durban
4000

Dear Ms Solwandle

Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council

I am pleased to inform you that Provisional Approval has been granted to your proposal REC 19/15 subject to:

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

Full approval is subject to meeting the above condition.

The Proposal has been allocated the following Ethical Clearance number **IREC 027/15**. Please use this number in all communication with this office.

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

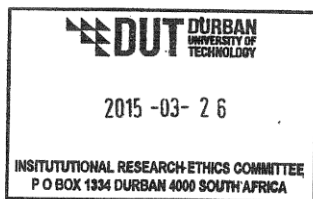
Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

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

Yours Sincerely



Professor M N Sibiyá
Deputy Chairperson: IREC



ANNEXURE B Letter of Application for Permission from the KwaZulu-Natal Department of Health to carry out the study at the selected regional hospitals

Section 2 Mooredene
25 Glengariff Place
Glenwood
Durban
4001


The Head of Department
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3200

Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a lecturer at Addington nursing campus under KwaZulu-Natal College of Nursing and presently registered as a Masters of Technology: Nursing student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is *Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council*. The aim of the study is to explore and describe the competencies of professional nurses during the first year of registration. Data will be collected using semi-structured interviews.

I hereby request your permission to conduct the research project in eThekweni regional hospitals which are Addington, KingDinizulu, King Edward viii and RK Khan. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.



N.C.Solwandle (Miss)

P.M. Orton (Mrs.)

MTech student

Supervisor

Contact number: 0786786741

Contact number: 031-3732 606

E-mail: swozasolwandle@gmail.com

E-mail: penny@dut.ac.za

ANNEXURE B1: Letter of Permission from the KwaZulu-Natal Department of Health
to carry out the study at the selected eThekweni regional hospitals



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 110/15
NHRD: KZ 2015RP23_435
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Ms N.C. Solwandle

Subject: Approval of a Research Proposal

1. The research proposal titled '**Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Addington, King Edward VIII, King Dinuzulu and RK Khan Hospital.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely


Dr E Lutge

Chairperson, Health Research Committee

Date: 19/07/15

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE C: Letter of Permission from eThekweni District Health Office to carry out the study at the selected eThekweni regional hospitals.



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

NAME OF INSTITUTION/DISTRICT/COMPONENT

Postal Address
Physical Address
Tel: 031 240 5455, Fax: 031 240 5500
Email: henry.sunpath@kznhealth.gov.za
www.kznhealth.gov.za

To, Miss. Solwandle Nomawonga Corona
Student - BA Hons in Health Studies,
Student number: 19908563

Re: Research proposal: Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council

Your letter dated 30/03/15 refers. I have read your research proposal approved by the REC at Durban University of technology, number 19/04/15.
Permission is hereby granted to conduct this research project in eThekweni regional hospitals which are Addington, King Dinizulu, King Edward viii and RK Khan.
Please note that all work must be structured within these hospitals in a way that will not compromise work commitments within the clinical unit. Please liaise with the nursing managers to arrange this.

This is a good study and we look forward to hear about the outcomes of your work.

Yours faithfully

Dr. Henry Sunpath
MBBS; MFam Med; Dip HIV Man, MPH (UKZN)
eThekweni District Health Office
Chief Technical Advisor
Tel: 031 240 5455
Fax: 031 240 5500
83 Jan Smuts Highway,
Highway House,
Mayville, Durban

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE D: Application Letter for Permission to carry out the research in Addington Hospital

Section 2 Mooredene
25 Glengariff Place
Glenwood
Durban
4001

The nursing service manager
Addington Hospital
16 Erskine Terrace
South Beach
4001

Dear Miss Zwane

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a lecturer at Addington nursing campus under KwaZulu-Natal College of Nursing and presently registered for a Master of Technology: Nursing at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council*. The aim of the study is to explore and describe the competencies of professional nurses during their first year of registration with the South African Nursing Council (SANC). Data collection will include semi-structured interviews with professional nurses in their first year of registration with the SANC.

I hereby request your permission to conduct this research project in Addington hospital. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.

Yours obediently



N.C. Solwandle (Miss)

P.M. Orton (Mrs.)

MTech student

Supervisor

Contact number: 0786786741

Contact number: 031-3732 606

E-mail: swozasolwandle@gmail.com

E-mail: penny@dut.ac.za

ANNEXURE D1 Letter of Permission from Addington Hospital to carry out the Research



health

Department:
Health

PROVINCE OF KWAZULU-NATAL

ADDINGTON HOSPITAL

OFFICE OF THE HOSPITAL MANAGER

Postal Address: P.O. Box 977, DURBAN, 4000
Physical Address: 16 Erskine Terrace, South Beach
Tel.: (031) 327-2970, Fax.: (031) 368-3300
Email: reshma.boodhai@kznhealth.gov.za
www.kznhealth.gov.za

AD/9/2/3/R

Enquiries: Dr M Ndlangisa
Extension: 2970/2568

15th May 2015

Principal Investigator:

➤ **Miss Nomawonga Corona Solwandle**

PERMISSION TO CONDUCT RESEARCH AT ADDINGTON HOSPITAL:
"LEADERSHIP COMPETENCIES OF PROFESSIONAL NURSES IN THE ETHEKWINI
HEALTH DISTRICT DURING THE FIRST YEAR OF REGISTRATION WITH THE
SOUTH AFRICAN NURSING COUNCIL"

I have pleasure in informing you that permission has been granted to you by Addington Hospital Management to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Addington Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Addington Hospital.


DR M NDLANGISA
HOSPITAL MANAGER
ADDINGTON HOSPITAL

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE E: Application Letter for Permission to carry out the research in King Edward VIII Hospital

Section 2 Mooredene
25 Glengariff Place
Glenwood
Durban
4001

The Nursing Service Manager
King Dinizulu Hospital Complex
P.O.Box
Dormeton
4015

Dear Mrs Ngubane

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a lecturer at Addington nursing campus under KwaZulu-Natal College of Nursing and presently registered for a Master of Technology: Nursing at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council*. The aim of the study is to explore and describe the competencies of professional nurses during their first year of registration with the South African Nursing Council (SANC). Data collection will include semi-structured interviews with professional nurses in their first year of registration with the SANC.

I hereby request your permission to conduct this research project in King Dinizulu hospital. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.

Yours obediently

.....
N.C.Solwandle (Miss)

.....
P.M. Orton (Mrs.)

MTech student

Supervisor

Contact number: 0786786741

Contact number: 031-373 2606

E-mail: swozasolwandle@gmail.com

E-mail: penny@dut.ac.za

ANNEXURE E1: Letter of Permission from King Edward VIII Hospital to carry out the research



**DEPARTMENT OF HEALTH
PROVINCE OF KWAZULU-NATAL**

KING DINUZULU HOSPITAL COMPLEX

**PO DORMERTON, 4015
75 Dr R D NAIDU DRIVE, SYDENHAM, DURBAN 4015**

Enquiries : Dr S B Maharaj	Telephone Number : (031) 2426000 Extension : 6101	Fax Number : (031) 2099586
Email : shamin.maharaj@kznhealth.gov.za	Your Reference :	Date : 15 July 2015

Ms N C Solwandle
MTech student
Durban

Dear Miss N C Solwandle

REQUEST FOR PERMISSION - TO CONDUCT A RESEARCH STUDY AT KDHC

1. Your letter dated 8/6/ 2015 refers.
2. Permission is granted for the above mentioned purpose, provided you obtain BREC approval.
3. Your attention is once again drawn to the maintenance of confidentiality as discussed.
4. Arrangements should be made for you to work with the Nursing staff at KDHC.

Yours sincerely,


Dr S B Maharaj
Medical Manager KDHC

ANNEXURE F: Application Letter for Permission to carry out the research in KDH

Section 2 Mooredene
25 Glengariff Place
Glenwood
Durban
4001

The nursing service manager
King Edward VIII Hospital
Private Bag x02
Congella
4013

Dear Mr Khoza

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a lecturer at Addington nursing campus under KwaZulu-Natal College of Nursing and presently registered for a Master of Technology: Nursing at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council*. The aim of the study is to explore and describe the competencies of professional nurses during their first year of registration with the South African Nursing Council (SANC). Data collection will include semi-structured interviews with professional nurses in their first year of registration with the SANC.

I hereby request your permission to conduct this research project in King Edward VIII hospital. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.

Yours obediently

[Redacted Signature]

N.C.Solwandle (Miss)

P.M. Orton (Mrs.)

MTech student

Supervisor

Contact number: 0786786741

Contact number: 031-373 2606

E-mail: swozasolwandle@gmail.com

E-mail: penny@dut.ac.za

ANNEXURE F1: Letter of Permission from KDH to carry out the Research



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

OFFICE OF THE HOSPITAL CEO

KING EDWARD VIII HOSPITAL
Private Bag X02, CONGELLA, 4013
Corner of Rick Turner & Sydney Road
Tel.031-3603853/3015; Fax.031-2061457:
Email.rejoice.khuzwayo@kznhealth.gov.za:
www.kznhealth.gov.za

Ref.: KE 2/7/1/ (26/2015)
Enq.: Mrs. R. Sibiya
Research Programming

17 June 2015

Ms. NC Solwandle
Flat 2611
John Ross House
22/23 Victoria Embankment
DURBAN
4000

Dear Ms. Solwandle

Protocol: Leadership competencies of Professional Nurses in the eThekweni Health District during the first year of registration with the South African Nursing Council

Your request to conduct research at King Edward VIII Hospital has been approved.

Please ensure the following:

- That King Edward VIII Hospital receives full acknowledgment in the study on all publications and reports and also kindly present a copy of the publication or report on completion.
- Before commencement:
 - * Discuss your research project with our relevant Directorate Managers
 - * Sign an indemnity form at Room8, CEO's Complex, Admin. Block.

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

Yours faithfully

SUPPORTED/NOT SUPPORTED


DR. LP MTSHALI
SENIOR MEDICAL MANAGER

23/06/2015
DATE

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE G Application Letter for Permission to carry out the Research in RK Khan Hospital

Section 2 Mooredene
25 Glengariff Place
Glenwood
Durban
4001

The nursing service manager
R.K.Khan Hospital
336 R.K.Khan
Chatsworth
4092

Dear Mrs Ngidi

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am a lecturer at Addington nursing campus under KwaZulu-Natal College of Nursing and presently registered as a Masters of Technology in nursing student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council*. The aim of the study is to explore and describe the competencies of registered nurses in their first year post registration. Semi-structured interviews will be conducted to collect data.

I hereby request your permission to collect data from the registered nurses who have completed their remunerated community service placement and who are now fully registered with the South African Nursing Council (SANC) in your institution. My research proposal has been attached for your perusal. Your support and permission to conduct the study at your institution will be highly appreciated.

Yours obediently

[Redacted Signature]

N.C.Solwandle (Miss)

M.P.Orton (Mrs.)

MTech student

Supervisor

Contact number: 0786786741

Contact number: 031-3732 2606

E-mail: swozasolwandle@gmail.com

E-mail: penny@dut.ac.za

ANNEXURE G1: : Letter of Permission from RK Khan Hospital to carry out the research



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

R.K.KHAN HOSPITAL/ETHEKWINI
DISTRICT
OFFICE OF THE CEO
PRIVATE BAG X004
CHATSWORTH
4030

Tel.: 031-4596001
Fax. No. 031-4011247
Email: reena.ramcharan@kznhealth.gov.za
www.kznhealth.gov.za

ENQUIRIES: DR P.S. SUBBAN

5 May 2015

Ms N.C. Solwandle
MTech Student
UKZN – College of Nursing

Dear Madam

**RE: PERMISSION TO CONDUCT STUDY : LEADERSHIP COMPETENCIES OF
PROFESSIONAL NURSES IN THE ETHEKWINI HEALTH DISTRICT DURING THE FIRST
YEAR OF REGISTRATION WITH THE SANC**

Permission is granted to conduct your study at this institution.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Institution with regards to this research.
2. Please ensure this office is informed before you commence your research.
3. You will be expected to provide feedback on your findings to this institution.
4. Kindly liaise with Mrs F. Ngidi, Nursing Manager on Ext. 6030.

Yours faithfully,


HOSPITAL CEO

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE H: Letter of Information



Title of the Research Study: Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council

Principal Investigator/s/researcher: Miss Nomawonga Corona Solwandle (BA Honours in Health Studies)

Supervisor/s: Mrs. Penelope Margaret Orton (Masters in Nursing) and Dr Ayisha Razak

Brief Introduction and Purpose of the Study:

Outline of the Procedures: This study focuses on leadership competencies of the professional nurses during the first year of registration with SANC at eThekweni regional hospitals. While acknowledging the many factors found in the various literature that considerably influence the transition of the professional nurses to the workplace, leadership competencies is the phenomenon of interest in this research study. The purpose of the research is to explore and describe the competencies of professional nurses to lead a healthcare unit. The study will help in identifying the leadership competencies of the professional nurses during first year of registration with SANC. A qualitative, exploratory, descriptive approach will be undertaken to generate information on the professional nurses during one year of registration. Purposive sampling will be used to select professional nurses during the first year post registration with SANC. Semi-structured interviews will be used to collect data. The research strategy steps by Creswell (2012:185-190) will be followed for data analysis, which are to organise and prepare the data for analysis, to develop a general sense of the data, to code the data, to describe and identify themes, to represent findings and to interpret the data..

Risks or Discomforts to the Participant: I do not envisage that you will suffer any risks or discomfort by participating in this study..

Benefits: To present the findings of the study to the management of the selected eThekweni regional hospitals, so as to devise induction programme, that will assist the professional nurses in developing their leadership skills; to publish at least one article in a peer reviewed journal.

Reason/s why the Participant May Be Withdrawn from the Study: There will be no adverse consequences for the participant should they choose to withdraw.

Remuneration: You will participate in the study voluntarily and will not be remunerated for your participation in the study.

Costs of the Study: The researcher will be liable for any costs.

Confidentiality: Before the commencement of the research, you will consent to participate. The participants will also be told that the researcher intends to publish the results of the study, but that the researcher will make every effort to you, as a group, to obtain data in such a way that personal characteristics will not be made. Completed interview guides will be locked in a steel cupboard for a period of 5 years and thereafter be shredded. A Password protected computer will be used to store electronic data and will be deleted after 5 years.

Research-related Injury: This is qualitative research enquiry; there will be no harm/injury to the participants.

Persons to Contact in the Event of Any Problems or Queries:

Mrs. P.M. Orton (Supervisor)

Contact number: 031-373 2606

E-mail:penny@dut.ac.za

Please contact the researcher:

Miss N.C.Solwandle

Contact number: 0786787641

E-mail:swozasolwandle@gmail.com

Or the Institutional Research Ethics administrator on: 031 373 2900.

ANNEXURE I: Consent form



CONSENT

Statement of Agreement to Participate in the Research Study:

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

Full Name of Participant Date Time Signature /

Right Thumbprint

I, Miss Nomawonga Corona Solwandle herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the study.

Full Name of Researcher Date Signature

Full Name of Witness (If applicable) Date Signature

ANNEXURE J: Semi-Structured interview schedule/guide

SEMI-STRUCTURED INTERVIEW SCHEDULE/GUIDE

Thank you for agreeing to be interviewed for my study. I am interested in the leadership competencies of professional nurses in their first year of registration with SANC and would be most grateful if you would not mind answering my questions. Remember, nothing is right or wrong but it is all about your experiences, understandings.

I will start with a question and maybe after you have had an opportunity to share your thoughts we can probe a little more with some specific questions.

As a recently registered professional nurse can you share with me any thoughts and /or experiences you have with leadership in the unit.

Prompts:

1. How did that prepare you to deal with conflict, delegation of tasks and unethical practice?
2. When faced with conflict in the unit do you think you are adequately prepared to deal with it? Tell me about some of your experiences.
3. Tell me how your community service placement equipped you to manage conflict arising in your unit?
4. When it comes to delegating tasks to other staff in the unit do you find it easy or challenging? What is it about delegation which makes it challenging? Or what is it about delegation that makes it easy?
5. Tell me how your community service placement equipped you to manage delegation of duties in your unit?
6. Have you identified any unethical practices in your unit, tell me the actions did you take after that?
7. Tell me how your community service placement equipped you to manage unethical practices in your unit?
8. Did you gain sufficient experience in the area that you were placed for community service, if not what were your expectations?
9. What do you think are important competencies needed to lead this unit?

ANNEXURE K: Demographic questionnaire

DEMOGRAPHIC QUESTIONNAIRE: PROFESSIONAL NURSES

To be completed individually by all participants.

Please mark only one box with an “X” next to the response that best answers the question for you.

1. What is your gender?

- ☐ Female
- ☐ Male

2. Please indicate your race

- ☐ African
- ☐ Asian/Indian
- ☐ Coloured
- ☐ White

3. Age group

- ☐ 20-25 years
- ☐ 25-30 years
- ☐ 30-35 years
- ☐ 35-40 years

4. What is your educational background (mark all that applies)?

- ☐ One year nursing course (ENA-R2176)
- ☐ Two year nursing course (EN-R2175)
- ☐ Four year comprehensive diploma in nursing (R425)
- ☐ Other specialty training (specify).....

5. How long have you worked as a professional nurse?

- ☐ 0-3 months
- ☐ 3-6 months
- ☐ 6-9 months
- ☐ 9-12 months

ANNEXURE L: Transcriptions

DATA COLLECTION TRANSCRIPTS

RESEARCHER: R

PARTICIPANT: P

PARTICIPANT ONE (Jabu)

DURATION: 43:04

R: As a recently registered professional nurse, can you share with me your thoughts or experiences you had with regards to leadership in the units?

P: It was a big change moving from being a student now that you are on community service as a professional nurse. I trained in another institution and did my community service in another institution.

R: So it was not easy?

P: It was like basically you throw yourself in the deep end. For me it was like you throwing yourself in the deep end because they expect you to do a job of a PN, mhhh..., you have to be responsible, you have to do all the duties of a PN, and being a student we are not exposed that much so to just run the whole ward yourself, so for me eeey... it was a big change from being a student to professional nurse, because they made me to run a ward.

R: What exactly happened on the first day when you were left to run the ward?

P: One day when I first worked, the whole weekend the senior did not come, and it was me, junior, and I had to run the whole ward by myself. So it was a big thing that you learn on the go, there were lots of people to help.

