# Exploring the working environment of enrolled nursing auxiliaries in private hospitals in the eThekwini District

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# Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

Signature of student — 18 October 2020 Date

Approved for final submission

Dr TSP Ngxongo — 18 October 2020 Date

RN, RM, D Nursing

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# Abstract

## Background:

The nursing professionals are recognised worldwide as being critical to the delivery of high quality, efficient nursing management and patient care in the healthcare services. However, shortage of skilled nurses in most countries, including South Africa, has led to an overburdened healthcare system with certain nursing categories doing much more than they are trained to do. The enrolled nursing auxiliaries (ENAs) are junior members of the nursing team who, on completion of a one-year basic nursing certificate programme, work either in public or private healthcare sectors.

## Aim of the study:

The aim of the study was to explore the working environment of ENAs, in private hospitals in the eThekwini District, KwaZulu-Natal, South Africa.

## Methodology:

An exploratory descriptive design was used. Data was collected by in-depth one-on-one interviews with ENAs, Registered Nurses (RNs) and Unit Managers (UMs) working in the medical and surgical units of the selected healthcare institutions and were analysed using Tesch's method of data analysis.

## Findings:

Three major themes that emerged from the data analysis were a) working experiences of the ENA, b) challenges experienced by the ENA, c) supervision of the ENA. This study found that due to the shortage of skilled nurses in the country, brain drain and cost containment in the private health sector, the dynamic healthcare environment resulted in ENAs endangering their professional status by functioning out of their scope of practice and performing a role for which they were never intended or academically prepared.

The ENAs under study were dissatisfied by a lack of clear career development pathways from the private healthcare group to assist them with transitioning to the next level of qualification. They also felt that they were not recognised or rewarded for their contributions to nursing.

## Conclusion

The private healthcare group under study should, as a priority, communicate to ENAs the plans for career development and funding which will allow ENAs to undertake training to the next level of qualification. The nursing agency utilisation should decrease from 40% to the benchmark of 25% to ensure sufficient numbers of skilled staff are working in the general nursing units. The emphasis by nursing leadership must be on teamwork to build a motivated workforce.

## Dedication

This study is dedicated to all the ENAs who work tirelessly to provide dignity and respect to our patients and to the many ENAs that have remained committed to service delivery of the highest quality in the face of mounting challenges.

# Acknowledgement

- My wonderful Lord and Saviour Jesus Christ who has seen me through all of life's journeys. To him be the glory and honour forever.

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# GLOSSARY OF TERMS

**1. Enrolled nurses (ENs)** practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education across the life span to health consumers in community, residential or hospital settings. Enrolled nurses contribute to nursing assessments, care planning, implementation and evaluation of care for health consumers. The registered nurse maintains overall responsibility for the plan of care (South African National Department of Health 2013a:5).

**2. Enrolled nursing auxiliary (ENA)** refers to the person who completes the one-year training programme and is placed on the South African Nursing Council (SANC) roll as an ENA. This course is designed to support registered nurses (RNs) and enrolled nurses (ENs) in the delivery of general patient care. The duties that a trained ENA may undertake are always under the supervision of a registered nurse (South African National Department of Health 2013a:5).

**3. General ward** refers to either a general surgical or medical ward where care is provided by registered nurses, enrolled nurses, enrolled nursing auxiliaries and supported by care workers (Booysen *et al*. 2012: 43).

**4. Patient acuity** is defined as the number of nurses required in a nursing ward to provide safe nursing care. There are different patient classification systems in use that are used to align the type of nursing care needed to patient requirements (Duffield *et al*, 2011:250).

**5. Private hospital** refers to a hospital that is a wholly owned subsidiary of a private healthcare group. They function independently of the public sector, with the goal of making a profit (Econex 2013:22).

**6. Registered Nurse (RN)** is a nurse who has graduated from a nursing program and met the requirements outlined by a country, state, province or similar licensing body to obtain a nursing license. An RN's scope of practice is determined by legislation, and is regulated by a professional body or council. They are responsible for supervising care

delivered by other healthcare workers, including enrolled nurses, enrolled nursing auxiliaries and student nurses (South African National Department of Health 2013a:7).

**7. Role**, in the context of this study refers to the duties, functions and responsibilities expected of a person holding a certain position in the healthcare organisation (Haakestad 2012: 43).

**8. Skills** mix refers to the different levels of nursing skills that are required to provide a suitable standard of patient care. It is the proportion of registered nurses to the other categories of staff (Twigg *et al*. 2016:199).

**9. The South African Nursing Council (SANC)** is the regulatory body for nursing in South Africa. They provide a scope of practice and code of conduct for all categories of nurses. Only nurses who are on their roll and pay the annual licensing fee are considered legal practitioners (Geyer 2016:51).

**10. Scope of practice** refers to the permissible functions, tasks and acts that each category of nurse on the SANC roll can perform (Geyer 2016:51).