R: Tell me how your community service experiences prepared you to deal with conflict management after completing your community service

P: For me I've seen lots of cases like let's say staff nurses and ENA's, they like stick to their own work, they do not want to work

R: You think so?

P: I think we have to train about conflict management, sometimes we have in-service where we are taught about how to manage conflict situations, but like with you just have to call them aside and you need to be assertive, Some of the cases are to seniority, and they are like junior, and I am PN now and eeh... they are now older than me,

R: What makes you feel that way?

P: They don't want to listen, they'd be like I am small, but you try to be assertive. I think when it comes to seniors they don't want to listen. They don't verbalise but they don't do what you have delegated them to do, but would keep quiet and not say they won't do it.

R: Have you experienced conflict in your unit?

P: I have experienced conflict indirectly, but not with me, but now you have to follow the protocol, like how you will manage conflict, like let's say I am unit manager now, so I must speak with them individually and find out what is wrong, and then I must call them both together, and try and solve the situation.

R: What can you do if you can't solve conflict?

P: If as a PN I can't solve the conflict, then I am going to tell the matron in charge of the department, but if she fails to solve it, then the issue have to be reported to somebody senior like the hospital matron.

R: Okay, are you finished with conflict so as to move to the next question?

P: Yes, I think I've covered what I know

R: Have you ever been exposed into observing the unethical practices in the unit?

P: Yes

R: Tell me more about your experience with regards to those unethical practices

P: The operational managers can be unfair when treating staff, they can be very rude.

R: Really, what happened?

P: Like what happened to me, one day I did not come on duty because my grandpa passed on, so I phoned to tell them that I am unable to come on duty as my grandpa has passed on. So the sister in charge knew, but did not tell the matron in charge. So they did not accept the death certificate that I brought as evidence, and the leave form I filled, and I was made to sign the leave without pay.

R: Mhhh

P: Again, other nurses are also rude towards the patients; they are having negative attitude, especially when the patient may be wants to know something and is asking the nurse.

R: Yes, I'm listening

P: The doctors also are always engaging in doing unethical practices, whereby the doctor will poke the patient more than five times then doing the lumbar puncture to a patient, so you as a PN, you need to tell the doctor to stop now because it is unfair to the patient.

R: Tell me how you have dealt with unethical practices that you identified in the unit

P: I think if you find someone doing something unethical or wrong procedure you actually stop them from what they are doing, and you call them aside, and you tell them you know, but then you also in-service your staff, so that next time they know how to do that procedure.

R: So did you manage to correct the staff?

P: There is a resistance that you meet when you are trying to rectify people when they do something unethical, but you just have to tell them in a nice way, and sometimes you rectify those practices when you doing in-service education in the ward for your staff, then indirectly you correct what you have seen being done wrongly.

R: So nursing staff accept improvements

P: I think the nursing staff needs to be more careful for the things that they do not know or understand. Just ask or refer to the personnel who will be more helpful, if you do not know or understand.

R: How did you correct the staff?

P: You don't need to be rude, just follow the protocol to solve some problems. The doctors need to be stopped if they inflict unnecessary pain to the patients like poking the patient looking for vein or doing a lumbar puncture. So the PN, as an advocate of the patient, you need to stand up for your patients. You need to know how to speak to your staff.

R: Tell me when it comes to delegating tasks to other staff in the unit, do you find it easy or challenging

P: I feel like with senior staff are posing the problem when it comes to delegation of tasks.

R: What makes you feel that way?

P: I think the fact that I am younger than most staff and they are older in age and senior by years of their service, they tend not to listen and won't even execute the duties delegated to them, but with the younger staff, I feel like they listen to what you tell them and will do the duties you have delegated them to do. The senior ones they don't care to listen, because they think they know their work, so they don't expect someone else to tell them how to do their work or to do their work. So I think that is a bit of a problem with delegation of tasks.

R: What is it that you think you can do to make the delegation of tasks easier?

P: I have to tell them in a nice way, or we can, like if they are doing something right but in their way and not the way I know it's being done, so I think as long as it does not put the patient's life at risk, so I don't have to be upset about them doing some procedures in their way, so we can still doing some procedures their way.

R: So how do you achieve delegation of duties?

P: I think allocation of tasks for the members of staff to do, and you make them sign for those tasks, so that if they do not do the tasks that they signed for. And to make sure that the tasks are all done by the people allocated for them, you as a PN, you need to do direct and indirect supervision of all the tasks in the unit.

R: How do you think your community service equipped you to deal with delegation of tasks in your unit?

P: When I first came to do my community service here, I did not know how to delegate, and instead of asking or delegating staff to do some work, I used to just do it myself,

R: Then what happened?

P: Until the unit sister called me and told me that I have to learn to delegate tasks for the members of staff to do those tasks, instead of doing them by myself. So the unit sister used to delegate me to do delegation of tasks, and that is how I learnt to delegate

R: Do you think you have gained sufficient experience in the areas you were allocated during your community service?

P: The thing is over twelve months you are only given two months rotation in each component rotating, and in some areas you don't perfect it, like in maternity. I felt like I can't grasp or master everything. When you are allocated in maternity if you are on community service, they expect you to be as efficient as they are, without teaching you, and even the way they work, because I did not train in this institution, so the way of doing things is different according to institution.

R: What is it that they expect from you?

P: They expect us to know everything, like know how to deliver, how to do episiotomy as perfectly as they do. They forget that we only do our midwifery module over 5 months and only few weeks in labour ward. They leave you to do things on your own without being supervised and they don't even

teach you, they just expect you to know everything. They tell you things like you are now doing community service so you should know what you are doing, but you know nothing.

R: What were your expectations there in maternity?

P: I expected them to teach and supervise us so as to learn more.

R: ooh, okay, anything else you want to share?

P: No I'm okay now

R: Tell me how all these community service experiences have prepared you and equipped you as a competent professional nurse

P: Yes I have learnt a lot, I feel now I am confident enough to delegate, I can do a lot of things on my own without being assisted. I feel I can even run the ward properly, even if now I am left alone in the ward.

R: What do you think are important competencies that are needed to lead the unit?

P: As I am now allocated in NICU, I think the staff should be trained in the specialty. At least as a unit leader, you should know your management, supervision, job description, scope of practice, and know the patients' rights and again you should be clued up in the national core standards.

R: Is there anything else that you can share with me pertaining to your community service?

P: I also experienced matron taking me everywhere, going to all wards as a relief, and I think this was unfair to be placed as a sister in charge on night duty in the ward I never worked in, even during the day. When I verbalised my feelings to the matron, she said I am rude as I am telling her what to do

R: Yes, what else you experienced?

P: Also I feel having trained in other institution and being allocated in another institution for community service, I think it is unfair because their management is not the same and others are not willing to teach you when you are still on community service; you are just thrown into the deep end.

R: So what to do as you are already allocated?

P: So you have to be sharp and learn fast, but it is hard. You have to be keen to know more by following those who know and ask them to assist you when you are doing something. I heard now that if you are coming from other institution, here where I am working now, they give you hard time, but if you trained here and placed here for your community service, then you will be treated differently from those coming from other institutions, and I think that is very unfair because we all need to be treated the same.

P: But now it is better after community service, the sisters even teach you now how to even set certain trays. Two nights I was taught how to use the ventilator, and I was using it on my own with success. It is like they do not teach you when you are still doing community service to fix you.

R: How is your relationship with the doctors as you are newly registered?

P: Doctors do not want to do rounds with the junior sisters; they only want senior sisters to do rounds with them. And even the patients they have that negative attitude towards the junior sisters, as if they do not know what they are doing,

R: How do you overcome that?

P: Until you show them your epaulettes to show that you are a sister and you know what you are doing. They even undermine you when you are small and younger.

R: Is there anything you want to add?

P: No I covered everything I experienced

R: Thank you for your participation

P: It's a pleasure mam to share my experience

PARTICIPANT TWO (Sandra)

DURATION: 22:23

R: As a recently registered professional nurse, can you share with me any thoughts or experiences you had with regard to leadership in the unit?

P: Yes, there were a lot of some leadership qualities, especially with this ward here, with unit manager, and I learnt a lot from her, it's the way she does things, you know it's like and as professional nurse you want to be like her, the way she does things, the manner she talks with her staff.

R: How she does things?

P: She always gives everybody an opportunity, it's not like particular person she'll always be part of what we are doing, she'll always participate, like doing the dressing room, it's not like you are the sister so you won't do certain things, like dressing room and it's only staff nurse, we all do things as a family, as a team, there's that team spirit.

R: When you are faced with conflict in the unit, do you think you are adequately and well equipped to deal with it?

P: Sometimes I like to overlook certain things but so far I didn't experience any conflict, but if you feel that it's continuing and it's the same person then I feel like ok, it's time that it should be dealt with, but so far I didn't experience any conflict management with regards to staff or patients.

R: Have you observed even if you were not directly involved, any conflict and or management thereof?

P: There was one conflict situation, it was about the student who was giving bath to the particular patient, and the rule in the ward is, if you give the patient a bath, then it is your duty to feed the same patient, and as a sister, it's my duty to ensure that the patients have eaten, and whoever is giving bath to a particular patient must also feed the patient afterwards,

R: What happen to that particular patient?

P: So with this particular patient, the food (breakfast) was still lying by the bedside, and it was late already, but the patient was not yet fed, and I asked the student why the patient was not yet fed her food, and the ward clerk intervened, and said I was shouting at the student,

R: What was the student response?

P: I had the similar situation with the same student again, and the ward clerk came into the student's rescue, when I was correcting the student as to how to do the blood pressure checking properly, and the same ward clerk said how the student is checking the BP is right, I was not very happy with the ward clerk, she undermined my leadership in front of the student,

R: How did you deal with the situation?

P: I didn't get any joy from the sister in charge so I took it further, and the ward clerk was reprimanded. And from that conflict management I learnt that the way it was managed it was like there are other underlying issues that the staff knew were involved, that I was not aware of, so that's why they couldn't manage it effectively.

R: Is there another incidence you want to deliberate on?

P: One incident that happened between me and the doctor, where the patient was on blood transfusion and the student came to tell me that the drip of the patient has infiltrated. I told this particular doctor that the drip of the patient needs to be recited because it's infiltrated and the patient is on blood transfusion, and she told me that, 'sister, I don't know how many times I told you that I will do the drip of the patient later, but not now, because I am busy',

R: And then

P: Then I said to her, 'so if you are going to do it later, what if the blood clots, where are we going to get another blood, because that will be the waste of blood', she said, 'oh sister, you are too difficult to work with, I say to you I will do the patient's drip later'. Then I said, 'ok doctor, I will just document that I told you', she just went away and only did that drip around 18h00 late, when I reported at 16h20.

R: So what happened then?

P: I reported the incident to the sister in charge and the matron. The doctor was doing the locums and was coming from another hospital.

R: Do you think you can manage in the unit as a leader if you are faced with the conflict now that you have completed the community service placement?

P: Yes, I can manage, you have to deal with the conflict when you are in the right state of mind, and your attitude should be a positive one and again you have to remain neutral and non-judgemental and always follow the protocol for conflict management.

R: Yes, Im listening

P: Again you have to have a witness when you dealing with the conflict situation. Your attitude and your manner of approach play an important role in dealing with the conflict.

R: Tell me how your experiences with conflict management have prepared you to deal with conflicts

P: Most of the wards that I worked in, we did have a lot of challenges like work overload, shortage of staff and equipment for patient care, but not much with conflict.

R: Okay, can we move to the next question then?

P: Yes please

R: When you are delegating tasks to the staff in the unit, what is it that you think makes the delegation of tasks easy or challenging?

P: It is very challenging because when delegating the tasks you need to look at how competent the person is, also look at the previous allocation of duties, so that you do not repeatedly allocate the same tasks to the same people, because that can create frustration, boredom and tension in the unit, and the staff might even take out their frustration onto the patients, and you do not want that in your unit.

R: Mhh, I'm listening

P: Again, you have to always in-service your staff to keep them abreast of the new developments, and after you have delegated tasks, you have to check if those tasks have been carried out,

R: How do you ensure that tasks have been carried out?

P: The personnel has to report any abnormalities, and you have to ensure fairness when delegating, not overloading one person but equalising the duties among the staff, you also need to check if documentation is done and guiding those who are not sure about some procedures, especially with the checking the blood glucose levels of the diabetic patients,

R: Yes

P: Because when it comes to students they do not seem to understand the fifteen minutes checking of the blood glucose levels with some patients, and they won't even document or report the abnormalities, so you need to always check on them and use those teachable moments for teaching the students. You have also to check if they do the task correctly.

R: Have you met any challenges with regards to delegation of tasks with the ward staff?

P: Yes I had, when I asked one of the staff members to put the Foley's catheter on a patient, she was a bit defensive, and she said, 'oh I must put the Foley's catheter on a patient with cancer', and I said 'the diagnosis of the patient has got nothing to do with you putting on the Foley's catheter'. If I had time I would have done it myself, but now I was the only sister in the ward because the sister in charge was busy in the matron's office.

R: Mhhh, so?

P: So it is very challenging because you end up getting silly questions from the staff. She said to me, 'but it is not ordered by the doctor', and I said, 'it has been ordered telephonically because I told the doctor that the patient's bladder is distended and the patient is oliguric', but she undermined me and still went and asked the doctor herself despite the fact that I told her.

R: So how do you handle such situations?

P: When I am doing allocation I try to be fair to the staff, and sometimes I include myself in the allocation of duties in the ward, whereby I would even do bed bath, because anyway we have been doing that as a students.

R: Is there any other challenge you want to tell me about?

P: Yes, I did come across a staff member at one stage who would tell me after I have allocated her to do the bladder washout, and she told me that, 'I do not do that, it is not within my scope of practice', that time she is a staff nurse. So you do come across those kinds of people who are choosy when it comes to doing certain tasks.

R: Tell me about your experiences of being left alone as a sister in the unit, how it has helped you now that you have finished your community service.

P: The truth is, I can manage on my own, and that's when I learnt even more, because when I am alone, I have to work with more open mind, knowing that it's only me and I am in charge and answerable for my acts and omission. Sometimes we get the psychotic patients, so that is when I have to focus because I do not want to write statements when those patients start harming themselves or assaulting other patients.

R: So what you do in those situations?

P: It is the time when I have to supervise effectively how the staff is doing in the ward, because at the end of the day, all the problems of the day will come back to me, as a sister who has been in charge of the unit for the day.

R: Tell me about the unethical practices that you have identified during your community service placement

P: I have not identified any unethical practices because I would tell the doctor before he does anything unethical, so there were no unethical practices that I identified at all so far.

R: Tell me how your community service placement equipped you to be able to manage the unit

P: I gained a lot out of my community service placement, and also about being rotated, especially in this ward I learned a lot.

R: Can you tell me more about what you learned?

P: I learned how to do peritoneal dialysis, which I did not know how to do, and even in other wards I learned a lot about how to order drugs, and how to take the expired drugs back to pharmacy. I am also confident about being autonomous now, I think I am competent enough to manage the unit on my own, because you really need to look and learn, not just follow, follow without learning, so I can proudly say that I have learnt a lot, especially with the leadership of the unit.

R: Yes, what else you learned?

P: I have learnt that you have to work as a team, you need not dominate in the ward because you are a sister, you also need to include them in the management of the unit, by taking some of their ideas, because that motivate them and they feel they belong and their morale gets boosted.

R: If there is nothing you want to share, I like to thank you for your participation

P: You welcome Miss.

PARTICIPANT NUMBER THREE (Thobile)

DURATION: 1hr:00

R: As a recently registered professional nurse can you share with me any thoughts or any experiences you have with leadership in the unit?

P: First of all mina I was in three different units, because we used to rotate, so in the paed's unit, paediatric unit there was a PRU which is a paed's resuscitation unit, so when I got there the leadership there they were quite together I think, yeah, the in charge or the operational unit manager was very open, she was very willing to teach, she was always around regarding supervising and she delegated someone who was able to help and assist with a lot of things that I wasn't familiar with, especially in that unit, there had new machinery and what not. So she was very, and I felt very involved especially during my community service, I was fresh out of psychiatry, so most of my administrative work, I won't say forget, but you need, and to use in a practical setting, so with her delegating someone to kind of guide me along, I was able to ascertain what leadership qualities do I need to have as leader, within that unit.

R: So you were exposed to leadership

P: Yes I was, but what I noticed there they did not really enforce the peer teaching, where the professional nurses teaching the subordinates and students, it was more or less an informal in-service

teaching, they did not do a lot of in-service like in the institution I trained, it was more an on spot teaching, when someone does not know something, then you will teach her that at that time. Other than that, in that unit. When I moved to the medical units, it was not the same at all. They kind of have an insinuation that, 'agh, you know everything', to a point whereby, when I got there, another individual who was doing community service, but she was six months ahead of me, she said she has been left by herself in the ward, on her first day, to guide the staff and to fend for herself. Basically she did not know anything, she does not even know how to delegate, but the unit manager at the time just diddle daddle off, and she said, 'agh, staff will help you', which is the staff nurses, the ENA's whatever that were there. And especially with the older or senior staff nurses, they tend not to really be open with the knowledge of how to help you and how to go about doing things, even if they do know the sisterly duties, you know, you'll find out that some of them have covered for the sister during the night when there is no sister, and they are aware of how to do things, but they won't tell you how to do those things, if there is a situation they will tell you that 'you have three bars on your shoulders' kind of thing.

R: What about your experiences, rather than that of another individual?

P: In the medical units it was not as free flowing, it was a bit tougher, but I found out that as time goes by, staff respects you if you are working with them, instead of working above them, so you have to be on the same level with them, but not on the educational level. So much so that, I think to an extent that I stayed longer than I have been intended to stay in the medical area, because we were rotating every three months, so that is four wards overall, so we ended up moving and we stay there

R: So for how long you stayed there?

P: I think it was seven months, and I stayed there, and the feedback I got from staff regarding my own leadership in the unit, I was very respectful, I was able to stay on their level, but when the time came, I was also able to delegate them accordingly and to lead them accordingly, it was easy because of that, and it was challenging with regards to the senior staff, but again the senior staff I think they have that thing of, 'I am the mother of the house', so I just found like ok fine, I have this motto, as long as you do your work, I am not really going to be on your case, as long as the work is done and everything is done.