# Acronyms

| Acronym | Full word/sentence |
|---|---|
| AP | Assistant practitioner |
| CPD | Continuing professional development |
| CNA | Clinical nurse aide |
| CF | Clinical facilitator |
| DOH | Department of Health |
| ENA | Enrolled nursing auxiliary |
| EN | Enrolled nurse |
| FTE | Full time establishment |
| HCA | Healthcare assistant |
| HCW | Health care worker |
| ICN | International Council of nurses |
| NNA | National Nurses Association |
| NEI | National Education Institute |
| PN | Professional nurse |
| RCN | Royal College of Nursing Registered nurse |
| RN | Registered nurse |
| RPL | Recognition of prior learning |
| PPE | Positive practice environments |
| SANC | South African Nursing Council |
| SAQA | South African Qualifications Authority |
| SLE | Service level agreement |
| UM | Unit manager |
| WHO | World Health Organisation |
| WSP | Work skills plan |

# CHAPTER 1: ORIENTATION TO THE STUDY

## 1.1 INTRODUCTION AND BACKGROUND

The World Health Organisation (WHO) (2013: 7) has reported that the average life expectancy of the global population has increased, but the large number of evolving comorbidities has contributed to people being sicker and needing more expensive healthcare technology and care than before (WHO 2013: 7). According to Garrett (2013: 7), findings of this nature have positioned the nursing profession as a pivotal and essential force in terms of patient care service delivery, and recognising the nursing professional as being critical to the delivery of high quality, efficient nursing management and patient care in the healthcare service industry. Nevertheless, Garrett (2013: 7), discovered that, despite more financial and human resources needed to provide suitable healthcare, challenges such as dwindling resources and lack of funds allocated to healthcare and its impact on individual health demands, the expectations of the nursing team in the 21$^{st}$century have increased (Garrett 2013: 2).

The increased burden of disease places an additional burden on healthcare and nursing efforts in South Africa and Africa as a whole. Littlejohn, Campbell, Collins and Khayile (2012: 24) found that South Africa faces a nursing shortage in both the private and public sectors because of migration of professional nurses and an increase in the nursing attrition rate due to ill health. In South Africa, the shortage of professional nurses is attributed to the limited number of new nurse trainees entering both the private and public Nursing Education Institutions (NEI). Garrett (2013: 5) states that the healthcare challenges are exacerbated as South Africa has 25% of the disease burden of the world and is not training or producing adequate numbers of professional nurses to deal with its health needs. In addition, the World Health Organisation (WHO) abandoned funding the African AIDS pandemic in 1994, causing a surge in the disease and opportunistic infections. Garrett (2013: 5) further explains that government spending on healthcare has decreased globally, with other sectors demanding a greater portion of the economic budget. This has led directly to a decrease in the remuneration of nurses as well as

decreased spending on training adequate numbers of skilled nurses. As a result, nurses seeking an improved financial future and career prospects look for employment in countries that offer competitive salaries. The WHO (2013: 8) agrees that the resultant shortage of skilled nurses has led to an overburdened healthcare system with certain nursing categories doing much more than they are trained to do to fill the void left by their more skilled counterparts.

### 1.1.1 The Current South African Nursing Hierarchy

The South African Nursing Council (SANC) is the nursing regulatory body that outlines the scope of practice, limitations and code of conduct for all categories of nursing that render nursing services in South Africa (South African National Department of Health 2013a: 3). The nursing team is made up of different categories of nurses, namely, registered nurses (RNs), enrolled nurses (ENs) and enrolled nursing auxiliaries (ENAs) (Mackinnon, Butcher and Bruce 2018: 10). The RN, who completes a four-year degree or diploma in nursing, is regarded as the senior member of the team and is responsible for the management of care provided by the other two nursing categories. The EN, who completes a two-year training programme, is in the middle of the hierarchy and works under the direct or indirect supervision of the RN, as outlined in the EN scope of practice. The ENA who completes a one year nursing certificate programme, is considered a junior member of the team because of the limited training and scope of practice and works under the direct or indirect supervision of the EN or RN, as per their scope of practice (SANC 2013a: 4). These nursing training programmes are accredited by the South African Nursing Council (SANC) and all nurses in South Africa must be registered with the SANC and pay an annual fee to remain on their roll and continue to practice as a nurse in South Africa (South African National Department of Health 2013a: 4).

### 1.1.2 The Nursing Scope of Practice

According to the SANC, the scope of practice of the various categories of nursing differs in terms of responsibility, accountability and the type of tasks that can be performed.

According to the South African National Department of Health (2013b: 7), the RN maintains full responsibility and accountability for the provision of treatment and the delegation and implementation of nursing care, while the EN is fully responsible and accountable for the nursing care delegated by the professional nurse and delegation of tasks to competent junior members of the team. The scope of an ENA, as outlined by the South African Nursing Council, is limited and the primary function is to provide for the elementary needs of patients, which have been prescribed and delegated by a registered nurse or enrolled nurse (SANC 2013b: 4). With the economic decline, neither the Government nor the private sector can afford to employ only professional and enrolled nurses (Econex 2013: 16).