R: Ooh, okay that's what helped you?

P: Yes, and I got this from a sister who used to be in charge in one of the wards in the institution where I did my training, who passed away. She was very forthcoming and open, and she was happy with you as long as you have done your work and done your work correctly, then you wouldn't find her shouting at people at anything for anything. So I found that leadership style worked for her because as a result her ward ran very smoothly at that time when I was a student there, because I went back there I think twice, and staff was very happy, under her leadership, they worked and they thrived well, you know, they didn't even want to leave the ward, I found something that I took and I used.

R: Yes, anything else?

With regards to the students being equipped, I think we are equipped in theory but it's more practical when you are on community service. So during the community service placement, that's where we get to put our theory that we got at college in practice now, and the different leadership styles that we

have been taught in college like autocratic, democratic and so forth, that is where we get see that okay this is how different people are lead, and then you see from how different people have learnt, okay this is the leadership style, but it is more suitable for a certain work environment and for a certain work situation. So I found it was a mix, a bit of both, you know, democratic leadership style will be applicable in certain aspects, but there are times where you need to kind of like be autocratic, that is where you need to use the situational leadership style. So that is how I found the leadership in the medical units.

R: Then, when you moved from medical units what happened?

P: When you are working as a community service professional nurse, when I got to the third unit, which was MOPD, I was able to adjust because of previous experiences, and it was easier to get on the floor of delegation, and staff liaison, dealing with problems, and trying to resolve whatever disputes that have occurred, which is usually among relatives and patients, that is more of an acute place, where you deal with patients a lot, you deal with relatives a lot, that's where the health in pilot in question, what's going on, and staff like that, so..... I think there is where I learnt more of how to deal with more leadership of patients complaints, where I used some of the Batho Pele principles. I did not even know that the National Core Standards will come into play, but that will come into play as well.

R: Yes.., what else you learned there?

P: I found that the sister that was there, she was able to use those Batho Pele principles and National Core Standards more readily because I think she has been kind of involved. I think patients are happier with care as long as they know what is going on with their care, especially waiting in the queue, especially knowing that such and such will happen, and this is where you are standing and this where you are going to be now.

R: Yes, Im listening

P: I also found out that even though you are impatient as a human being, but you more readily open with ohh ok I can wait, or ooh....., ok this is what is happening, whereas if they do not know anything, they become very irritable, especially relatives, they do not know what is happening, they see the patient is just depleting and they feel like nothing is happening, nothing is going on because you have not informed them, so that is what I learnt, I kind of learned from there with regards to leadership is that you have to enforce on your staff and yourself, do things that you want your staff to do, besides the fact that you are teaching them, be exemplary, so that is what I found when I am just analysing with regards to all the leaders in the different units and areas that they were an example in everything, they were more, 'do as I do, not do as I say', so that was basically what I learnt.

R: Are you finished with leadership, can we move to the next question?

P: Yes I'm done with leadership

R: Now that you have finished your community service placement, how did all the experience that you have with regards to delegation of tasks prepare you to deal with delegation of tasks in the unit?

P: Written delegation, I found it very easy, off duties which I found it simple, as well as balancing the numbers, I did not find that too hard, as well as daily self-delegation a well, I did not find it too hard, as

long as you are familiar with the scope of practice for all individuals from EN to ENA,GA, whatever it may be, I did not think it was too difficult for me, But it's more of the verbal delegation whereby you get a bit of resistance, and younger staff members and all the staff members in this sense are kind of the same,eeeeh, because you are new sister, you are new in the field, and you kind of feel like you know you getting a sneaker from them like, 'ah, who are you, to tell me what to do?' So in that regard, I think I was faced with that challenge.

R: How did you deal with that challenge?

P: After a while I was able to deal with it by just being polite when I am delegating, just be polite, don't be abrupt or rush, sometimes I found that other sisters that I have been working with were very abrupt and they are like, 'do this now!!!, why have you not done it now'?, whereas I would ask the staff member to do a certain thing or a certain task, if the task hasn't been done I'll check in an hour later, if I haven't got the feedback, 'so and so have you done the task? If the task still hasn't been done, I'll ask why the task hasn't been done, I'll get the reason, if the reason is valid, I'll accept the reason, if it's not valid,

R: What to do if the reason is invalid?

P: Then I'll start a verbal somehow of disciplinary whereby I am saying, 'ok, you know I have asked you to do the second task because of such and such a reason, but you haven't done this task and the patient care has been compromised, if the third time liaising which I haven't really got there, but I found out that it's better to pass it on to senior member, but it hasn't gotten to that, it's been ok.

R: Anything left on delegation?

P: So the delegation of tasks it's more the verbal delegation to take a patient to x-ray, or do this to a patient, then you will get a dirty look from the staff. This kind of attitude was more across the board.

R: Can you share with me the experiences you had with regards to conflict management during your community service placement

P: With regards to conflict, I think it's the same thing as more about learning from other people's mistakes sometimes, and not making your own, because personally I did not have to deal with conflict from staff but I saw conflict being dealt with by other sisters from staff, especially conflict within the unit,

R: Can you share that experience?

P: You'll find that if there is a certain staff member on duty, other staff members will either literally be not around, the clique thing, but I found out that it was such an engraved internal conflict that if you are coming along in trying to resolve that you know, you kind of trying to bang down the china wall and disturb it, so I think the sisters when I saw in certain units, they will only resolve conflict or try to intervene in certain conflicts, especially among staff when it has gotten to a point of them being aggressive towards each other, that's where they will step in, they will take whoever persons are involved, resolve the issue, listen to both sides, and gets them to kind of resolve the issue and apologise to each other and so forth, otherwise if it is still a cold war, then they will just turn a blind eye, as long as nobody is getting burnt.

R: Yes, continue....

P: There is even conflict sometimes between the doctors and staff members, I think the doctors, especially with the newly qualified doctors, they have this air of superiority, if I can put it, that 'ok I am newly qualified, I am now a doctor, so not bearing in mind that they are basically blank slates, they are also doing a community service, they barely know how to put up a venflon without poking the patient five times, and they basically need nursing staff.

R: Did you experience conflict with the doctors?

P: Yes, heee... and it's funny because when I speak to some of the consultants, they tell us that, 'you know sister, we tell them that the best place to learn, and the best place to learn is from the sisters in the wards, there is no other place that you are going to learn, the theoretical skills you have done is great, but now you need to acquire skills practically, so I found that there was a lot of tension, a lot of conflict especially with the newly qualified doctors coming to the units, and there was a lot of resistance with regards to assisting them and showing them and orientating them. And I think as time goes by, the doctors themselves feel the pain, this is how we need to be behaving and this is where we need help. They then kind of mellowed down and they are more participating. The nurses here do not join the doctor's rounds in most of the units I worked; they do that only if they want to. The doctors do their own rounds and if the doctor needs anything from the sister, he would go up to the sister and tell her what he needs.

R: Did you experience conflict with the doctors?

P: Not exactly, but...., kind of on the fence. You know..., mhhh..., the resuscitation trolley is checked every day, but there is not enough staff for resuscitation, and if I prepare the doctors rounds trolley, the staff will be asking me, 'what are you doing?', they just do not care about doctors rounds because of the bad attitude of doctors towards the nursing staff. I learnt that the understanding between the nurses and the doctors was lacking, because I feel there should be a level where you meet as the healthcare team members. Doctors will not even introduce themselves, they will just walk up into the ward, with no name tag to identify themselves, and they are not even wearing the coats, they do not even say nothing to the nurses, they just walk up to the patient and walk out of the ward without saying nothing to the sister.

R: So how did you cope in that situation?

P: The better way of dealing with the other members of multi-disciplinary team is to respect each other and try to be there is a better way of dealing with the other members of the multi-disciplinary team, you know there needs to be a certain level of respect, but there need to be a certain level of understanding as well, I think from the get go. I think that is the thing that probably I found a bit lacking. But the sisters they were very forthcoming, and straight with the doctors, whoever came into the unit they would say, 'this is such and such behaviour is not allowed and unacceptable, but when things got out of hand, they would kind of eeh..., you know...civil them down and' they were very cut-throat.

R: So, what did you learn there?

P: So there I learnt that ok, even now that I have finished and I am starting to practice now I understand when a certain doctor is coming into the ward you introduce yourself, they have got a very bad tendency of not introducing themselves as well, so even before you speak with me now I ask,

'what is your name; what is your surname, where did you study,'. Even though they have stethoscopes, but that is not good enough, because they don't wear identification, they don't wear a coat.

R: Tell me about your experiences you had with the nursing staff in the units during your community service placement

P: Just a recent one, when I was on day duty, there was a sister that was bridging from a staff nurse to become a sister. At the time you are bridging you supposed to be gaining practical experience of what you are going to be, which a sister is. So she is older than me, which is ok, fair now, I have established myself and I was very familiar with my administrative duty so.., I was encouraging her, because she was very new into the ward, ok, that's fine but she avoided clerical work, she avoided administrative duties, and I said to her one day, so and so, listen, if you are not doing this, when you become a qualified professional nurse you are going to come upon a number of problems, because you won't know what you doing, whereas you will be by yourself most of the time and there are not great number of sisters in the medical wards especially

R: Yes, what happened?

P: She gave me a look, and she said...," 'arg, you say as if you know what I am doing', ok fine", that was it. Funny enough, she worked on my behalf when I was on leave, for the month, absolute disaster. I think I phoned my staff after the first week they have worked with her, and they said, 'please come back', she doesn't want to take any suggestions, if you suggest something to her she tells you," 'I am the sister, and I don't want to hear anything from you". To a point that she did something wrong, and the staff was trying to help her, but she still had that attitude, she was very adamant, didn't want to hear anything from anyone. She was just very stubborn. The worst part is they said she did not know how to do any administrative duty, to a point whereby the night matron as well started complaining about her, because when you come to work there are certain things that you are supposed to do and take them downstairs to the matron's office, but she never did that at all.

R: How about you, what were your experiences with the staff?

P: There was no cohesion at all. With the EN's they have got this mentality that I have been here for so long so you can't tell me anything, or I have seen certain sisters just sitting in the duty room, doing nothing, but it's not necessarily just sitting and doing nothing, because our system is getting more computerised .

R: Tell me about your experiences with regards to unethical practices that you identified and what you learned from them

P: There were a lot of unethical practices that I identified, especially among staff members and the patients; those are the ones that were more vast. Simple things that we learn, basic things that we learn, no identification, to a point where the staff member was disciplined for giving the wrong medication to a wrong patient, the file I think was, so she thought the patient was another surname and was not surname, she gave, fortunately enough there were no side effects led to that medication, the patient was flushed and was detoxed out of the system, there was no permanent harm or damage to that patient. It was an antihypertensive medication, and it was not really a strong form, that was one of the unethical practices that I identified and that happened in one of the medical wards.

R: What happened to that staff member?

P: The sister there pulled the staff member aside because she did not want to embarrass the staff member. We did not hear how she reprimanded her, and the staff member was newly qualified staff nurse. So the sister was more involved in the patient care, so that is how she found out about the act. After that the sister started monitoring that staff member closely, whenever she was allocated some task, and she in-serviced us as the ward staff.

R: Tell me more about other unethical practices you identified

P: Also another unethical practice that I identified, was in MOPD, it was a community service professional nurse that had come in, and she was asked to give an actrapid infusion, gave sixteen or seventeen units, because of the type of insulin syringe that was used, the nurse gave double the prescribed dose. The patient's insulin levels started dropping rapidly, and the patient started getting sweating, very weak, then the doctor ordered to stop the infusion. It was only discovered when the community service sister was now giving another patient the insulin. So when I saw that I told the sister and also told the sister in charge, so an in-service on the use of the new insulin syringes was done, so that the mistake does not recur.

R: Yes, I'm listening

P: Another unethical practice that I identified was more or less involving was in PRU. A baby was getting pavalex, so the prescription was 3500mg, and the pavalex vial is a gram. So I saw the nurse opening three vials

R: What did you do?

P: I asked, 'why are you opening so many vials and yet you only need one vial?', so she said, 'no its 3500mg and the vial is 1gm so I have to open three and a half of the forth vial', but she did not believe me because I was still new and on community service. But at least she did not give the baby, she was still preparing and luckily the sister came in when we were still arguing, and told her that no, it has to be one vial only.

R: Then, what you did after that?

P: That is when I realised that what we were taught in college to always check when giving medication was really important. But now I was also being weary whenever she was giving medication to the babies, if she is giving the right prescription.

R: Is there any other incidence that you were involved in?

P: Yes, at once I reprimanded a student; she would just grab a patient's arm, without even explaining when doing a procedure to a patient. I asked her aside and asked her what it is that she was taught in college to do before she even starts with the patient. She eyed me but I insisted that she should answer my question. I told her what she was supposed to do first. Then I started doing in-service, setting expectations as a student, I taught them about the medico-legal hazards and I enforced the five rules of giving medication.

R: So, can you tell me what you learned with unethical practices

P: I think the unethical practices are more the result of the lack of teaching, in-service education and training, and again we tend to forget about what we were taught in college and start getting accustomed to the easy way out of doing things in the wards.

R: Did you gain sufficient experience in the areas you were placed during your community service placement?

P: Out of the entire year of community service, it was a bit of yes, or no.

R: Tell me more about your expectations of community service placement

P: Okay, on my first day of my orientation I sprained my ankle and I was limping, but then I thought, yeah at least it is the orientation so I won't be working in the wards with my sprained, so we called to the board room, and was introduced to each other, cracked some jokes and we laughed. After that we were told where we were allocated, but not even the map plan of the hospital in general. We were just taken to the corridor and were told that if you go to this ward, you go like this, you turn there and there. I couldn't believe this and thought it was a joke.

R: What is it that you didn't believe?

P: We were not even told who our unit managers are, so we learnt the setting and the layout of the institution on the go. You kind of fend for yourself. But the initial experience, where I started, in PRU, kind of encouraged me, because the sister there was very open with regards to teaching, she was up to date, was on cue, and on par with the new developments, and I found that there I was very happy, but then after that I was a bit down

R: Why were you down?

P: Because of the experiences I got especially in medical wards. But then finding your way, I found to be very helpful, and you grow to be very confidence. So the expectation I had was somebody guiding me through the community service journey.

R: So what happened then?

P: I learnt to find my feet and know everything even when I literally knew nothing, it was a shaky ground and had to stabilise it yourself because the staff is looking up to you as a sister, regardless of your experiences, to them as long as you are the sister with three bars, then they expect you to know everything. There's no this is your mentor, these are the things we are going to do, but it's just "find your way". There is certain work that we are not familiar with as students, things like infection control files, you know the certain part of administrative duties that we are just kind of taught as briskly, and there are certain things that you need to learn in the ward. So those things you will literally be taught along the way, even they have a lot of committees within the hospital or in the ward, and those things you are not familiar with, and as a PN, they somehow literally kind of throw you into that pit and expect you to know and be familiar with those things, which you aren't. Those are the kind of things I found them a bit of a challenge as a PN, and I think it's after those challenges that your expectations are kind of thrown out of the window, when you initially came in because the expectations I had literally was like someone guiding you along, showing you what do to, showing you what is expected of you, teaching you the five coping skills of a sister, how are you going to implement it along the line as a PN, and you know, if you need assistance, this is where I can go to, this is the guidance that I can get.

R: So you didn't found what you expected?

P: Not at all

R: So what you did in the units that you were allocated in as a professional nurse?

P: You know, literally, it might come that you honestly start asking whoever, ENA, EN, sister whoever is available, you kind of find your feet and find your way. Resuscitation as well, that was the major thing for me, because I worked in acute medical admissions very briefly, but that's where you literally learn to think on your feet, MOPD, you literally learn to think on your feet, to know where everything is, even though you don't know where it is, because as much as they say resuscitation has you and three other staff members, but those other three staff members still need your guidance while you resuscitating. So those are the kind of things that you still raw and you don't know what is going on but they are kind of expected from you, I understand there are certain things that of course when you qualify you will learn in the practical field, but you not really as well equipped and prepared, as expected and you find that you are thrown into a well. So there it was a shaky ground, but you had to stabilise it yourself.

R: What about other units that you worked in?

P: For the paed's resuscitation I found it very free flowing, very easy, because the sister there she was very competent, when you come in, she shows you how old the equipment was, what are the expectations when you resuscitating the baby, and by the time the resuscitation is actually being done, she is still with you, she is still guiding you along the way, and there were lot of sisters there who already done child nursing science, they were very competent, they were very able to be around and help you and to guide you along the way. There I found it was absolutely excellent, and then along the line with the adults not so much. But the whole year all in all, I didn't find it as too bad, but one thing I think I toy-toyed against, was, they wanted to send me to maternity, and maternity had absolute terrible record from community service to community service all around, so I just said I am not going there, I think that's the only time when I had a bit of a hard head.

R: So, what happened did the matron buy your story?

P: I told my unit manager, I was in medical ward at that time, and I spoke to her, and she spoke to the matron who was doing our allocation, and she was able to talk to her and said, "she is a very hard working person", so I ended up staying there but I think, you know, if I went to maternity may be I would expect something else.

R: What made you not like to work in maternity?

P: The other community service professional nurses said, "yuuuu, don't ever", because there they said they are just literally leave you to stand by yourself. They said it's terrible in maternity and they say you've got the green bar. They don't bear in mind that you have only done 15 deliveries, 3 episiotomies within a space of 2 and half months.

R: Were you ever left alone in the unit to be in charge during your community service placement?

P: Very often, in medical wards, it was kind of sadly a much known thing that you are left by yourself, but all the other sections there were lot of sisters there, so it was not the problem with MOPD as well, but medical wards, you were literally left there alone, and there were crickets in the background in your head. I found that it goes with respecting you, but I found that the few sisters had a negative attitude; unfortunately that attitude came mostly from those individuals who bridged into being professional nurses. I found like, ohh it used to be the absolutely lovely day, even with the hectic day,

but you don't feel that because your staff was very in tune with each other, there is not something that they can say, 'I'm not doing this because you are not doing it'. I was very nice, I must say, so I didn't find it like a huge challenge, you know, even if I was left alone, you know because sometimes the sisters will not be there, and I'll be the only one there and the unit manager will be in the meeting, so she still lives early in the morning when she's gone from then, and will come back at four o'clock and take her bags and go. Didn't find very like difficult so as long as I find, if there is staff cohesion, then your day is made, you know you can even work alone.

R: So what did you gained in that unit?

P: That experience in turn, enabled me to be competent to do the same thing post community service now, because in December, the busiest month of the year, in medical ward, we were able to work as two sisters and it was just after my community service, but no problems were encountered, I think that's why my in charge and I are very close and we have same ideas and she was very happy with me and she was surprised, she even said, "you just came out from community service but you are so competent", because I was able to say ok, this is the leadership style that I am comfortable with, and that I can work with, and if conflict arises or challenges arise, it's how I can deal with it, and I enforced the very same leadership style from there to the institution I am working in, and I found out it worked for me and it's still working for me. I found out as a very good thing, I think community service enables you to identify who you are as a sister, that's why I found it very helpful.

R: What important competencies do you think are needed to lead the unit?

P: Teaching is very important, you need to be open to learn, you need to have positive attitude, and you need to have patience with your staff, you need to keep abreast with new and latest development or information, you need to be exemplary in a good and professional way, you need to respect yourself first, so as to be able to respect your staff, you need to know the policies of the institution and the protocols, you need to be competent in what you are doing as a sister in charge, you need to refrain from practising favouritism, you must treat your staff equally.

R: Okay then, thank you very much for your participation.

P: No problem Miss

PARTICIPANT NUMBER FOUR (Meandre)

DURATION: 59:46

R: As you have been on community service placement, and now a recently registered professional nurse, can you share any thoughts or experiences that you have with leadership in the unit?

P: Firstly the whole of my community service I did it in one ward, medical ward, of which I'm still in that ward, so whatever I have learnt and the experience I have I got from that ward. My experience is that there's not much loyalty among the staff, there's a shortage and a very bad shortage of staff, so as soon as you start, they know you trained in this hospital, you know this hospital, we know you as a student, we know your competence, you do you just swim. So from the very first five days, from orientation you get into the ward and you are a sister, whatever the students, or the ENA or the staff nurse wants, you should be able to answer.

R: So, you were orientated

P: Yes, so first thing orientation, from orientation, three days of informatics, so that's the computer, you learn the system three days, you should be able to know what the system of the hospital, ordering, to retrieve information, to order, matron's report, its paperless, the only paper you use is only when you writing entry in a patient's file, so it's paperless, ordering the staff, it's paperless, so you should be able to just get in, swim, and when we were students we never used the computer, we used to see the permanent staff on the computer but we don't know how to do things and the system gets updated now and again, so you don't know, and with matron's report you've seen, you just think out of your head what to write and what you have seen, but you have never been hands on.

R: What exactly you are doing now in the ward?

P: So the only thing you would do is IV's and we are experts in IV's because we were doing them full time when we were students, but the actual paper work and administration duties you have to be well equipped, and mind you, you have been doing psychiatry on your last year of the training, and midwifery. So you get into the work you are a sister, in the morning you get into the ward, handover, you should be sharp, you should be sharp with the terms, you should be able to come back to the duty room and make allocation of staff, in my institution we make allocation on your first day in the ward. In my ward there is no sister in charge, so the sister will tell you, 'we understand that it's your first day in the ward, you have just come from the orientation, but because you trained here and you know the institution, there is no time we are short staffed', and I understand, they are really short staffed, so they will take you around and say, 'you know the layout of the ward, and you know the hospital, you are a sister now, today we will just take you around, and you will help wherever you can, but the thing is you get allocated, you better do your job. So you learn as you go along, may be for two days, then by third day, for me I remember, the first weekend I worked, was my first weekend I worked alone.

R: What happened on that weekend?

P: I was in charge of the unit, and I was praying the entire day, 'Lord, please give me strength for this', and you have to work forty hours, so the first two days I was in informatics, third day I am working and I am alone Saturday and Sunday. So I had to learn everything, matron's report, how to log into the system, ordering of staff, you know I have to learn, like today, and each day I have to make notes, how to do this, how to do that, because I know the weekend, there is no one who is going to help me, and as much as I had senior staff like staff nurses and bridging staff nurses, but they did not know how to use the computer, so that was my domain. And even with decisions, they look at the sister, what we do now. But luckily I am a person, who just keeps a straight face smile, I told them, 'you know, I know I am new, but you know what, it is going to be fine, but they knew I was just making a brave face. Anyway, you know I am small, and when you coming to this ward, you have got this negative thought, that what am I going to do this, I feel bad, how am I going to delegate, how am I going to voice out what I feel or how am I going to not put my feelings on what I am saying and be professional about it.

R: So what is your experience for that weekend you were alone?

P: So I quickly get in and the staff was fine, not what I thought before, I quickly got into it, delegation shame I mustn't be anything, every delegation I gave, it happened, I think maybe they were feeling sorry that I am small, but every delegation I did, but well there were people who would drag their feet but I have heard that they were just like that to everybody, it was not me, it was just their way of dodging. With delegation we would do it on a paper where people would sign for their delegated staff so as to accept their duties and to take the responsibility for those allocated duties, so with that I had no problem at all at first, even though I was new and younger, but they respected me as a sister, even though they were calling me 'baby sister', but were giving me my place. Usually it helps if it goes in teams, because you get used to same people and the delegation gets easier to do because if this one has done this today, then you know that tomorrow it is someone else. And it helps even when you are short staffed, but you know that if I have so and so, then I know that with medication I am okay.

R: How do you think community service prepared you with regards to delegation of tasks?

P: As much as I had senior people in my unit, but they never tried to put me down by saying, no we are not doing this like this; they never told me that they are senior to me so I should not tell them how to do things. The problem now is that the community service went by, they got used to me, was that, as we got more short staffed, because of some reasons staff is moving away and the construction going on, so as much what we have gotten as a problem in the ward, is that I have noticed the problem in that as we gotten short staffed, you have got to delegate more tasks to one person, and then they will be complaining that 'even yesterday I was doing this, why am I still doing this even today', but then there is no category to do those duties, I know it is tough, but even if I phone the matron asking for more staff but the matron would just say, 'ask the ward for staff yourself', and yet staff do not want to be taken to work in other wards that they are not allocated in, and they call that 'ukudayiswa', but they do not like it.

R: Is that the only problem you had?

P: That is the only problem I have with regards to delegation of tasks, the staff shortage and being unable to get the right category for certain duties and the other category of staff will start complaining if you allocate them for those duties. With other sisters I heard that they really have a problem with sending their staff to other units that are short staffed, to help, because the one who is asked to go and help will ask 'why me'. For me I think I have that advantage, I talk freely with my staff and I will tell you straight what I don't like, even though I will tell it as a joke, but I will tell you straight what I don't like, and what you shouldn't do, but I will be polite when telling you, so they will understand, and one ends up laughing but will apologise and say, 'I am sorry, I know I am wrong', so I think staff listens to me easily because of my attitude towards them. I also do some tasks with the staff, even if I am sitting in the duty room, doing my administrative duties, but I know what is happening inside the ward, so if I am supervising and I can see that you are struggling, I will come to you and help you, show you how to do that, but will respect my staff, because even if she is an ENA, but she is senior to me by experience, and I will do it with you, but then I have to leave you and go and supervise the students. So in the ward because of staff shortage, we tend to overstretch and go beyond the scope. But with other sisters now I feel inferior, phela I am still on community service, but with the staff there is no problem, because they respect me, they even see that okay, when with this sister in the ward, we are

more relaxed, she is even showing me the staff I have not yet reached, but this other sister it is more tiring because of her attitude, because she does not even show me how to do things, so there will be conflict in the ward because of the manner of approach of some professional nurses, the staff will end up not wanting to do certain tasks and would be weary of their job description, they will not work flexibly now. So I have noticed that attitude goes a long way, and it is important when it comes to delegating tasks. So you learn from those experiences and again you must learn to listen, and because of shortage of staff, you have to be nice to the staff, because they even get sick from working very hard. Again the shortage of staff has created a very low morale in the nursing staff, because despite the fact that they have to overstretch, but they do not get any appreciation from the unit leaders.

R: What have you learnt from the experiences you had with regards to ease the delegation of tasks?

P: I have learnt from those experiences that I came across in the ward. You must also learn to listen to your staff, because these people have families that they have left behind, so they do not need your bossy attitude from you. You also do not need to be rude to the staff and you have to explain why one person has to do more than one task, in the case of staff shortage, because that might also create some tension and conflicts among the staff and with the sister.

R: So how was your relationship with the ward staff?

P: They were so respectful to me. This attitude of staff not wanting to do their allocated duties, or defying the other professional nurses has never been displayed on me.

R: What is it that you think you were doing right to avoid this attitude from the other members of the staff?

P: I have learnt that it is important for the sister in charge to discuss with staff, like when she wants the staff to do something that is beyond their scope because of staff shortage, but you must ask them nicely. I also learnt that as a sister, the staff must see you in the ward working with them, but not just sitting in the duty room. Also the attitude and the manner of approach have an impact on the way the staff reacts towards you as a sister. You have to have the desired manner of approach towards your staff.

R: What else did you find out to be causing delegation of task challenging?

P: Because of the lack in manner of approach from the sister, there will be confrontation among the staff. Again when it is short staffed in the ward, you will find out that there are members of staff who would not want to do dressings because maybe she is a sister or because her category does not allow her to do it. So with delegation basically, even though I never had a problem, but I think the shortage of the staff makes it very difficult for one to delegate duties to staff. Negative things I have noticed is that people will give you hard time not wanting to do the duty that they feel is not their duty, like doing the dressing room, they feel that is a staff nurse duty, but now it becomes a problem when there is shortage of staff and you do not have enough staff in the ward.

R: When it comes to delegation of tasks to other nursing staff in the unit, do you find it easy or challenging?

P: It is, but it is not very easy, I will not lie, you do delegate, but sometimes it will not be done, and the reasons you are getting for not doing the task usually are not valid reasons that you can take, like staff going to the bank to do their personal staff during the working hours, and not even reporting, knowing very well that you have not done the task that was assigned to you and you even signed for it. Now you end up doing the task yourself as a sister because it is the patient that is at risk, so you end up doing it just for the sake of the safety of the patient. May be the patient is diabetic and on metformin, but the glucose levels are not checked.

R: When you are faced with conflict in the unit, do you think you are adequately prepared to manage and deal with it with regards to your experiences with conflict?

P: It is not a personal experience, but something I observed or identified.

R: Tell us about what you have observed or identified

P: There will be members of staff who would not be talking to each other in the ward, which makes the working environment very toxic. As much as you are not part of the ward conflicts and confrontations, but you find yourself being dragged into these conflicts because those involved now will start telling you about their fight.

R: So what is your reaction when they tell you about their fights?

P: You just have to listen and keep quiet because sometimes these fights you find out that they stem from the situation that happened before you even came to work here.

R: What other factors that you think instigated conflict in the unit?

P: The sister in charge would be shouting at the staff instead of calling the member with the problem, sit her down and address her professionally. Now this attitude of the sister provokes the staff to react against the sister, and that will result in conflict. The sister would be sitting in the duty room, regardless of the ward being busy, and the other nurses are busy in the wards, so one staff nurse was a doing a dressing a dressing of the patient with gangrene, so she needed someone to help her. I was busy with the patient who was to go for an ultra sound, so I could not help her.

R: So what did the staff nurse do?

P: The staff nurse understood that I could not help her, and then she went to the sister who was sitting in the duty room and asked her to come help her do the dressing.

R: What did the sister in charge say?

P: The sister said, 'But I can't help you because I am busy, and you know I am suffering from the back pain', and the staff nurse said, 'if you are not fit to work because of your back pain, then why don't you go and work in CSSD and pack the gauze, you are not fit to work in this ward, we are very busy here to have people like you who always complain about their illnesses, you getting paid at the end of the month just to sit there in the duty room and watch us while we working hard'.

R: How did you manage this conflict?

P: I could see that this was not going to end, and I felt too young and inexperienced to handle this, so I went to the sister next door, but now she was in the meeting, so I asked the student to go and offer to help the staff nurse, so as to stop the conflict. I initially offered to help the staff nurse myself.

R: And did the staff nurse accept your help?

P: The staff nurse did not want me to help her even when I offered because she said the senior sister in the duty room is not doing anything, and she further said, 'sister, you cannot help me, you are busy and you always working with us inside the ward, I need that sister to help in the ward, what she knows is to shout at us in the corridors'. The student ended up helping the staff nurse, because the sister did not move from the duty room.

R: What other factors that could create conflict in the unit did you experience?

P: When there is a patient to be taken somewhere, may be to x-ray department, you as a sister have to go and ask someone to take the patient, but now you meet resistance because of the shortage of staff, now people have to do one task repeatedly, but I do understand, we are short staffed in this ward, so you have to approach your staff in a professional way.

R: What is it that made it easy for you to avoid conflict in the unit?

P: If you respect your staff, they can do anything you ask them to do, and that way there won't be any conflict. As long as you explain to them why you have to ask same people to do the same task, in the case of shortage of staff, whereby you end up asking the same people to do things that are sometimes not within their scope of practice. Sometimes you end up saying to your staff when they are resistant to do a certain task, 'please do it for me and the patient', with a smile on your face. Attitude goes a long way, so you do not need to be nasty or even undermine your staff, because they are your backbone. So on Wednesdays there is always a lot of staff in the ward, so that is when we hold our ward meeting just to iron out the problems of the ward.

R: What did you learn from all the experiences with regards to conflict management?

P: I learnt that most of the time the attitude is important and approach, and you don't have to give people what they want, but learn to listen to your staff, and also to reason with them, like to say, 'I know I have been giving you this task, but because of the shortage, and I have phoned the matron asking for more staff, but there is no staff to give. You must communicate with them; they must know what your efforts are to relieve them of overwork. And again they must see you in the ward participating in the rendering patient care; you must now and again get out of the duty room to join them. You need to come down to their level, they must not see you aloof to them, and again you should take their ideas sometimes.

R: How is your relationship, and what are your experiences with the doctors in the unit as a newly qualified with regards to conflict management?

P: I did not get much negativity from the doctors, I remember my first time in the doctors' rounds, and I was not wearing my epaulettes, so the consultant doctor asked the sister I was with in the rounds, and the sister told them that I was a new sister in the ward, and that was that. Otherwise I really have no bad experiences with the doctors. So as soon as they know you are a sister, they only expect you to work with them and know your work, they do not expect you not to know your work when you were introduced as a sister to them, so you just need to learn fast and stay clued up with your sister's duties, especially the duties concerning the doctors and the patient, you must know your patients.

R: Can you share with me some of the experiences where you have identified unethical practices in the unit during your community service placement?

P: Yes, it seems minor, but it is not minor, it's just that it's the things that some of the nursing staff sees them as minor, but it's the things that can be detrimental to the life of the patient.

R: Can you give the examples of these unethical practices by the nurses that you have identified?

P: Examples of these is when the nurse does not check the blood pressure of the patient who is hypertensive or hypotensive, or when the blood glucose levels of the diabetic patients have not been checked before a meal, and you find out that even the medication has not been given, and nobody reported anything to you as a sister in the ward.

R: How did you deal with these unethical practices?

P: So to deal with these, in the morning we always have some in-service education especially about the common problems that we have noticed our unit, so that we are on the same page. That is where you get to know if some staff is ignorant or do not know about the importance of doing certain tasks. You teach your staff about the common conditions of the unit, so that they are well versed about the nursing specifically for those conditions. Supervision of the delegated tasks also is the integral part of managing the common unethical practices that are identified in the unit.

R: And did you observe any unethical practices done by the doctors in the unit?

P: Yes, a lot of them, but you won't hear about those because doctors, unlike nurses, cover each other's backs.

R: Tell me about these unethical practices that the doctors do

P: Mostly that I have noticed and that I can't tolerate, is when the doctors would talk about another patient during the doctors' rounds when dealing with another patient and would even be loud about that. In the meantime, the patient they are dealing with thinks the information is about him. They will even call the patients about the affected parts, or the diagnosis. They will carry on in front of the patient as if the patient is not there. They are treating the patients like they are subjects; they do not involve the patient in their treatment.

R: Can you elaborate as to how you say they treat patients as subjects?

P: The doctors have a tendency of using the patients as guinea pigs, and also as learning tools for medical doctors, without even informing the patient and the patient will just allow them thinking they are there to help him. Sometimes when there are medical exams, the patients will be used as students as models. If students need to learn anything, then the doctors would use the patients for that. Some doctors would even go to the extent of performing some operation on the patients when the condition or the diagnosis does not warrant the operation, just for them to teach students about something.

R: Okay, carry on about the unethical practices

P: They sometimes leave the patient exposed as if they are coming back. Even when they disclosing the diagnosis to the patients, they tend to be careless and just blurt it out, without counselling the patient before. Once the doctors are gone then the patient will start asking questions as to what the doctor said about him, because even the language the doctor's use will not be understood by the patient.

R: What measures or approaches did you apply to stop or control this unacceptable behaviour of the doctors?

P: I always tell the doctors and medical students to first explain to the patient what they are doing and explain the benefits thereof to the patient. I also advise the patients to say when they do not want to be done anything by the doctors because he has got the right to refuse. I suggest to the medical students not to come as a group to one patient, because the patient gets uncomfortable and also feels his privacy and space has been invaded. The doctors are told to always cover the patient after consultation. When doing some procedure on the patient, the doctors are always advised to always use gloves for cross infection control. Doctors are advised to always use the language understood by the patient, or to get somebody to interpret for the patient and the doctor during exams.

R: Tell me more about these unethical practices

P: The doctors do not communicate with the patients and the patients now are even scared of asking questions about their condition. They also have a tendency of poking the patient many times to get the vein for putting up the drip, and sometimes this will occur during the meal times, and the food of the patient will go cold, while the doctors are busy with the patient. So the doctor-patient relationship is not good at all, but you as a sister, you need to strengthen that relationship

R: What did you do to strengthen the doctor-patient relationship?

P: So to manage this problem, I always call the doctor back to come and explain to the patients what they need to know, and. So you as a sister you need to encourage your patients to talk to the doctor and ask questions about their conditions. And again, the doctor is always reminded to introduce himself to the patient so as a way of respect.