### 1.1.3 The Role and training of ENAs in Healthcare

Historically, the ENAs worked without formal training and certification. They received on the job training and learnt their skills from their work experience in the hospitals and the training differed from hospital to hospital (Booysen, Erasmus and Van Zyl 2012: 44). In 1972, the President of the SANC announced a formal one-year nursing programme for ENAs (Booysen, Erasmus and Van Zyl 2012: 52). The individuals who practiced as ENAs before this period were given up to the 02 June 1973 to register with the SANC as ENAs (Booysen et al. 2012: 45). According to Uys and Klopper (2013: 4), the ENA qualification was a one-year certificate course leading to enrolment as a Nursing Auxiliary. Numerous private nursing colleges that have been accredited by the South African Nursing Council (SANC) offered this course resulting in a high number of nurses in this category. The accreditation standards are set out in the SANC Regulation 2176 as amended (SANC 1997(a)). These standards includes development of the curriculum in line with the prescribed regulation approved by SANC, availability of hospitals to provide clinical learning and accreditation of the hospitals as a suitable training centre with adequate

resources. The career pathway for the ENA was to bridge to an EN by completing the one year course leading to enrolment as a nurse.

However, in 2010 the SANC announced plans to change the legacy nursing qualifications to new nursing qualifications that are aligned with the Higher Qualifications Sub-Framework (HEQSF) (SANC 2016:1). This change affected the career pathway of the ENA. This meant that the certificate course leading to enrolment as a Nurse was stopped and the last date of enrolment was the 30 June 2015. After this date, ENAs who wanted to move to the next level of qualification would have to apply for recognition of prior learning (RPL) to be eligible to study towards the three year Diploma in Nursing (National Department of Health 2019: 12).

The ENA is mainly responsible for providing elementary bedside patient care and is required to report changes in patients' condition to the RN (South African National Department of Health 2012b: 3).

Individuals may use the title of an ENA if they have met the prescribed educational requirements and maintain their competence to practice as ENAs. They work under the direct supervision of the registered nurse (RN) or the EN (SANC 2013a: 4). This means that the ENA can carry out the nursing tasks that are planned for the patient by the registered nurse. This is referred to as the nursing care plan (South Africa Department of Health 2013b: 3). The ENAs work in both the private and public sectors of healthcare, internationally and nationally, although the range of their roles, titles and responsibilities may differ (South African National Department of Health 2013a: 7).

It is also the cheapest nursing course to pursue as compared to the professional or enrolled nursing course that runs over four years and two years respectively. Many people want financial stability and feel that becoming an ENA will give them a guaranteed job and income. In South Africa, compared to other nursing qualifications, many ENAs qualify annually because of the ease of access and affordability of the qualification. Another reason for more ENAs qualifying is the increasing number of nursing colleges that are given the licence to train this category of nurse (WHO 2014: 12). This category of nurse

is not suitably qualified for overseas employment, hence available in large numbers in the job market in South Africa. In contrast, as per The Colorado Health Institute (2011: 12), there are shortages in this category of staff abroad, mainly due to job dissatisfaction.

The ENA forms part of the skill mix in both private and public healthcare in the South African healthcare context (Rispel and Blaauw 2014: 17). However, Uys and Klopper (2013: 4) believe that there are challenges associated with this role and that ENAs are doing more than they should be doing, are bored by a routine, non-stimulating environment and are not recognised for their work.

The role of the ENA has received little attention over the years as only one study that explored the role of the ENA was conducted in South Africa. This was undertaken by Mabunda in 1995 in a rural healthcare setting. The findings of Mabunda (1995: 72) concurred with Uys and Klopper's opinions that ENAs were increasingly challenged in their work environments. The majority of ENAs in Mabunda's study felt that they were working out of their scope of practice but had no choice as staff shortages were commonplace. They also felt that they were not recognised for their work because nobody understood the role they played in healthcare, that their work appeared to be taken granted by their peers, and they did not have a clearly demarcated place in the work environment. The career development opportunities and training provided for this category of nurses were limited.

In America and Europe, the equivalent of an ENA is the clinical nurse aide (CNA) and health care assistant (HCA) respectively. In a survey on job satisfaction conducted by Colorado Health Institute (2011: 14), the majority of CNAs replicated the feelings of the ENAs interviewed in Mabunda's study. The majority of the CNAs felt that they were not respected or rewarded for their work and that they worked out of their scope of practice due to limited resources (Colorado Health Institute 2011: 15).

Lubbe and Roets (2013: 60) state that many individuals have worked as ENAs for numerous years and have learnt to do tasks that fall out of their scope of practice such as the administration of oral medication. Currently, in the healthcare group of this study

there has been no communication regarding funding for ENAs to progress to the next level of qualification. If ENAs want to develop their careers, they will have to leave their permanent employment and enrol at nursing colleges as self-funded students. Twigg, Myers and Duffield (2016: 192) emphasised that most of the permanently employed ENAs are unable to afford this option due to financial commitments and opt to stay in the healthcare system as ENAs. There have been no concrete plans to address the challenges experienced by ENAs in the workplace.