R: How did these experiences empower or equip you to deal with the observing of unethical practices?

P: I have learnt to be an advocate for the patients, and to take charge of the unit. I also learnt to speak out and stand firm on what I believe, I have grown to be so confident and say when I do not like what the doctors or even nurses do to the patients, but I approach them in a professional manner, and I still respect them.

R: Thank, that is all for now, and thanks for honouring our appointment

P: You are most welcome ma'am

PARTICIPANT FIVE(Celeste)

DURATION: 29:10

R: As you are a recently registered professional nurse, can you share with me any thoughts or any experiences you had with leadership in the unit, your fears,

P: From the time I know I started, within the first month, because I trained in the same institution, so my in-charge felt that I already knew most of the things, so I was left alone I think within the third day of me working in the ward.

R: How was your experience then of working alone as in-charge of the unit?

P: It was a bit of a disadvantage to me because I didn't get to learn a lot about what the professional nurse should be doing in the unit, for example like practising how to delegate, because as a 3rd year

student sometimes you are used as a workforce in the unit and less time doing the administrative work and delegating and all of that.

R: So did you survive the challenges of the day?

P: So when it came to me dealing with conflict and unethical practices, I basically was thrown into the deep end, so that is how I learnt because I saw that when things were not getting done, that is thrown back on the professional nurse, even though you were not with that patient at that time, but you will be held responsible for that patient.

R: How did you remedy the situation?

P: So that is when it threw me back to my theory when I was in college and the things that I learned like my regulations.

R: What do you mean by you were thrown back to your theory?

P: So what I used to do was a lot of in-service training and talk to the nurses and tell them you see according to the regulations I am here to delegate you, so if you do not do your work, I am just going to put in the regulations, for example acts and omissions, so by you signing the allocation, that means you are responsible for that patient, so if something happens to this patient and you did not do what you were allocated for, then you will have to answer in the court of law.

R: How did you find the doctors towards you as a newly registered professional nurse?

P: In terms of the doctors, I found out that one of the main things that you need to be is to be confident when you are talking with and to the doctors about the patients, know what you are talking about, so when you are with the doctors in doctors rounds, speak up, in front of the patient. Be an advocate for your patients; do not let the doctors do as they wish about the patients, like discharging of the patients who still need to be investigating and when you know that the condition of the patient does not warrant discharge.

R: How did this experience prepare you to deal with?

P: Basically, now I am more confident to speak up.

R: Could you please elaborate on that?

P: Like with conflict when your staff feels that you are uncertain about your decisions, they tend to take advantage of your indecisiveness, especially when you are young and are newly qualified, especially with the community service professional nurses. They always take advantage. One of the things that I used to do, I used to wake up early in the morning, I used to think about certain things that needs to be done in the morning, for example your ordering, get all of your administrative duties out of the way, and sort out your things with the doctors, and your staff, make sure that you properly delegate, you need to be organised, because if you are not organised then things tend to go haywire in the unit.

R: Can you share with me any experiences that you had regarding the delegation of tasks?

P: Yes I had an experience, where there will be pressure care to be done, and it should be done two hourly, then you would allocate the staff accordingly, and then what will happen some staff will swap the allocation of tasks with others without telling you and they will not even alter it on the allocation book, and what will happen is that that task ends up not being done, especially with the students.

R: So in this case, how did you manage or deal with that situation?

P: You have to approach the one who has been initially allocated for the task, and you need to talk to them and tell them that they should stick to the allocation for the day and not to make changes, but then you as a professional nurse your duty is to always check if all tasks allocated are done. You also need to know the competences of your staff and encourage them to say when they are not sure about a certain task. Also tell your staff that when they have a problem with their allocated tasks then they should approach you as the professional nurse in charge of the day.

R: So what would you do in the case of a member of staff having a problem with their allocated tasks?

P: If you find out that a certain nurse is not competent enough to execute the task, then as a professional nurse, you need to assist that nurse to achieve the desired level of competence in that task. Teaching your staff in the duty room early in the morning after the report hand over is imperative and also using effectively the teachable moments. This can help you to be able to identify the weaknesses of your staff and also their strengths.

R: Can you tell me if you have learnt anything from your experiences that you had with regards to delegation of tasks that can help you to be autonomous?

P: In terms of delegation, yes I've learnt a lot, you have to take charge of things, because if you don't, then things are not going to get done and then indirectly your patients are going to suffer at the end of the day.

R: What is it that you think it is important when delegating and what is it that you think it makes delegation easy or challenging?

P: You have got to have relationship with your staff, talk to them, see where they feel uncomfortable, and try to relieve their anxiety as well because may be one person doesn't like to work with another person, so you have got to come in between that and make sure they not working together all the time, or sort out the conflict between two of them, sit them down and find out what the problem is and what can be changed as well

R: With regards to conflict management, can you share any experiences you had?

P: From our ward I know there was a problem, and what our in charge decided to do because there was texting of each other, the nurses were uncomfortable with it, and the nurses that were texting each other didn't feel the other one was appropriate and didn't like the way they were in the ward, and then the other one was gossiping about them, outside the ward.

R: How was this conflict managed by the professional nurse in charge of the unit?

P: What happened was we have a day in the ward when all permanent staff will meet, for example on a Tuesday, so all permanent staff will be on duty and that would be the day that we choose to have our climate meeting. So that is what our in charge sister did, and everyone had to view how they feel and the professional nurses would also have to give their opinions as well, if they have identified anything and the way forward. So on that day of the climate meeting everything will be discussed and finished, and after that no one needs to talk about it, we not going back, today it is solved, so you did not like the way the other one was talking, its fine, no more texting each other, deal with what we have to do in the ward.

R: How do you think you would manage the conflict in your own unit when you are in charge, taking from the experiences you had with conflict management?

P: I think the climate meeting was a very good idea, so that's something I would do, it's also good to have in the morning, when all staff is there and present, and they know what problems they have and they are not with patients at that time, so that's a good idea, and also to talk about it, it's good to talk about it and come to a conclusion together as a unit.

R: With regards to observing unethical practices, are there any experiences that you can share regarding your observing of unethical practices and the management there of?

P: Unethical practices that I have seen in the wards, is with the doctors.

R: Can you share those experiences with me?

P: Doctors tend to walk around in the ward with the exposed needles in their hands, secondly they don't talk to the patients during the rounds, but they talk to each other and to the consultants who are standing at the back, instead of talking to the patient who is right in front of them

R: What did you do to manage this situation?

P: So some of the things that we've done for example for controlling the exposed needles, we've given them the ppe's, provided them on the trolley, for example, or your equipment, like your receivers, and then if you see the person not using it, you confront the person, 'please use the receiver'.

R: What were the measures in place if the doctors did not comply?

P: If you see the person is still not listening to you, the next thing you will follow the channel of communication to lay a complaint. So we would, if it is the intern, complain to the registrar, still nothing being done, complain to the consultant, still nothing being done, just go straight to the medical manager, the medical HOD and then complain to him and say, 'you know what, this is the interns are doing, and it's going to lead to needle stick injuries', especially when we cleaning the beds and things like that, poking of needles on beds, which is not allowed, we've seen that that has improved.

R: So in the case of the doctors not discussing with their patients, how did you deal with that?

P: In terms of talking to the patients, like they don't talk to the patients, patients do not know what is happening with them, what is being done for them, so you've got to advocate for your patients during the rounds, doctor please talk to the patient, also speak with your patient as well, feel free to ask the questions to the doctor while the doctor is still there, which is important, so I've learnt to speak up, and know your channels of communication.

R: As a professional nurse who has just finished community service placement, what are your experiences with regards to your period of community service and what have you gained out of this period?

P: I have a lot of experience, I feel that sometimes as a professional nurse, you really are alone, there's no one to stand by you, and the doctors have each other, the patients will complain to relatives, and then all the blame just comes to you, even if you did not do anything, so some things are always to document, everything you do. The other experience I have, a lot of discrimination, because now you have these three bars, I have heard comments like, 'you know some of the nurses that are in the four year course, do not know anything because you were just pushed to do this

course, and then you can't now just go and work', I've even heard comments like the fruit cocktail, you don't know.

R: Were you in any way emotionally affected by these comments?

P: Yes, initially, you get offended, but with time you learn to stand on your own, and work hard to prove them wrong.

R: How did you prove them wrong, expatiate on that?

P: By working so hard to grasp anything that you can. If there is a task for you to do, you try and gather some information from those who are willing to help you, and once you get a grip of that task, you can never forget it again. You learn to grasp fast and on the go, until you achieve the self-confidence. You also have to go back to your textbooks for knowledge update reasons. You also have to be always willing and keen to do things that sometimes you never did, like being involved in resuscitation.

R: How was the attitude towards you from other professional nurses in the unit?

P: it's a lot of discrimination especially with the sisters with plain epaulettes and you coming there as a young person with your three bars and they have been working so hard, so they tend to look at you funny as well and they even sometimes even say ok you've got this but you are working in the medical ward, not like you getting paid extra, so what's the point. I even heard comments like you know especially like midwifery, they have a lot to talk about that because I know if you bridging you have got to do it one year, and we were doing it six months so one sister even said; 'you can't even deliver a baby but you have got all these three bars'.

R: Is there anything else that you can share with me regarding the attitude of other professional nurses towards you as a community service professional nurse?

P The sisters in the wards who are not R425 trained expect you to do more than you can, especially my experience in the medical ward, where you get acutely psychotic patients, now they don't want to go closer to these patients, they expect you to be the one to go there and handle this patient because you have a psychiatry bar. They always remind you that they are not psychiatric trained. Even with the administrative duties, they will leave you to do things on your own just to spite you.

R: What is it that you think is the reason you cannot deliver your baby especially during your community service placement, or what is it that you think should be done?

P: I think we need to be given more time, especially in the practical area, we need to get more exposure, and I think the four year programme is cramped too much of work in that four years, whereas especially when I look at those that are bridging and I look at their work programme, compared it to us, it's a lot lesser, I feel we could have done better you know.

R: How do you think you could have done better?

P: in terms of more time to study, more time in the practical area, and more experience so that when you do qualify you can be able to do all these, and now in the wards they expect you to know everything. This I find it very unfair because we don't even have seclusion ward for these patients, we are not in the secured environment we are in a high rise building. Some of the staff is getting abused by these patients, and now because you are a sister who is psychiatric trained although you don't even get paid for that you must just go and nurse this patient, which is just hard.

R: What is the attitude of staff in general to you as a newly qualified professional nurse of a four year programme?

P: They take you know it all, so if you don't know something you are seen as being incompetent, but I really don't have so much of problem with the staff because in the ward that I'm working in now they seem to draw more to me than the other sisters, may be because I am more friendly, and I'm still young so they don't really have that much of a problem with me, but I did have problem with one nurse and it was an ENA.

R: What happened?

P: When I told her that there was a patient to be taken to ultra sound, and I said to her, 'you have to take this patient to the ultra sound' and she said, 'hawu, sister phela sister I am busy now', but she was standing there talking to another nurse, and I said, 'excuse me, I am your supervisor, and I am delegating you and you will take this patient to ultra sound', and I walked away leaving her standing there, because you need to be firm on your decisions some times. So she took the patient to the ultra sound.

R: What is it that could be reason the staff is more drawn to you than other sisters?

P: I think it's because they think they can get away with things, so they could rather be with me than a person who is more strict, also they can take things lighter, it's not so serious because I am there and I am young, and they know that all of the burden just gets pushed over to the sister, so I can also say its lack of responsibility in their part.

R: What experiences do you think will help you as a unit manager?

P: I think delegation is very important, being confidence in what you do, know or say things that you know what you are doing, even if you don't know sometimes, it's okay. Everything has a learning curve, you might make mistakes, but you can learn from them; also I think patients are important as well especially because you are in charge so you have got to make sure things are done for patients. You have to also confront the doctors when things are done wrong, confrontation is very important, you have got to stop them there and there; and sort problems out while they are on the turn, same time, don't wait for things to get done.

R: What do you think needs to be rectified, or your expectations about the community service placement?

P: A lot of things, I think you need to give more time, don't just push us to the deep end so quickly, we need also to be supervised, we are also learning, so they need to supervise us as well, because they live us alone to be in charge of the units, and is not working out, also like even to be right now if the unit manager is on leave, you are really left alone, just like my unit manager is on leave, so you have got to do things like your equipment, monitoring of drugs and ordering, less staff in the ward, you are not properly staffed, critical patients, so you have got nobody to advocate for you as even a nurse in the ward, so added duty to us.

R: We are not done with the interview, and I would like to thank you for your time and allowing me to interview you.

P: It's been my pleasure miss, thank you

PARTICIPANT NUMBER SIX (Marlene)

DURATION: 1hr 16:23

R: As you have been on community service placement, and now a recently registered professional nurse, can you share any thoughts or experiences that you have with leadership in the unit?

P: It wasn't so bad, the sisters were so supportive, and with my first ward I was very lucky, the structure there was so supportive and very understanding.

R: How were they supportive and understanding?

P: They were always ready to show me the road and to guide me, they used to tell me that if I'm here to work I must just do my work and not try to change the institution, because I came from nurses home with the attitude of being a young person. Where I trained, I was used to professional nurses sitting in the duty room, doing their administrative duties and doing nothing in the unit and with an authoritative attitude, they are more paperwork orientated.

R: So how was the situation different from where you were placed for community service?

P: In this institution there's more team work, and there's nothing like hierarchy when it comes to working in the unit, everybody is actively involved regardless of the position the people hold in the hierarchy, it only comes in terms of specific nursing care, but even so, if there's no professional nurse, I'm the junior professional nurse, they won't say, no you going to do the medication because you are the sister, we'll all do medication, we'll all do dressings, even there are some other units as well where you do get some people do use power to undermine you, who will tell you that I might not have as many bars as you are, but I'm more experienced than you and will people start to learn who even try to turn the staff against you in an attempt to expose your lack of knowledge. But when you are then the situation changes

R: Tell me about of your experiences regarding delegation of tasks

P: It wasn't bad considering the structures that they used to delegate.

R: What structures did they use to delegate?

P: It was a matter of just allocating people in those categories and everybody knows their duties that they are supposed to do.

R: Did you encounter any problems or resistance with older staff with regards to delegation of tasks?

P: Funny enough you would think that its older people that will give you problems, but older people know what they are supposed to do, they don't need to be told, and they actually know that I'm here to work.

R: So how was their attitude towards you as a community service professional nurse with regards to delegation of tasks?

P: They respect me, they give me my position because they know that regardless of my age, but they know that in the ward I'm a sister, and when I'm delegating you, I delegate you according to the level of education and competence; then in the tea lounge I am a baby, you can send me anywhere, but once we are back to the unit I'm the sister and I give orders. The older ones won't give you problems when you delegate them to do something, for example, if the doctor needs the patient's wound

exposed, they will not question you because they respect the fact that you are the professional nurse. So I really didn't have many problems with delegation of tasks except with the students.

R: So how was your relationship like with the students in the unit?

P: The students are the most trouble makers, they bunk work, and they get lost during the course of the day without reporting. They display a negative attitude when I'm delegating them.

R: What do you think could be the reason for their lack of respect towards you?

P: Because the students are almost my age and even older, they take advantage of the new professional nurse, especially those still on community service placement. So it's like they querying how come I delegate them, but I always tell them that I'm sister in the ward and I have a right to allocate them by virtue of my position in the profession.

R: How did you deal with such a behaviour from the students?

P: Dealing with the students, I would reprimand them, and when they need me to sign their reports, I would tell them that 'I will write exactly how you have been behaving yourself in the ward', and I would even report them to their lecturers when they come to the units for student's accompaniment.

R: What did you gain from delegation of tasks and the management thereof when you now work on your own?

P: There were times when I worked with the lazy senior professional nurse.

R: What makes you say she was lazy? Elaborate on this

P: She would not leave the duty room, so I would do all the tasks, and it was in medical department, even when it came into writing the report, and I went and ask her how to write the report as I was not sure how to write the report. She said to me, "where have you been working that you cannot even write the report because even if you have been working in surgical department, a report is a report", and it ended like that

R: You mean she never helped you at all?

P: That was the end of the story, and she continued doing what she was doing in the duty room, and I was left alone to write the matron's report.

R: So what did you do, did you manage to write the report without help?

P: That is what I like about being left alone to fend for yourself, because you never forget the skill you mastered under difficult circumstances.

R: Did you learn anything from that incident?

P: Yes, I learnt something, what she did helped me somehow, because I was able to do things by myself, without being helped, even when there is resuscitation, she would disappear into thin air, and sizzle away, leaving me alone as a sister, but I would survive.

R: So in situations like that how did you survive?

P: As much as I am junior than her, but I will be there with doctors, delegating people, and one thing I learnt is that when you delegate, especially in an emergency, you need to call people by names so that there is no confusion as to who does what.

R: What do you think could be the reason of her running away from situations like resuscitation while she was senior than you?

P: I think all the running away of the senior professional nurse was just a sign of her lack of knowledge about resuscitation, but not necessarily that she was trying to fix me or to expose me, the problem was more with her, than me.

R: Did you learn anything positive from these incidents?

P: This helped me to become more confident and to be independent, knowing that I am as good as working alone. She had this bossy attitude and other senior professional nurses in other units were scared of her.

R: How was her attitude towards the staff in the unit?

P: She would also choose the people she wanted to work with in the unit, and she would show you if she doesn't like you, she would just single you out. She was acting like a dictator. People use their positions in power to bully the staff around, and mostly these kind of senior professional nurses are doing this because they lack knowledge.

R: Was there any orientation that you got in each and every component that you were placed?

P: There was, sometimes it was empty orientation, but at the end of the day you would pick up some things on the go. If you are lucky enough to have supportive staff in the unit, then they will guide you and tell you what the in-charge nurse of the unit likes the things in the unit to be done. Another thing that I noted is that with each and every unit there is a different system of working according to the likes of the professional nurses in charge of the units. In different departments there are different ways of doing things because of the certain person that is running the unit, there is no consistency or a formula

R: What do you think it is, with the experience you have regarding delegation of tasks made the delegation of tasks easy or challenging?

P: I am not going to say I had challenges with regards to delegation of tasks, I am not going to lie, because I would not be running to blood bank or laboratory or pharmacy, because the staff in the unit knew their work. From the word go, I stipulated it very clearly that I will not be running to the pharmacy when there is an enrolled nursing auxiliary in the unit. I made it clear that in the unit I am in charge and a professional nurse, and I will delegate the staff according to the level of competence, education, and I think positive attitude is the key to smooth running of the unit. Being firm when giving authority and respecting each other regardless of the category is important when working as a team.

R: Were you ever left alone when you were still on community service placement?

P: Never, I was very lucky, but it did happen to one of the community service professional nurse.

R: Do you mind sharing the experience with me?

P: It was her first day of community service placement, and she was asked to go and work as in-charge of the other unit, where the professional nurses did not turn up. In the unit she was allocated there was in-charge professional nurse and another professional nurse who knew the institution.

R: So did she go and work there?

P: No, she did not.

R: So what did she do?

P: Fortunately this community service professional nurse had her mother working in trauma unit as a nurse also. She went straight to her mother and told her that she is asked to go and work alone in the

unit as in-charge, on her very first day of community service, but in the unit she is allocated there is somebody who could be sent to this unit as she knows the institution and is senior than her.

R: And how did her mother assist her in the situation?

P: The mother took the issue up with the management and that was rectified. Now my concern is what if this happened to someone who did not have anyone to speak up on her behalf, as she was new, on her first day in the institution. What if something happens while I am allocated there alone as in-charge of the unit, who will speak up for me, those were the questions that were going on in my mind.

R: With the conflict management, what are your experiences, and what is it that you learnt from them?

P: I didn't have any conflict situations, because I always strived for everybody to be happy.

R: How did you do that?

P: So I made it clear from the word go that if there are any problems that could instigate fights or conflicts among the staff, we should just sit down and try get the solution to the problem at hand before it escalates into something ugly, so as to make the environment flowing and going as we spend the most of our time at work. So I think if there is anything that could cause friction among the staff members.

R: Tell me about your experiences with regards to any unethical practices you identified during your community service placement

P: There are plenty of unethical practices that I identified, from the nurses as well down to the doctors; we can go on for days.

R: Can you mention but a few that you have identified?

P: From when the nurse decides that you are not going to check the blood pressure of the patient but will just take from your head and write the figures down, and doctors deciding to just take the patient to theatre without even checking how far the patient is with cervical dilatation, in cases of the labour ward patients. Sometimes the nurses would not carry out the emergency doctors' orders in time. The doctors sometimes they do not want to listen to nurses when you giving them the advice about the patient.

R: What could be the reason behind this bad attitude?

P: The doctors think and feel they know too much and more than a sister and they tend to undermine the nurse's opinion about the patient. For an example you as a nurse, will be augmenting the patient, then the doctor authorises the patient to be taken to theatre now, and you tell the doctor that the patient is still being augmented, and she should at least first p.v the patient,(in cases of labour ward patients). The doctor will tell you that, "but I have p.ved the patient at 15h00 and she was at 5", but the time now is may be three hours since that 15h00 of the last pv, they tend to make hasty decisions about the patients without following the necessary steps of decision-making, they will say the patient must be ready for caesarean section but the doctor has not even checked how far the patient's cervical dilation.

R: What measures would you take to manage this kind of unethical practice?

P: I will have to go and report to the professional nurse in charge of the unit, that the patient can still deliver on her own but the doctor wants to take the patient for caesarean section without checking her first. They make mistakes and they do unethical things with patients.

R: And what about the nurses, with regards to observing unethical practices?

P: Even the nurses are so careless with the patients but to me, the doctors are worse but they always get away with murder. But now lately the doctors are sort of changing the attitude towards nursing staff now, the consultants will tell the junior doctors not to undermine the nurses as they are the very rich sources of knowledge.

R: Can you share with me your high points and your low points of community service placement?

P: I think the lows would be like getting ill-treated, I won't lie; I did get to the ward where I was ill-treated by the in-charge, so when I get ill-treated by the in-charge, and it was during December time.

R: How were you ill-treated?

P: Apparently there was somebody that was supposed to be allocated there, but because there was conflict or whatever, she kept on with people to work in her unit, and was on leave, so when I was back from leave, I just went back to labour ward. I was told by the matron to go and work in this surgical ward, so when I got there the in-charge told me she was expecting a male professional nurse and not a female, and I also told her that the matron sent me to come and help in that unit.

R: How was the in –charge's reception of you in her unit?

P: The in-charge professional nurse was nasty to me, she told me that there is nothing like helping, everybody works and not help. I told her that I finished my hours in surgical so I am here to help out, and I told her that the matron promised me that I will still get my day off requests.

R: And how did she react to that?

P: She flatly refused to honour my requests saying her staff have already requested. I was not even orientated in the unit, I was just told to put my bag there and start working. She told me that I was not going to teach her how to do off duties.

R: How did you handle the situation?

P: That is when I decided that I am not going to work in that unit where the in-charge had such bad attitude, and I also told myself that if the in-charge is the first one to ill-treat me, that means everybody in the unit, even her subordinate are going to ill-treat me, then I decided to report in sick for a week, and the next week was going to be the changeover, so I was not going to go back to that unit.

R: Do you think you handled the situation professionally?

P: Initially then, I thought I handled it very good, but when I look at it now I think it was a bit immature on my side to retaliate in that way, but then I was pushed into behaving the way I did, and because I was a community service professional nurse. That is when I realised that the reason why people did not want to work in that unit was solely because of the attitude of the in-charge. In other units they groom you; they make you develop that self-confidence and that independence to work on your own without fearing any challenges.

R: Is there anything else that you can say was your low point of the community service placement?

P: Another low point is for a community service professional nurse to be allocated in only one department for the entire community service placement, but it never happens with me, but I know that with others it does happen.

R: What do you think it is that the community service lacks?

P: I think the in-service training and induction, and mentoring structures are lacking, so as to help and guide community service professional nurses. It is like you are just thrown in the deep end and it is either you sink or you learn how to swim, or you drive on against the wall and you make a way around, but you have to try and keep afloat. Because it's either do or die. It's either you can let them swallow you up and eat you whole and then spit you out.

R: What can you suggest the management should do to make things better for post community service professional nurses?

P: I think the induction programme of the new staff should be done at least during the first month of your employment and not after three months when you have already found your feet, because by then it is no more effective. By the time they give you that information, you are already lost or it contradicts what you have found on your own; Again the medium language is a problem with the institution, because when I was still new, it came as a shock to me that with some units the report will be handed over in vernacular, instead of English, and if you only stick to English then you are seen as someone who thinks she is better than others

R: What were your expectations about your community service placement that you think were not met?

P: I thought we were going to be taken as a group and be orientated about the departments of the institution, and I also thought we were going to be told that we will be rotating in periods of three months in each department, but we were just told to go to the units that we were allocated in, without even getting orientation of the institution first, but we were lucky enough to be escorted to those respective units. I thought at least there was some protocol or procedure in place to guide us as to how we were going to work as community service professional nurses. But with my group we were a bit lucky, because it was not as bad as other group would tell us, and again in the units I was allocated I was very lucky because it was always nice, except for the unit that I was ill-treated in.

R: What do you think was the reason for you to be treated differently from other community service professional nurses?

P: I think also, your attitude goes a long way for you to be happy where you are allocated as a community service professional nurse. If you respect people regardless of their level of education, then you are likely to learn a lot because people will like working with you and they get very helpful. You just need to know that respect is a two-way process. I still believe that there are people who did not enjoy their community serve, but it starts with you as an individual, if you come with that pre-judgemental attitude, and then you are bound to see faults in people.

R: Thank you so much for your time and the information you have shared with me. We have finished now.

P: You are most welcome ma'am, anytime

PARTICIPANT SEVEN (Deidre)

DURATION: 1hr 10:54

R: Do you have the support system as a new in place?

P: There are some support systems that are in place, like in-service programmes and induction programmes, but are not much helpful to us professional nurses on community service.

R: What do you mean about them not being helpful?

P: Because you find out that there is an induction programme that is on, but you are unable to attend because you are all by yourself in the unit. Like tomorrow there's an induction programme for newly qualified professional nurses but I won't be able to attend.

R: Why will you not be able to attend?

P: I will be all by myself tomorrow in the unit, there won't be a senior professional nurse, and it will be my second day in the ward from community service placement, so I have already missed the tomorrow one, and might end up never going to attend those programmes even the next time there is one, maybe I will be held up somehow because of staff shortage.

R: Is there a shortage of staff?

P: Yes, too much, and it is causing a lot of problems.

R: Can you share with me the problems you encounter as a result of staff shortage?

P: There is the reduction of professional nurses into only three in the ward, and if one professional nurse gets sick, then you have to work opposite the second professional nurse, and that means only one professional nurse per day. This leads to staff ending up getting overloaded with work, and the shortage of staff has led to high levels of absenteeism because staff gets tired. Then it happens that each professional nurse will then work for may be three to four days without rest, then will get tired and report off sick, so you end up working without having an off because you are covering for the staff that is not on duty.

R: So what happens if you are supposed to be off duty and there is no sister to cover for the ward?

P: Even if you were supposed to be off but you cannot get your day off because one nurse has to be on duty and one has to be off. Even the level of sickness of staff has now gone high. Sometimes you have to rejuggle the off duties to cover the unit. Sometimes you are called from home to come and work during your off duty day because there is no professional nurse in the unit to take charge.

R: As you have been rotating during your community service, what are your experiences and your observations regarding leadership of the different units?

P: Firstly, with the assistant nursing managers, most of the times they don't even know that you are in the unit.

R: What do you mean about that?

P: They don't even come to the wards just to welcome us professional nurses on community service; they don't even care about the community service professional nurses. Even if they do come to the unit they don't even ask who you are, they seem not to be interested, if they do ask about us then I don't know, but never bother to even ask who you are, and they just see a professional nurse.

R: Really?

P: Yes, but if something happens in the unit, like there is a mistake, that's when you will then see the nursing managers coming in, and even then they just don't bother knowing how the professional nurses on community service are managing. They know that may be, for example, they have about two community service staff in my department, but they won't even come and welcome you.

R: Now tell me, when they eventually come to the ward, do they consider the fact that you are still on community service?

P: Even if they come, they don't even ask who you are just to know you as someone new in the department. In the units there are operational managers but we don't even see them, because there is this new thing that have been introduced in this institution, where the operational managers are having their offices outside the ward, so they just sit in their offices that are far from the wards. They seldom come to the units, they just come to do rounds with files under their arms, they don't care about the shortage of staff and of stock like linen, you learn everything on the go, without any assistance, you learn to sink or swim, you rely on your own decision-making, regardless of your lack of experience and lack of knowledge as someone who has just come out of training.

R: Do you at least get some assistance from the operational unit managers when you encounter the problem in the unit, as a community service professional nurse?

P: The operational managers act as if they don't know what is happening in the wards, that there is shortage of staff and they don't even assist. I feel that when we are on community service placement we need to be orientated, helped and guided, but it does not go like that, you are just left there to fend for yourself from your first day in the field, you sometimes end up working with the doctor who is around as the unit managers and other staff are not there to mentor you. Operational managers won't even organise staff to work with you as someone who is new in the profession, you just have to work through trial and error and through your mistakes. Even if you are falling short of staff and you need assistance in the unit, they won't come in to offer or even organise assistance for you, they just tell you that that is how you grow.

R: So how do you manage to get through the day working alone?

P: As a new staff member in charge of the unit you are not even well versed with, you need to know the policies and the protocols in place, so that when you are taking some decisions, you relate more to the policies and protocols of the hospital and of the unit. You end up going around asking nurses from other units if there is something that you do not understand.

R: Do you get any help or support from other members of staff like ENA's or EN's?

P: There is this low morale in the staff because of the staff shortage, nurses have lost the zeal, and turnover has gone high, with the work production going down, the quality of work is appalling.

R: What do you think could be the reason for all this low morale?

P: Absenteeism rate is very high and it's the main cause of low morale and poor productivity in nursing staff.

R: I'm listening

P: They have to check on you since you are alone in the unit and you are new, you feel like you are just thrown into the deep end. When the matrons come in for a round, they sometimes take more or less twenty minutes, and you get anxious because you are alone and as you are taking rounds with

them, your other duties are on stand still. They expect to do the rounds with you, you have to leave the patient and attend to them, and you feel that time is wasted and there is still a lot that you need to do as you are working on your own as a professional work.

R: Why is that?

P: The nurse patient ratio is limping; the ward of thirty five patients will have only three staff members with only one professional nurse in charge. I know that the matrons have to take the report about the ward, but I think they should consider the fact that you are all by yourself in the ward, but they don't even get somebody to come and help you as a new professional nurse, they just need and expect everything to be done to perfection in the unit. If they do organise a person to come help you they bring someone who will be unhappy and who will not even be of help, and will just end up going before the kickoff time, leaving you alone again. Now you can't even phone and report this person because the next day people won't come to help you because you report people who have come to help you, so you end up doing everything by yourself.

R: Were you ever left alone in the unit without a senior person to assist you,

P: I was left alone and it was for two days in a forty eight bedded male medical ward.

R: What were the challenges of the day?

P: It was a very stressful day for me and I was very frustrated as I was new in the profession and did not even know the unit as it was my first day. There was nobody to orientate me as to where what is, and I had to take charge of the unit I did not even know, but I survived the day somehow. Different teams of doctors (about three teams) came in and you had to attend to them, sometimes all these different teams would come in at the same time, and you are all by yourself, taking all those orders, and they need different things. Even when you delegate some tasks to other staff, but at the end you have to see to it that everything has been done and you have to carry out all the doctors' orders, write a matron's report before the kickoff time.

R: What did you learn from the challenges you were faced with?

P: Being left alone in the unit to find my own way has somewhat groomed and grown me, moreover it has made me develop the independent decision-making skills and problem solving skills. The ward consists of haematology patients among other medical conditions, and the haematology unit is treated and managed as a special unit in the ward.

R: How did you manage throughout the day?

P: Having the ward clerk who was so dedicated to his work and was curious to know what the ward requires for sustainment of the unit helped me a lot, because he would order all the stock that was needed, so I did not have to run around asking for stock from other unit. I ended up giving intravenous medication to more than thirty patients as this is only done by professional nurses. Yes the staff in the ward was very helpful despite the shortage, and we worked hand in hand and harmoniously. It was a very busy day but on the second day the weight was a bit light as I learnt from the last day's experiences. I was torn between doing the administration duties, ward doctors rounds, matron's rounds, carrying out doctors' orders and taking care of the patient care and also the daily ward report.

R: How did the day go?

P: The day was smooth ran because everybody was hands on.

R: From those two hectic days that you were left alone, what did you learn from that experience?

P: At first I gain confidence in the ward management, it was not easy for me to come to the fore when I need help. I was less scared, and also it taught me to be assertive and to ask when I do not understand. It helped me to know the different types of patients and to embrace their uniqueness, so as to make things easier for you. I would be scared when I saw the doctors coming into the ward and I would say to myself, 'ahh we mha ngasala ngedwa ewardin, naba nodokotela bengena, ngizokwenze njani?' as not sure whether to join or not to join the doctors' rounds.

R: I can imagine how you felt

P: I gained confidence and it's now easy to even join the doctors' rounds, or even ask if you can join them, which was not easy when I was still new and in the early months of my community service placement. You are even scared to be left alone in the ward, and it's not even easy to ask who the doctors are and which team they belong. What am I going to do; here are the doctors, so now I am able to tell them that I am new here in the unit, so if you need something please bear with me, let's work hand in hand, and do not fight with me or shout at me, and control our emotions. You learn to be assertive but with positive attitude, also learn to respect and appreciate people you work with, because they are senior to you by experience, and they are knowledgeable and you can get a lot of information from them. You must also thank your staff at the end of the day. Sometimes you get to know things that you never knew from your training days. You learn to know and understand your scope of practice so that you do not encounter problems.

R: What do you think is important to do as a professional nurse so as to ensure the smooth running of the unit?

P: Educating the patients makes the day easy for you because the patients get to understand their sick role. Conducting In-service of your staff also makes the workload lighter because now the nursing staff in the unit know their professional role and what is expected of them. Keeping abreast with the new developments makes you as a professional nurse, efficient and updated knowledge helps you to be even more confident. You also get confident with educating your patients and benefiting from your own teachings. You learn to be assertive to the doctors and tell them to make use of other categories of nursing staff and not necessarily the professional nurse. You have to tell them that I am all by myself, so make use of anybody in the ward that can help you, so as to make our day run smooth.

R: When you were rotating in different components during your community service placement, how was the treatment that you got?

P: With different departments, I got varying treatment.

R: Please elaborate

P: For example in maternity the staff was so welcoming and they appreciated us, community service professional nurses. May be we were performing our duties well.

R: In what way do you feel you were appreciated?

P: In maternity they were very happy with us, and are always welcoming to the new staff, as long as you perform your duties well. Every day there is a learning opportunities like doctors' rounds, so it's

like in-service every day. In maternity that is where you learn even things that you missed in your training.

R: So you mean you benefited, is that so?

P: Yes we did. That's where you get proper training about things that you were not sure about. Even the experiences about the patients are not the same, because in maternity there are so many patients and they are in and out, they do not stay and they are not bed ridden. The staff in maternity is very appreciative and they also appreciate the students that are placed there. That is where you get to know more about the patients, because there is enough time also and in the mornings there is that session whereby the doctors are being taught and the nurses are allowed to join those educational sessions. Even the patients are very appreciative of the nurses.

R: Now let's talk about your experience in the medical directorate

P: In medicine directorate is where I learnt most of the work and gained more experience and independence, as I was always left alone to fend for myself.

R: How was the staff towards you?

P: They were also appreciating, especially the junior category of nursing staff, but that's where I was not very happy about the working environment and attitude displayed, especially by other senior professional nurses.

R: Can you share your experiences with me?

P: It is where I was left alone and it is the busiest directorate. I did not have a very good experience like other directorates. Even the operational manager of the unit had an attitude, she expected you to drop everything and attend to her, and she felt that you have to jump when you see her, even if you are still busy with the patient. Then you have to explain why you did not attend to her in time as she was walking in.

R: Did you get the same attitudes in all the medical units?