### 1.1.4 Private Healthcare in South Africa

The private healthcare groups in South Africa work with a nursing skill mix that totals 100% of all nursing categories. The skill mix depends on the case mix and level of care required by the patient. The declining economy and increasing cost of healthcare has resulted a change to this skill mix, with the percentage of ENAs increasing and the percentage of RNs decreasing (Nkatha 2016: 2).

To ensure distribution of the workload to the appropriate category of nursing staff, there are different modes of nursing care delivery implemented in South Africa. Team nursing is a common mode. Ferguson and Cioffi (2017: 6) refers to team nursing as an approach whereby a small team of nurses are brought together and led by a RN who has strong leadership and communication skills. The team comprises the RN, EN and ENA and each category of nurse is allocated nursing functions that are within their scope of practice. They work collaboratively and collectively to deliver a better level of care to the patients. However, Ferguson and Cioffi (2017: 7) adds that inadequate staff numbers influence this mode of nursing and foster an environment where nursing staff work out of their scope of practice.

The other common mode of nursing care delivery is the total patient care. In this mode, the RN and EN are solely responsible for the care of a group of patients allocated to them for the shift, while the ENA performs the basic nursing care for a group of patients. The RN still maintains supervision of the overall care that is rendered by the EN and ENA (Duffield, Dier and Roche, 2011: 53).

Task shifting has been used in South Africa as a part solution to ensure the effective delivery of quality nursing care (Armstrong, Bhengu and Ricks, 2013: 101). The delegation of nursing responsibilities to the different members of the team along the hierarchy, according to their scope of practice is referred to as task shifting (Armstrong, Bhengu and Ricks, 2013: 102). The aim of this type of nursing is to ensure that all nurses have a share of the workload and contribute to a high quality nursing care (WHO, 2013: 2). However, a study done by Haakestad (2012: 72) revealed that if the incorrect skill mix is used in a nursing unit, then this type of nursing will fail as functions cannot be delegated to the correct category of staff.

## 1.2 RESEARCH PROBLEM

The shortage of skilled nurses in the country, brain drain, the growing cost of healthcare and cost containment in the private health sector are factors that are impacting the work environment of the ENA. The ENA has a clearly defined scope of practice as outlined in the SANC Regulation 2598 (South African National Department of Health 2013(a)). Previous studies by Haakestad have revealed that ENAs have endangered their professional status by functioning out of their scope of practice and performing a role for which they were never intended or academically prepared (Haakestad 2012: 42). Certain circumstances such as high levels of nursing agency utilisation (40%) within the private healthcare group under study, which is greater than the benchmark target of 25%, may have led to ENAs performing tasks that are out of their scope of practice. This includes tasks such as doing complete patient admissions with history taking and receiving patients that underwent minor surgery post- operatively from the operating room. The study conducted by Mabunda in 1995 revealed that the level of supervision given by the RN or EN to the ENA is also decreasing because of dwindling healthcare resources, allowing the ENA to work as an independent practitioner with minimal or no supervision. Decreasing the level of nursing agency utilisation to safe acceptable levels and increasing the numbers of permanent nurses according to the approved skill mix will ensure a competent workforce where ENAs are able to work within their scope of practice.

Many ENAs have years of experience in their roles and are eager to study toward the next level of qualification, which is that of EN but a change to the current nursing qualifications has delayed this. The private nursing college that is affiliated with this private hospital group was accredited by the SANC to provide training for the bridging course from ENA to EN, the bridging course from EN to RN and post basic courses for RNs in ICU, operating theatre and emergency department nursing. As a result of the new qualifications framework, the bridging course from ENA to EN was stopped in 2015, as per SANC directives. These courses were completely funded by the private healthcare group for individuals that met the selection criteria. At the time of the study, the private healthcare group was still running the bridging course from EN to RN and post basic courses for RNs in ICU, operating theatre and emergency department. The effective date of last enrolment will be the 31 December 2019. The commencement date for the diploma in General nursing was January 2019. At the time of the study, the private nursing college was still awaiting SANC accreditation to provide this course, and no formal plans were communicated to staff regarding the availability and funding for the new qualification. The delay in providing ENAs with answers to their queries surrounding career development has left them feeling dissatisfied and perceiving that they are being treated unfairly. Provision of clear plans for career development and funding opportunities for ENAs to move to the next level of qualification will assist in improving their job satisfaction and productivity.

## 1.3 RESEARCH AIM

The aim of the study was to explore the working environment of ENAs, in private hospitals in the eThekwini District, KwaZulu-Natal, South Africa.

## 1.4 RESEARCH OBJECTIVES

The objectives of the study were to:

- Explore and describe the working environment with regard to role and functions of ENAs in private hospitals as perceived by ENAs.