P: No, not all of them were bad, because others are just as welcoming as those nurses in maternity. With the other medical units it was nice, I was comfortable, even the operational managers were so helpful and they would also join in the duties of the unit. But then in medicine that is where I learnt a lot because I seldom had assistance, I was just learning from my mistakes.

R: How?

P: I like being sent by those who are senior to me, for some unit errands, because I tend to learn a lot from those errands. These errands help me develop some independence when I am left alone, because with those errands I get to know what needs to be done for the unit. I like asking questions from those who are more experienced than me. There was professional nurse whom, whenever I ask a question from her, she would tell me she does not know.

R: What did you do about that?

P: So I asked not to be allocated with her anymore, because I felt like I am not gaining and learning anything from her, and I still needed some people who are assistive around me as I was still new.

R: Now tell me about your experience in out-patient department

P: In outpatient directorate I felt that they were welcoming but then there are those few from the staff who want to expose you and they make a laughing stock out of your many bars. They also want to show you sometimes that they know better than you do, despite your so many bars.

R: What do you mean about that?

P: They are on the mission of exposing your lack of knowledge, instead of helping you.

R: So how do you survive tolerating such negative attitude?

P: In this kind of a department you as a community service professional nurse, you just need to be tolerant of the negative attitude, and just tell yourself that you know nothing and you are just there to learn. Those negative people are the very people that I stick to and ask them to show me how to do some certain things, so that they feel special and from that I am gaining a lot. From that you end up becoming friends and that makes the learning even easier.

R: So tell me what do you do to win their friendship?

P: You just need to act stupid and put yourself down so that s/he feels good, while in the process you are learning a lot and gaining some experience.

R: Did your trick work for you?

P: Others will remain negative and won't even be interested to help you and teach you. So with that kind of staff I just ask not to be allocated with that kind of people whom you will never learn nothing from, they always say they don't know when you ask them something.

R: Is there any other department that you worked in during your community?

P: Yes, in the operating theatre.

R: Did you like it there?

P: Ohh I loved working in OT

R: What is it that you loved about it?

P: It was very nice and the staff was very welcoming, I felt at home, and the nurses there were so helpful and they taught the new staff. They understand that we are new from college so we still need some mentoring and some orientation to the system of working and also the setting of the ward.

R: So were you also working with the surgeons in OT?

P: No, we were not allowed inside the theatre when we were still community professional nurses, you have to work in recovery room, but still you learn a lot, especially from the doctors and the anaesthetist doctors. You get to know the basics even if you are based in recovery area.

R: Can you share your experiences of working in the recovery room?

P: The operating theatre doctors they are very professional and they listen to your opinion as a nurse and that makes you feel confident. They make you feel comfortable with them, because as long as you do your work to the best of your ability, they trust your judgement about the patients in recovery room.

R: How did you feel initially about working in OT?

P: But initially I was so scared of working in theatre, but I learnt a lot, as much as they do not allow the community service professional nurses inside the theatre, you only work in the recovery area, but still I learnt so much, and I gain so much knowledge and developed problem solving skills that enhanced my confidence and strengthened my decision-making

R: Regarding the delegation of tasks, what were the challenges that you encountered during your community service placement?

P: Delegation of tasks is a bit difficult responsibility because you find that some people do not really know their work, and they don't want to ask, but now the same people have signed for the execution of the duty. It is also challenging because sometimes you find out that the staff is not competent regardless of the level of their education. Sometimes you find out that there are people who distance themselves from certain tasks, because they do not really know what is expected of them when it comes to the delegated task. Others can't even do admission process, and they don't even want to ask.

R: Don't say that, are you serious?

P: I am telling you, it is a disgrace. The admission entry is an embarrassment having been written by a professional person. They don't even know the policies and the protocol of the institutions. When you try to correct them, some won't take the correction in a nice way, they take it negatively. They don't understand or even see the need to know the internal policies and protocols of the unit. Others will even defy you when you delegate them to do certain tasks, and will even be brave to tell you that they do not do that kind of task and will further tell you that even the sister in charge of the unit knows that she cannot be allocated to do such task.

R: And how did you manage those challenges?

P: So you as a community service professional nurse you should in-service your staff the importance of these policies and protocols, and to also teach them how to correlate these documents with the duties of the unit. You also need to teach them how to do the procedures on one to one basis, and the best way is to let the person does the procedure herself than doing it yourself, so that the next time you delegate her, you know for sure that she knows how to do it.

R: And do you think it worked?

P: Yes, it does work. Because it makes it easier for you to delegate, knowing very well that you have in-serviced your staff. They do not understand that by signing for execution of a certain task you are taking responsibility that you know that task and you are competent in it and you will do it. You as a professional nurse you should be well versed about the internal policies and protocol of each unit and those of the institution so that when you teach your subordinates then you know what you are talking about and you need to teach them how to work in conjunction with these documents. Updating your staff about the procedures you feel that they are not competent with, is imperative for the smooth running of the unit and for making the delegation of tasks easier.

R: Can you elaborate on that?

P: As the generic names of the used drugs keep on changing, you as a professional nurse should keep abreast with those changes so as to be able to teach your subordinates about the latest developments. Whenever the opportunity arises in the unit, to teach your subordinates, like when there is a patient on TPN, use that opportunity to teach your staff so that they know how to prepare the TPN, the indications for TPN, and everything pertaining to the procedure.

R: What else do you think can make the delegation of tasks a little easier?

P: Making delegation of tasks easier, you also need to supervise the subordinates and also, you need to check if the delegated tasks have been executed and in a correct way.

R: How would you ensure that the delegated tasks are done?

P: You can make sure by doing direct and indirect supervision.

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P: You can make sure by doing direct and indirect supervision.

R: Tell me more about making delegation of tasks easier

P: You also need to be firm and stand your ground when you are delegating tasks to the subordinates, and also when delegating, you also need to consider the scope of practice of the staff, you need to also consider the level of competence and the level of education.

R: How does this benefit you as sister in-charge and the unit?

P: If your staff is willing to know more, it makes you to be interested in updating yourself and keeping abreast with the latest developments for the benefit of your staff. It is also easy to delegate when everybody is on duty, so that you do not end up allocating one person for the same task, or even end up allocating more than one task to one person, so you need to rotate the duties to all members of staff. If also, the nursing staff is willing to learn, that makes delegation of tasks easier.

R: Tell me about your experiences with regards to conflict management in the units during your community service placement

P: I have noticed that most of doctors have a lack of respect towards the nurses in almost all the units and departments, but then lately the nurses have learnt to stand up for themselves and be assertive.

R: How do nurses stand up for themselves to the doctors?

P: They do confront the doctors for their negative behaviour and the doctors would apologise to the nurses.

R: What do you think are the other reasons or the causes of conflict in the units?

P: Another cause of conflict in the units is the shortage of staff, and again working in teams, because when they are working together they tend to fight because they are not used to working together. I think the teams are making more rifts among the staff, but the sister needs to speak with them and remind them that we are not here to socialise but to work together for the benefit of the patient.

R: Do you think it is possible for conflicts to be resolved in the units?

P: The conflicts do get resolved but because of staff shortage and shortage of supply, it will take time.

R: Why do you say so?

P: You end up borrowing equipment from other wards because if you order you find out that it is out of stock from the stores. Sometimes you end up fighting with other wards, especially when your unit does not have equipment, and other wards won't borrow you, then that ends up creating a conflict between the wards.

R: So what is optional that you have to do in case of the equipment supply shortage to avoid conflict?

P: So you improvise if it is something you can improvise you end up working very hard because now you do not have the supply to work effectively.

R: What have you learnt from those experiences, and how has it prepared you as professional nurse?

P: From all this, I have learnt to accommodate some personalities because we are unique individuals, and you make her understand that we are all here to work, so I have also learnt to solve whatever problem we have and not wait until it gets out of hand.

R: Tell me about your experiences with regards to observing unethical practices and what you have learnt from them and their management

P: There are so many unethical practices that I have identified especially being done by the doctors, like in theatre, when I worked there.

R: Can you share with me those unethical practices that you identified?

P: Doctors who have private practices have a tendency of abusing public hospital's equipment for their selfish need, like coming with the specimens from their private practice to the public hospital to be sent to the public pathology department for diagnoses purposes. They also order blood from blood bank and to find out they are not ordering for the patients of this institution but they are ordering the blood for their private practice patients.

R: How were these unethical practices managed in OT?

P: When the specimens are sent to the pathology unit they are signed for because the doctors come with the specimens from outside, from their private practices. The specimens are now entered in the book, and are kept under lock and key. Another thing they steal the equipment from the public hospitals to use it in their private practice, so if may be the laryngoscopes have been used, you have to make sure that they have been returned and locked because if they get lost and you are the one who was the last one to use them with the doctor, then you can end up writing statements for something done by the doctor.

R: What else have you identified as unethical practice that you have identified?

P: Other doctors will even threaten the patients that if they do not allow the doctor to perform a certain operation, and yet the doctor just wants to teach other doctors about that operation, not that the patient's condition warrants that operation. They also speak very rudely with the patients, to an extent that you, as a sister, you have to call the doctors to order, because if the patient takes further steps legally, the sister will have to be answerable. Again the doctors will also threaten the patient about signing RHT, all those unethical practices are common with the doctors, because they want to use the patients as guinea pigs.

R: So what is your role as a professional nurse to stop this bad habit?

P: So as the sister, you have to play advocate for the patients when they are being abused by the doctors.

R: What were your expectations with regards to your community service placement, and what did you get?

P: I was expecting to be guided as we were told in college that we will be working under supervision for the entire year of community service. So when I was there, I found out that there is no supervision that you work under, you are just left alone, and I was taken by surprise because during my first week of community service I was left alone as the in-charge of the unit. I thought I was going to be taken in and taught step by step, there is no step by step, you just have to go there and grasp whatever you have learnt because there is no time to waste. I was also expecting that before I start working in the ward I will be orientated, but then with some ward, you do not even get the opportunity to be orientated.

R: Did this experience help you in some way or the other?

P: It helped me a lot to gain self-confidence. So I learnt to control my temper and to be able to deal with the angry and rude relatives of the patients. So I gained a lot even about the different working

system of the different directorates in this institution. I also learnt to throw myself to be part of the procedures like the resuscitation, because one of the days you are going to be a sister alone and there will be resuscitation. I also learnt to work and maintain harmony with the staff I am working with for the smooth running of the unit. But then the experience that I had helped me a lot, because I learnt a lot that I would not have learned if I had someone to help me, because I knew that I had to learn very fast.

R: We have wrapped our talk, and I would love to thank you for your time

P: Thank you miss, I also learnt a lot from your questions too, they took me back down the memory lane.

PARTICIPANT EIGHT (Brooke)

DURATION: 53:47

R: As a recently registered professional nurse can you share with me any thoughts or any experiences you have with leadership in the unit?

P: The experiences with leadership can vary, you must remember, although we are trained a certain way, not everybody reacts in the same way, so although the textbook may say 1, 2, 3, you find that not all leaders will approach or have mannerisms or attitudes about going about their job.

R: I'm listening....

P: So in terms of leadership, it can really vary, to be honest with you, you get those leaders who, you can look at with understanding, with focus and you can see ok this is the kind of person I need to attach myself to, they'll be hands on, they won't be, you know, hasty to put on gloves and run if you say there is an obstetrics emergency or a crisis in the unit.

R: Yes, I hear you.....

P: But at the same time you also get those leaders who are a bit more introverted and you find it hard in order for them to express themselves as leaders, so they won't be that approachers, they will not go out and say, 'you know what, 1, 2, 3, you find out that you will have to go to them with the issue, but then they also expect you to come up with certain solutions.

R: I see....

P: And you must remember that with some leaders, a lot of the units that you are working in, you find out the R425 trained PN's are sort of like blessed in a way, because you getting everything comprehensively covered, as opposed they have to train from ENA to EN for staff nurse, and then to PN general and specialise, so they feel like maybe it's a bit unfair so to speak, that you know, they train for such a long period of time, and then this small*anyana* one just come up, and then they are qualified now, you know.

R: So what is your take on this, do you think what they say is true?

P: But like I was saying, it also depends on your personal belief and how you deal with things, because even though you have this training and the skill and this knowledge which is so amazing, you find out, when people see the way you conduct yourself, even those leaders can be touched or changed by you, you know, it goes both ways, because as we say we learn a lot from our leaders, because we coming with updated new information and we like fresh in the field, they also learn a lot

from us. But you can have different inferences, some leaders are not as approachable as others, so you may want to go to another person, but it just varies from unit to unit and person to person.

R: Tell me how all the experiences you have gone through prepared and equipped you with regards to dealing with delegation of tasks in the unit

P: As a new professional nurse, delegation can actually warrants the most difficult challenges.

R: How, can you clarify your statement a bit?

P: I am going to be honest with you. Because you find out many people are set in their ways, let's just say for example, this is one staff nurse who does the dressings every day, but you come there now, and you have this new mentality where everybody needs the equal chance to learn and expand on what they know, so you decide that I am going to change it, you will do maybe dressings today and you will do vital signs today, you find out that people are very resistant to change, but it's not because they are resistant to change.

R: So what do you think could be their problem?

P: it's because they don't feel confident in the skill because they have not been doing it for such a long time, so when you delegating tasks it is so important, not to just be the kind of leader who says, "it's my way and nobody else's way".

R: What is it that you think can be the solution to this resistance?

P: You must constantly be talking to the staff, especially when you are a new professional nurse, it's actually so funny because, they don't know what to expect from you, you know, so it's important to deal, like the problem that I personally faced with my own self, was that they would look at me and think, "mh, this one, look at her", and then you go to them and you tell them that, 'you know guys, I understand that we all are comfortable in doing some things', but the most important thing with delegation is in-service.

R: Yes, how?

P: if you teach the staff how to do staff in the ward, they will not be resistant to delegation, and explain to them, if you are doing delegation and there are two PN's in the ward, and the ward is a 40 bedded ward, you can't expect one sister to do the IV's in the 40 bedded ward every day, she must also do the doctors' rounds, she must also do delegation of tasks, part of becoming a leader, or becoming somebody who knows how to handle the unit, should be able to promptly delegate and efficiently, and also not neglecting some people's needs.

R: Yeah....

P: If you can see that there' is a need for that person, delegate them there by the system, but I know delegation can cause a lot of uproar in the unit, because not everybody feels that delegation is fair, but at the same time we have to look at it from both ways.

R: Tell me about the challenges that you had with regards to delegation of tasks

P: We were doing the delegation, so the unit that I am working in is very busy, fast pace hectic unit, so what we try to do is, everybody who knows how to do certain things are usually kept there because we want to push, we seeing like over a 100 patients a day, so I felt as though, as much as I get that, everybody needs the chance.

R: So what did you do about the needed change?

P: So I initiated that I was going to change, and not everybody was happy about that. I found somebody putting a probe in an actually wrong place as opposed to where it should have been. It was somebody who bridged from being a staff nurse into being a sister, and she was much older than me in every aspect and her nursing experience was maybe like as much as old as my age.

R: Did you correct that person?

P: Yes.

R: How

P: I called her aside, not in front of the patient and our colleagues, because I did not want to look like I am undermining her and I did not want to be funny, I asked her if she has ever done cardiotocograph before, she looked at me funny. I continued saying, 'In order to be good at it, you need to understand why you are doing it and you need to know what you are looking for on the cardiotocograph trace, but more so to get the correct and accurate results, how are you going to place the probe, and what are you going to do'

R: How did she react to your questions?

P: She looked at me and she was a bit upset, and then she just hushed me off. At the end of the day we are there for the patient's wellbeing. I did not want to probe into that because I could see that she was not very impressed with me at that point in time.

R: And then?

P: So I left it like that, but the CTG trace was very bad, you know, it was looking like a non-reactive deceleration, and then she called me, she said, 'hey sister, please come here', and she said, 'look at this trace', and I said, 'do you want me to assist you and to teach you how it is done, then she said, 'you know what I have not worked in this unit for a very long time and I am not well versed, I would appreciate'.

R: Did you help her?

P: Yes. I did, I said, 'sure, come no problem, and I taught her how you palpate and how you locate the fetal back, I explained the fundal dominance to her, and she was so happy, and she said to me, 'you know, maybe you not that bad after all, I thought I was not going to enjoy it working here', but I told her that "you know, you never too young or too old to learn".

R: What did you learn from the scenario?

P: That was a bad scenario, but it ended up so well. I learned from this experience that your approach to people, whether they are senior or junior, it does not matter, but your approach, there are some things that can't be taught from a textbook, like just your mannerisms, just the way you approach a person.

R: Tell me what it is about delegation that makes it easy, or challenging

P: I would say in terms of making it challenging, maybe it is the sister herself.

R: How?

P: She does not have the confidence to say that, 'I feel that we should swap things around, let's delegate this way', and that can sometimes be a dilemma.

R: How can it be a dilemma? Please elaborate.

P: Because if you can see that your staff has become so proud in doing something and you are so monotonous for them, you should not be doing that way, nursing is a dynamic career, so we need to change it up and make sure that everybody is well versed, you know, you can have knowledge but if you keep it to yourself, then it's powerless. It's only when you impart it on others.

R: Continue, I'm listening...

P: So it can be challenging because people are resistant, but also maybe you are scared to get up and say, 'you know, let's do it this way', but why it can be easy, it's when you know how to assert yourself in the correct manner, and be assertive and not aggressive, you find that it can be easy because your staff can understand, 'no she is putting me there because she can see that maybe I need help there'.

R: You think so?

P: Yes, I know so, and you will find the delegation to be honest with you, like the students, when I was teaching them in labour ward, the in-charge, actually came to me and hugged me, and said, 'you know what, you are inspiring my students', and I said yes, because I've been there not so long ago, and if you don't gain the skill now, once you qualify it's too late, and that's the mistake the students make.

R: Is it?

P: Yes of course, and I used to delegate them all over, and I used to tell them, if you have a question and you are delegated somewhere, don't shy away from it and ask your friend you know, because she was there yesterday, come forward and ask, it doesn't matter who it is, if you ask somebody and they are reluctant to help you, then you don't go back, but if you ask somebody and they are willing to help, ask, because there's never a stupid question. So delegation can be easy in that way.

R: How else can delegation be easy?