- Explore the working environment with regard to role and functions of ENAs in private hospitals as perceived by the RNs and unit managers (UMs).
- Determine if according to the views of the participants, the working environment in private hospitals foster safe clinical practice for the ENAs.

## 1.5 RESEARCH QUESTIONS

### 1.5.1 Main Question

What is the nature of the working environment of ENAs, in private hospitals in the eThekwini District?

### 1.5.2 Sub-questions

- What are the perceptions of the ENAs, the RNs and the UMs regarding the working environment with regard to the role and functions of ENAs in private hospitals?
- Does the working environment, with regard to the role and functions of the ENA in private hospitals, foster safe clinical practice?

## 1.6 SIGNIFICANCE OF THE STUDY

The role, function and the responsibilities of the ENA are not clearly understood in healthcare and often underrated (Mabunda 1995: 19). The shortage of trained nurses, health care inflation and the increasing burden of disease have been the catalyst for the employment of lower category of nurses (Nkatha 2016: 3). The current study explored the working environment of the ENA, providing insight into their role, functions and responsibilities that they assume and the experiences they have in a dynamic private healthcare environment.

With the last study on the role of ENAs in the public health sector conducted almost two decades ago and no recent study conducted on the working environment of the ENA in private hospitals in South Africa, it was impossible to deduce whether their roles, functions and responsibilities fostered safe clinical practice. This study is timeous in informing the

nursing governance structures and the nursing workplaces that ENAs are an important component of the nursing service but they experience challenges in the workplace that lead to unsafe practice and work dissatisfaction. An exploration of their role, functions and work experiences fostered an appreciation for their efforts and recognition of their scope of practice, which will enhance teamwork, motivation and productivity among the members of the team.

The study was beneficial to both the private healthcare sector and to the ENAs. The recommendations for provision of funding for further training for ENAs will ensure that competent staff progress in their careers, and result in the development of a highly motivated and skilled workforce. The development of a reward and recognition programme for ENAs is a simple and cost-effective method of building a productive workforce that will provide superior patient outcomes.

## 1.7 OUTLINE OF CHAPTERS

The outline of the chapters is illustrated in table 1.1 below

**Table 1. 1 Outline of the Chapters**

| CHAPTER | TITLE | OUTLINE |
|---|---|---|
| 1 | Orientation to the study. | Introduced and provided an overview of the study by identifying the topic of enquiry, research questions, and study aims. Background information regarding the current state of the SA health care system justified undertaking of this study. |
| 2 | Literature review. | Provided a review of the pertinent literature surrounding the role and function of the ENA. Analysis of existing knowledge and evidence served to inform the study's focus and design. |
| 3 | Research methodology. | Provided a detailed description of the study methodology with the rationale for the research design and methodological selection, implementation strategies and ethical considerations. The study population, sample, data collection, and data analysis methods were described so that the reader may appreciate the intricacies of study design and the potential for research findings. This chapter presented the theoretical framework that guided this study. |
| 4 | Presentation of findings. | Presented the results of qualitative data using thematic analysis of the data. Key findings included and elaborated on the themes and sub themes. |
| 5 | Discussion of findings. | Discussed the findings of the study in relation to working environment of ENAs in private hospitals and provided a review and interpretation the data obtained. The limitations and strengths of the study were identified in this chapter. Recommendations were made in relation to the key findings of the study. |
| 6 | Conclusions, limitations recommendations | Outlined the conclusions as well as the limitations of this research and made recommendations. |

## 1.8 SUMMARY

This chapter introduced the important aspects of the topic of inquiry and discussed the impact of current healthcare challenges in South Africa, such as staff shortages in

relation to the placement of additional burdens on healthcare and nursing efforts in the 21st century. In this chapter the current practice environment of the health care service industry, its skill mix and the relevant scope of practice as per the South African nursing regulatory body were discussed. The following chapter will provide a detailed review of the relevant literature, providing an in-depth understanding of the factors that influence the enrolled nursing auxiliary's role and function in his/her workplace.

# CHAPTER 2: LITERATURE REVIEW

## 2.1 INTRODUCTION

This chapter provides an analysis of the available literature on the role of the ENA in the healthcare industry, both nationally and internationally. The purpose of the literature review was to provide an explanation of nursing as a profession, highlight global and national healthcare challenges, explore the role that ENAs play in the healthcare industry, explore the challenges and concerns experienced by ENAs and determine the reasons why ENAs are an integral component in the essential and critical service of nursing.

## 2.2 LITERATURE SEARCH STRATEGIES

The literature search was conducted using books, journals (hard copies as well as electronic journals) and the relevant internet websites on the history of nursing as a profession, the various nursing categories and their functioning both locally and abroad, and the legislative control over the nursing profession. Healthcare databases such as CINAHL and Medline was used to retrieve relevant journals and books related to the topic. The literature search also extended specifically into the role of ENAs and their value and impact on the healthcare environment.

The challenge was the limited research available on the role of ENAs in both the South African and global healthcare context. The literature search revealed that, although the ENAs had a role to play in healthcare, they often worked out of their scope of practice, which had an adverse effect on patient outcomes. The work of ENAs was also taken for granted by peers and they received little recognition for their contributions to healthcare.

## 2.3 NURSING AS A PROFESSION IN SOUTH AFRICA

Nursing was recognised as a profession in 1891 despite arguments from numerous critics stating that nursing should be recognised as a semi-profession. However; nursing has fulfilled the criteria for professional recognition in South Africa and is regarded as a fully-fledged profession (Searle 2002: 14). The nursing profession in South Africa is regulated through an act of Parliament, the Nursing Act 33 of 2005. It enabled the establishment of

the South African Nursing Council (SANC) in 1944, which serves and protects the public in matters involving nursing services. The SANC regulates the formal training requirements for the three categories of nurses namely RNs, ENs and ENAs (Mahlathi and Dlamini 2017: 7).

### 2.3.1 The nursing qualification framework

At the time of the study, and in line with the provisions of related SANC regulations, both nursing colleges and universities produced registered nurses through a diploma program and degree program respectively. Up until 2015, nursing colleges accredited by the SANC produced ENA's after completion of a one-year certificate course and ENs after completion of a two-year nursing course. There were also provisions made for ENs to bridge to RNs and ENAs to bridge to ENs at SANC accredited colleges and clinical institutions. These qualifications are now referred to as legacy nursing qualifications (SANC 2016: 2).

In 2010, the first HEQSF- aligned qualifications for nursing professionals were classified, registered and published by the South African Qualifications Authority (SAQA), thereby locating nursing education qualifications within the requirements of post school education (South African National Department of Health. 2019: 9). These are referred to as the new nursing qualifications and will replace the legacy nursing qualifications.

#### 2.3.1.1 Legacy Nursing Qualification

The qualification type, duration in years and the professional registration enrolment with SANC of the legacy nursing qualifications are listed in Table 2.1

**Table 2.1 Legacy nursing qualifications (SANC Circular 7/2016)**

| Qualification type | Duration | Professional registration with SANC |
|---|---|---|
| Post- basic course (specialisation) | 1 year | Area of specialisation |
| University degree | 4 years | Nurse (general, community and psychiatric) and midwife |
| College diploma | 4 years | Nurse (general, community and psychiatric) and midwife |
| Basic Midwifery | 1 year | Midwife |
| Basic psychiatry | 1 year | Psychiatric nurse |
| Bridging course enrolled nurse | 2 years | General nurse |
| Certificate | 2 years | Enrolled nurse |
| Certificate | 1 year | Enrolled nursing auxiliary |

#### *2.3.1.2 Recent developments in the Nursing qualifications framework*

Nursing education reform has been identified as an important strategy for enhancing health workforce performance, and thereby improving the functioning of health systems. According to the foreword by Dr PA Motsoaledi in the National policy on Nursing Education and Training, the education and training of nurses is an essential aspect of the functioning of any healthcare system. The Government needs to ensure that the nursing education and training system be harmonized with service delivery needs (South African National Department of Health 2019:1).

The Director- General of Health, MP Matsoso, in the same policy document stated that the recent changes in legislature required nursing education to be positioned in the higher education band. Key to this was the creation of new categories of nurses, thus making it mandatory for the SANC to redefine the competency framework for nursing; develop scopes of practice and related regulations in preparation for the new Higher Education

Qualifications Sub- Framework (HEQSF) - aligned nursing qualifications (South African National Department of Health 2019: 2).

#### *2.3.1.3 Timeframes of phasing out of non- HEQSF aligned nursing programmes*

As per the Government Notice Number 40123 of July 2016, gazetted by the Minister of Higher Education and Training stipulated the 31 December 2019 as the last date for the intake of all programmes leading to national qualifications not aligned to the prescripts of the NQF Act, 2008 (Act 67 of 2008). The end dates for each of the legacy qualifications are outline in table 2.2 below.

**Table 2.2 End dates of enrolment for the legacy nursing qualifications (SANC 2016)**

| Course | End date of enrolment |
|---|---|
| Course leading to enrolment as a Nursing Auxiliary | 30 June 2015 |
| Course leading to enrolment as a Nurse | 30 June 2015 |
| Bridging course for ENs leading to registration as a General or Psychiatric Nurse | 31 December 2019 |
| Course leading to registration as a Nurse (General, Psychiatric and Community) and Midwife | 31 December 2019 |
| Phasing out of post basic programmes | 31 December 2019 |

#### *2.3.1.4 The new Nursing qualifications*

The new nursing categories, qualification type, NQF level and minimum duration are outlined in Table 2.3. Nursing qualifications leading to professional registration with SANC in these new categories will be offered in line with requirements of the HEQSF as follows:

*Higher Certificate in Nursing*

This one-year programme will lead to registration as an auxiliary nurse and aimed at producing a nurse who will deliver basic nursing care in a variety of settings. The commencement date for this qualification was January 2018 (SANC 2016: 6).