P: It can also be easy when you not doing it every day, so the staff do not feel like 'ohh now you are being unfair to me'. So when delegation is done by all sisters, you know, it can be very easy because now the staff will say, 'ohh maybe she does not know that I did dressing the day before yesterday, well it's fine'. It can also become easy when you tell your staff why you delegated them for that task, you know like, 'you are the only EN on duty today and there is no one to do dressings today, I know you did three days ago, but do you mind', you know, it can be very easy.

R: From your experiences and challenges if there were any with regards to conflict management, tell me how those experiences prepared you to lead the unit and to deal with the conflict in the unit

P: Conflict management, wow, people can really bring out your really true colours when it comes to conflict management.

R: Why are you saying that?

P: Dealing with conflict, the first thing I will never forget, don't ever be biased, don't listen to one side of the story and then the other, and call the people together. My experience with conflict actually involved myself. We had a colleague who was resigning because she was not happy, so her reasons for resigning were not good enough, because we need these PN's who are passionate out there, and if you are going to resign because somebody makes you unhappy, is not nice.

R: I'm listening

P: So I was explaining to the this colleague that you come to work because you have taken that pledge, you are here for the patient, so you don't worry about what the next person does, and you need to remember that you are here for a purpose. So the other sister assumed that I was talking about her, so she said, 'if you want to talk about me, then you do that to myself'.

R: And what was your response to that?

P: I completely ignored her because it was not the time and place, because you do not deal with conflict like that. And I did feel bad, but I kept quiet and the sister I was talking to, asked why I am keeping quiet, but I told her that I will talk to her but not now and not in front of you.

R: So did you confront the sister thereafter?

P: Not there and then, but later on I went to that PN, and I asked her if everything is ok, she kept quiet, and I asked what made her think that I was talking about her,

R: What did she say?

P: She said, 'yeah, because you came and asked me to do the screening tool and I said no', and I said you know, if you said no to do a screening tool, it doesn't mean that I am going to talk about you to somebody else, because I am not that kind of sister.

R: Yes?

P: I said, didn't I come to you directly and said I don't like your attitude, we need to work together harmoniously, but its fine, I said but don't ever feel that way, because if you have a problem when you working in the closed unit, you need to be able to deal with your staff, and not let it out there, because at the end of the day, we are here for one purpose, and then she asked what we were talking about, but then I could not divulge that to her, I said it was a personal problem she had.

R: Yeah, and then?

P: Then she said, 'ohh maybe that's why she resigned, and I said, we don't need to elaborate because it's not our concern. So I didn't leave it like that because for how long was it going to continue, because now she couldn't even come and ask for help form me, so she apologised and we were ok.

R: So how did you feel after you told her and she apologised?

P: I was happy I did not leave it like that because how long was it going to be like that, and I told her we can even take the matter to our in-charge if she is still not happy. Conflict can be a drama.

R: While you are still on conflict, tell me, in the units, did you ever been given a problem by other staff because you are R425 trained professional nurse?

P: As I was just saying to you, the one doctor asked me where I trained and how long I have been qualified, and I told him that, no, I just completed community service, and he was shocked and it was like his jaw was opened, and I said why, and he asked which campus I was trained, and I told him, and he said, 'my gosh, I am really impressed'.

R: Did that compliment motivate you in any way?

P: I said to myself you know what, we come to work every day because that's where we want to be, and you don't really know the impact of what you are doing until somebody turns around and say, 'do you know that you are doing a good job?' And you feel good, once you get those motivational

statements then you want to do even better, that's a general feeling, so other staff look and will be like, so I trained here and I am not good enough, you know.

R: Do you also think performance should be rated according to where you did your training?

P: No, I said, I don't think it's about where you trained firstly

R: So what do you think?

P: I think it's all about you as a person, because honestly at the end of the day we are all given the plain training, I can't study from one thing and you study from one thing and we both seat for midwifery or management examination, we have to all study the same thing, I said it also just depends on the attitude, but yes maybe some institutions will train you in a way that you learn better, as I said anybody can be a teacher, but it takes a master to impart knowledge and understanding, so that can always a problem, 'oh I trained here and we did it like this', you know. The sisters who did the general three year course, they would say, 'but I did the general nursing for longer than you, so I know better than you do.

R: What is your take on that, do you agree or disagree with them?

P: I disagree, and I said you know it's unfortunate that for us its crammed, but if you put us both in the unit, what matters is the output, you know, and the thing is once people stop training, they actually don't go back to their textbooks, which is a bad thing, because if you don't keep going back, or talking to the students to find out what is new, you will never be up to date, so still going to fall short, and that can cause a big conflict, because if you know that the blood pressure being this, and I come and tell you now that the new trend says this, there's a lot of conflicts, where you trained always becomes an issue, 'I train here, I trained there'. So updating your knowledge is of utmost importance.

R: Have you ever experienced or identified intraprofessional role conflicts, whereby same procedures are performed differently?

P: Yes, you get conflict when you are trying to show someone how the certain procedure is done, but she gets so adamant and starts telling you that I was doing this long before you were even born, and yet what she is doing can adversely affect the patient. There is also conflict between the way others were taught and the way the staff in the unit are doing things. If you see someone doing the wrong thing, you need to forget about what you think and think about the safety of the patient in question. It is so difficult because if you do not go about enlightening the next person, then you can be taken as a rude person you know.

R: Tell me about your experiences about conflict management, what you learnt from those experiences, and how it prepared you as professional nurse

P: I have learnt that you cannot treat all people like they are the same.

R: Can you expatiate on that point?

P: With lots of people regardless of how much tertiary education they can obtained, your ways that are set in you from wherever you came from your home, will always dominate that. So when you dealing with the conflict, I can be calm, someone else may clique her tongue or use the bad words, we deal with conflict in different ways, but that does not mean I must think you bad, but it's just you. I have learnt that it's sad but true that some people are not taught to do deal with conflict in an effective way, people think to resolve or manage the conflict, and one must fight physically.

R: What do you mean by fighting physically?

P: For them dealing with conflict means lifting up your sleeves and going to fight outside, but it happens you know. When there is a conflict, don't let it blow out of proportion, deal with it now and immediately, because you think it's finished and then something minor happens, and people starts talking about that one which was not resolved, so when there is a conflict, deal with it here and now, squash it and make sure all parties i

has adequately empowered you to be competent as a professional nurse?

P: I will be very honest. I think the only one advantage we have, is that as we learn something, we are perfectly placed in units where we can immediately grasp things. The four year course is crammed, let's be honest, when you go out into that unit, 30% of what you learnt in college you will remember, that's the fact, and the other 70% is what you got from the summative tests and exam, so now when you just qualify you go to the unit.

R: Do you think the staff in the ward trusts you when you are on community service?

P: I am going to be honest; they don't trust you, because they don't know what you know. And you can get a 100% from the college and come to the ward and find out that you crammed for that 100% but you never learned with understanding, and you are here now, and you can't do anything.

R: So in all, you are telling me that you still need some more time and supervision to be able to gain your confidence as a professional nurse

P: But it's the truth; you get those people who have that natural skill where they can learn and they pass and they come to the practical field and do well. But most often they are not, you gain your skill while you doing it. So when you come to the unit, unless you trained there, and the person knows that you can do 1, 2, 3 and 4, but when they don't know that, well you not really trusted and they won't just willingly give you big tasks, they won't willingly put you in the delivery room, they will first say go to the admission room, and then you find yourself for the first three months in admission room, and you are so fed up because it's all you've been doing.

R: Do you think that is fair to you as a professional nurse who is on community service and still learning?

P: But at the same time, I think, I don't want to say if it's right or wrong, it's unfair because you not getting the skill you need in that department fast enough. But at the same time may be they think about the safety of the patients, whereas if they let you buddy with somebody senior, you will learn fast. Like when I was doing midwifery as a student.

R: Please share with me your experience

P: I used to lie about my PV, I could never feel the cervix, and I used to pretend like I could not to, but miraculously I used to guess it right. And the first time I felt the cervix, I didn't know that the sister was on the other side of the curtains, and I screamed and said, 'at last I felt the cervix', and the sister was so shocked, she asked, 'do you want to tell me that you feeling the cervix for the first time, but you always guess the dilatation right?' But it's the truth I didn't feel the cervix, it was just God's will that I used to guess it right.

R: Were you ever left alone in the unit to be in charge during your community service placement?

P: Yes, I was

R: So tell me about your experience of being left alone

P: The institution that I was placed in is where I trained, and fortunately for me, I was placed in obstetrics and it is what I loved, so I have been there through out, so since I qualified I have only been in obstetrics.

R: So how did you cope?

P: I was working in labour ward, and I was not good when I qualified, not at all, but if you come to my house next to my bedside, you will see my Sellers midwifery textbook is there and my Newborn textbook is there. It's not that I was good when I started, no, when I started, the in-charge had a lot of faith and confidence in me, because she said I remember you and when I saw your name I asked the matron to please put you in labour ward. So it's not that I was good, I was not, I just knew what I needed to know to get me by.

R: So what is it that kept you going in that unit?

P: I had to keep referring back to my books, I don't know how come with the pathos, I have just got this thing I keep remembering them, but with other things like in-depth management and staff I had to learn on my own as I was going, and I am in 1 year and few months it's the long time to learn you can become quite skilled. Labour ward was all I had known, and I was on night duty, and there was no sister in the post natal ward, the normal delivery ward, and they decided to just throw me there.

R: How did you survive the night?

P: Now working there as a student and working there as a PN, we all know your roles are very different. And I am not the kind of person who will say no, because I might not know everything but I am going to know something, I know post-delivery I must check that there are not retained products, and I must check that nothing is left there. But I was just phoned, and told, 'stop what you are doing and report in ward D, there is no sister there' and if you are on night duty whichever sister is there you are in-charge, because there is only one PN. But I did manage throughout with no hassles.

R: Even if you are still doing your community service?

R: Yeah, yeah, and I said ok I will go there, so I took my back and went up there; and when I got there I said to myself, 'Ohh my gosh, what am I going to do here, because now I had to administer IV's to the babies, and the truth is unless you are working constantly in your nursery for those fall under obstetrics, you need to know your formula, but if you not doing it every day, you sort of become a blind idiot, so I get there and I am like, 'ohh gosh, and you know our institution is busy, so I am like okay, let me start from one side. I was very scared because I did not know what I was doing there, but I learnt from that scary experience because I never forgot.

R: Are there any structures to mentor or supervise you when you are still on community service or you are just thrown?

P: Honestly you are just thrown, and it's difficult to get motivated if you are allocated in a place you don't like. First of all you are so blessed if you are placed in the department or the field that you enjoy. I was lucky to be placed in the department I liked. But then when you get there and few weeks later you are happy because you learn. You have got a buddy, there is no community service manual of this department, and this is what you need to do, there is no such, you going to find who you think is

vukile and buddy with them, and beg them not to be annoyed with you, you know, it's like that. And later you develop self-confidence and you feel so much better in yourself, like, I can do it.

R: Can you share with me some of the experiences where you have identified unethical practices in the unit during your community service placement?

P: We all know that working in obstetrics is the most drastic experience one can ever have.

R: Can you elaborate on that statement?

P: You know what; it's amazing what you can learn within a year, or what you can be faced with within a year.

R: I'm all ears...

P: On my birthday last year I delivered the patient, and I was fine with it, and I was happier because they threw a party for me. You know yourself how you do things and more so, your colleagues know how you do things, so the sisters will say, no that one be careful, she is not so thorough, or that one, be careful, she is strict.

R: Mhhhh, ok, tell me more

P: I delivered this patient, and even if we are busy, and someone helps me, I will never leave anything untouched, and I don't like anyone to complete my notes, I want to do my own thing, because if I am going to get into trouble, I must know that it's me that did it, I am not going to say, 'that person wrote for me', I delivered this patient, and during the labouring process we all know we all get a very good report, because they labouring throughout with you, from 4cm they still coping with the pain, so that's when you health educate them and telling them how to breathe and doing everything.

R: Yes....

P: So I delivered this patient and I did my labour assessment, I have completed my graph, I did my new born, everything, and the patient's lochia was minimal, so she was transferred to the postnatal ward. I don't know what happened, but the patient called me, she took my number from Facebook, and phoned me at home, and I was off duty that day.

R: Yes, I'm listening, what did she say to you?

P: She said, 'Am I speaking with a sister, and I said, 'what you mean darling, a sister in-charge or a work sister', and she said, 'No, I got this number from Facebook, and please don't be upset with me', I said 'who am I speaking with' and obviously I can never forget her because I delivered her baby on my birthday, so she is like, 'you know what, is that sister so and so?' and I said 'yes it is, how can I help you? 'She said you know sister you delivered my baby, and my baby is hurt' and I said 'where?' she said the arm is like limp its dead', and I said, 'ok, I am off today, is this your number', she said yes, and I said 'give me 5 minutes; I will get back to you'.

R: Yes, I'm getting more curious, so what did you do?

P: In the meantime, I called sister in-charge and I told her everything. I was so terrified and was still in my pyjamas. I perspired and was wet from perspiration within seconds.

R: Mhhh, I can imagine...

P: I said to sister in-charge 'please locate this patient's file, because I know that there was nothing wrong with the baby until the baby was transferred to post natal ward.

R: So, how did the sister in charge intervene?

P: She said I should tell the patient to come to the hospital with the baby from home, and the following day I was going back on duty. I asked the sister if I have to come to work on that day, and she said no, because I was going back the following day anyway. The following day I was on duty, and POPD appointment was made for the baby by the sister in charge, and an orthopaedic consultant was organised for the baby. The patient (mother of the baby) was also back in the hospital. So the mother went up to the ward, post natal ward, and was greeted by another patient.

R: And then?

P: This other patient when she asked the mother why she was back in the ward, the mother told the other patient that she is back because her baby was hurt and the arm is limp, this other patient told her that your baby was hurt by the sister in this ward and not in labour ward, the sister was checking blood sugar levels of the baby, and she did not use the foot of the baby, but she used the arm and she wrapped the arm of the baby and left the baby like that .

R: Hawu! Did the mother tell you the new story now about her baby?

P: Yes, she came to me and said, 'you know what sister, my gut was telling me that it is not you who hurt my baby', and she told me what the other patient in the wars saw. Now I was going to take the blame for somebody else that was careless enough to leave the baby and did not even report what she did. What this nurse did was very unethical. I know I could have hurt the baby by mistake, but I was not going to keep quiet about that, but now I was quite positive that there was nothing wrong with the baby.

R: So how was that situation handled?

P: The post natal sister was approached by my sister in-charge, and was told what transpired. She was told that the other patient saw her when she hurt the baby and didn't report, but fortunately, the baby didn't need any surgical intervention, it was just manipulation that was done.

R: So did you speak with the post natal sister?

P: Yes, and she was brave enough to phone me first and asked me how the mother got to phone me, and I said, 'you've got a nerve to do such mean thing and you say that? So you were hoping that I would the cover for you. I asked her if she realised that what she did was unethical, she kept quiet. I was so angry with her.

R: Were there any unethical practices that you identified with the doctors?

P: Yes there were, a lot

R: Do you mind sharing them with me?

P: The doctor used the unsterile glove to PV the patient, and I said to him, 'are you going to PV the patient?' he said 'yeah', and I asked, 'with the unsterile gloves?' and he said, 'agh, does it make any difference?', and I said, 'you know what, what you have just said now makes a difference, would you be happy if your wife is done PV with unsterile gloves?' 'He said laughing, 'ok bring me the sterile gloves then'. That was unethical for the doctor to do to the patient.

R: Tell me more.....

P: Another incident was when the doctor would order pethidine when the patient is fully dilated, and I know that it is unethical to give pethidine to fully dilated patients as that would suppress the fetal rate. I refused to give the pethidine but then I was laughing when I told the doctor that I am not going to

give my patient pethidine when she is about to deliver. You need to be bold and stand your ground firm, but not be aggressive when you tell them about the unethical practices that they do.

R: Tell me about the expectations you had regarding your community service

P: When I was starting community service, I expected to be thrown into the deep end; I was expecting to come across as a stupid, not knowing what I am doing; I was not even expecting, but I was ready to be undermined, and I wouldn't have been surprised because I don't think I would have had the capabilities to do things that time, as I do now.

R: Yeah, tell me about it....

P: At that time I wouldn't have stood up and say 'it's wrong'. But I also expected people to be nice, and people are not always nice, and I also expected people to be funny, but then I learnt that people are not always funny, and I really expected people to not think that we had the skills, although some do think that way, but when they watch the way you work, you can be learning and still come across somebody who has got potential because you learnt well. But you can be doing something and you'll be doing it completely wrong, and people will say no, no, no, no, this is not right. And with nursing is not like other jobs, because we are so cautious about what you doing constantly, what you saying, how you acting, how you talk with the patient, never undermine the patient because that could be the CEO lying on that bed.

R: Tell me about your low points regarding your community service

P: It's just the general feeling that you are not capable enough at some point in time, like for example, there was an obstetric emergency, a cord prolapse and then I stick my hand out of the vagina to go and call for help as opposed to keeping the head up, which is what I did, but it was my first time.

R: Ahh! So what did you do?

P: But luckily by the time I ran back and repositioned the sterile gloves, the head did not come down, so I was still able to hold it up until we reached theatre. That for me was a very low point, and it affected me very bad, and I learnt from it. I will never repeat that mistakes, even when the students come to labour ward, cord prolapse is the first thing I teach them about.

R: Tell me about your high points with regards to your community service

P: When we went to theatre with the cord prolapse baby, the sister who caught the baby did not know about the in fundus resuscitation according to the new steps that we are using, and I had gone for the training, so as I stick my hand out and I cleaned and I regloved and resuscitated the baby, and the obstetrician was so proud of me. I have been doing a lot of training in my community service, and those were my high points. This community service has changed my life.

R: I think we are done now and thank you for sharing such information with me, and thanks for your time

P: It was. my pleasure ma'am, thank you

Annexure M: Editing certificate

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EDITING CERTIFICATE

Re: NOMAWONGA CORONA SOLWANDLE

Master's dissertation: Leadership competencies of professional nurses in the eThekweni health district during the first year of registration with the South African Nursing Council

I confirm that I have edited this dissertation and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. I returned the document to the student with track changes so correct implementation of the changes in the text and references is the responsibility of the student. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology I supervised numerous Master's degree dissertations.

Dr Richard Steele
01 November 2017
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