*Diploma in Nursing*

The three- year diploma will enable the nurse to function as a clinically focused, service orientated, independent registered general nurse, who is able to render general nursing care as per the appropriate legislative framework (South African National Department of Health 2019:9). The start date for enrolment for this qualification was January 2019 (SANC 2016: 9).

*Professional Bachelor's degree*

This four- year degree is aimed at producing a nurse and a midwife who contributes to the improvement of health outcomes for individuals, families, groups and communities through providing quality culturally sensitive and evidence- based nursing and midwifery health services (South African National Department of Health 2019: 9). The start date for enrolment of this qualification will be January 2020 (SANC 2016: 9).

*Post- graduate Diploma programs*

Post-graduate programmes (PGDs) will be offered in line with the schedule of nursing qualifications, which was not yet prescribed by SANC at the time of this writing. The start date for these programmes will be January 2020.

**Table 2.3 New nursing qualifications**

| Nursing category | Qualification type | NQF level | Minimum duration |
|---|---|---|---|
| Registered auxiliary nurse | Higher certificate | 5 | 1 year |
| Registered general nurse | Diploma | 6 | 3 years |
| Registered midwife | Advanced diploma | 7 | 1 year |
| Registered professional nurse and midwife | Bachelor's degree | 8 | 4 years |
| Nurse specialist/ midwife specialist | Post- graduate diploma | 8 | 1 year |
| Advanced specialist nurse | Master's degree | 9 | 1 year |
| Doctorate in nursing | Doctoral degree | 10 | 3 years |

## 2.4 LEGAL FRAMEWORK FOR NURSING

### 2.4.1 Global governance of nursing

Buhler, Wilkinson and De Antonio (2019: 2) state that the International Council of Nurses (ICN), a federation of more than 130 national nurses' associations (NNA's), representing more than 20 million nurses worldwide, regulate the international practice of nursing. Founded in 1899, ICN is the world's first and widest reaching international organisation for health professionals. Operated by nurses and leading nurses internationally, ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, the presence of a respected nursing profession worldwide and a competent and satisfied nursing workforce. The ICN states that the scope of practice of nurses compromises independent and collaborative care of all individuals of all ages, families, groups, and communities, sick or well and in all settings. National nursing associations provide detail on the scope of practice by determining practice standards and a code of ethics for nurses to follow. Together with national and state agencies, legal parameters and guidelines for the practice of nurses as clinicians,

educators, administrators or researchers are set (Buhler Wilkinson and De Antonio 2019: 2).

### 2.4.2 South African governance of nursing

The South African Nursing Council (SANC) is the body entrusted to set and maintain standards of nursing education and practice in the Republic of South Africa. It is an autonomous, financially independent, statutory body, initially established by the Nursing Act, 1944 (Act No. 45 of 1944), and currently operating under the Nursing Act, 2005 (Act No. 33 of 2005). The South African Nursing Council is involved in the monitoring of nursing standards by:

- Registering nurse practitioners, therefore permitting them to practise as nurses;
- Accreditation of new nursing education institutions and nursing education programmes;
- Inspection of nursing education institutions and clinical facilities;
- Constantly reviewing nursing education and training to be in line with the needs of the Republic of South Africa; and
- Providing counselling and guidance to the nursing profession regarding the implementation of the nursing education and training policies (SANC 2014a: 3)

The South African Department of Health (DOH) which is the executive department of the South African Government that is assigned to health matters, together with the SANC is instrumental in regulating the nursing profession by ensuring that every nurse who graduates at an accredited nursing school is on the nursing roll and pays an annual licensing fee. There are various policies drafted by the DOH that defines the criteria to remain a legal nursing practitioner (South African National Department of Health 2013a: 4).

#### *2.4.2.1 The scope of practice for nurses*

Each category of nurse, namely, RN, EN and ENA has a defined scope of practice that governs their clinical practice. The South African National Department of Health (2013: 7) states that all nursing categories are expected to work within this scope of practice that

stipulates that they perform functions that are permissible, legal and aligned to their professional training. SANC (2014a: 4) further emphasises that the scope of practice refers to a list of different tasks that are applicable to each nursing category. The scope of practice is a safeguard to patient outcomes and quality of care rendered (South African National Department of Health 2013b: 3).

Lubbe and Roets (2013: 40) define the scope of practice as the actions or procedures that are permitted by law for a specific category of nurse to perform. The scope of practice exists so that all cadres of nursing understand their roles and responsibilities so that the best and most appropriate quality of care is rendered to patients. The level of responsibility and accountability for each nursing category is encapsulated in the scope of practice. Legally, nurses are still required to perform competently but within their scope of practice (Lubbe and Roets 2013: 39). As a statutory body, the SANC is legally tasked with promoting and maintaining standards in nursing education in the country and with ensuring appropriate, safe and ethically sound professional nursing practice of a high quality (Bezuidenhout *et al.* 2013: 3). The differences in the scope of practice for the various nursing categories are outlined in Table 2.4

**Table 2.4 Differences in nursing categories (SANC 2013b**)

| | **Registered Nurse (RN)** | **Enrolled nurse (EN)** | **Enrolled Nursing Auxiliary (ENA)** |
|---|---|---|---|
| **Duration of study** | 4 years | 2 years | 1 year |
| **Qualification** | Registered nurse | Enrolled nurse | Enrolled nursing auxiliary |
| **Distinguishing devices** | Maroon epaulettes | White epaulettes | None |
| **Scope of practice** | Assessment, diagnosing, planning, implementation and evaluation of health needs | Following the nursing regimen planned and initiated by a registered nurse or registered midwife and carried out under his direct or indirect supervision | Attending to basic nursing needs of patients initiated by a registered nurse or registered midwife and carried out under his direct or indirect supervision. |

## 2.5 HISTORY OF THE ENA IN SOUTH AFRICA

### 2.5.1 Formal training

According to Booysen *et al*. (2012: 43), ENAs historically practiced in hospitals with no formal training. They did not require a Grade 12 qualification and most of them had only a Grade 10 (standard 8 pass) and acquired on-the-job training. The introduction of the Nursing Act 50 of 1972 sought to formalise nursing, with the intention of making it a closed profession. It was then that the SANC considered formal training for ENAs to attain recognition for their jobs (Booysen *et al.* 2012: 44). The individuals who practiced as ENAs prior to this could enrol with the SANC without undergoing any formal training (Booysen *et al*. 2012: 45).

The SANC Regulation R2176 as amended (Regulations relating to the Course leading to enrolment as a Nursing Auxiliary) outlined the conditions for enrolment as nursing auxiliary, conditions for the approval of a nursing school, duration of the course and structure of the curriculum. The subjects and subject content for the curriculum included nursing history and ethics, basic nursing care, elementary nutrition, first aid and introduction to comprehensive health care (SANC 1993: 1). This has since been referred to as a legacy nursing qualification. On completion of the one- year course and meeting the requirements as outlined by SANC, the individual was enrolled as an ENA with SANC and was expected to function within a clearly defined scope of practice.

Under the new nursing qualifications framework, all successful applicants will be enrolled in a one- year higher certificate program at a SANC accredited facility. On fulfilling the minimal requirements of the course, the individual will earn the title of registered auxiliary nurse (SANC 2013: 3).

### 2.5.2 Scope of practice of the ENA

According to SANC (2014: 3), the role and responsibilities of the ENAs in South Africa are guided by the scope of practice that is outlined in Government Notice Chapter 6 of Regulation R2598 as follows:

"*The scope of practice of an enrolled nursing auxiliary shall entail the following acts and procedures as part of the nursing regimen planned and initiated by a registered nurse or registered midwife and carried out under his direct or indirect supervision.*

- *The promotion and maintenance of the health of a patient, a family and a community.*
- *The provision of health and family planning information to individuals and groups.*
- *The care of a patient and the execution of a nursing care plan for a patient.*
- *The promotion and maintenance of the hygiene of a patient, a family and a community.*
- *The promotion and maintenance of the physical comfort, rest, sleep, exercise and reassurance of a patient.*
- *The prevention of physical deformity and other complications in a patient.*
- *The supervision over and maintenance of a supply of oxygen to a patient.*
- *The taking of the blood pressure, temperature, pulse and respiration of a patient.*
- *The promotion and maintenance of the body regulatory functions of a patient.*
- *The promotion of the nutrition of a patient, a family and a community.*
- *The maintenance of intake and elimination in a patient.*
- *The promotion of communication with a patient during his care.*
- *The preparation of individuals and groups for the execution of diagnostic procedures and therapeutic acts by a registered person.*
- *The preparation for and assistance during surgical procedures under anaesthetic.*
- *The care of a dying patient and a recently deceased patient".*

### 2.5.3 Career development pathway for the ENA under legacy qualifications

ENAs that met the selected criteria could complete a one-year bridging course leading to enrolment as a Nurse (EN). The EN could progress to the next level of qualification, which was the bridging course for enrolled nurses leading to registration as a General Nurse, if they met the prescribed criteria. However, a change in legislature in 2010 led to the creation of new categories of nurses that altered this career development pathway.

### 2.5.4 Career development pathway for the ENA under the new nursing qualifications

Some of the students who enter the new nursing programmes are already working in the nursing or midwifery setting and would have gained knowledge because of learning in the workplace Within the framework of the new nursing qualifications is a pathway that allows current ENAs to apply for recognition of prior learning (RPL) which will allow them to progress to the next level of qualification, which is the three-year diploma in nursing. RPL for access and advanced credit standing is conducted in accordance with the prevailing national policies on higher education such as the National policy for Implementation of the Recognition of prior learning, which provides for the implementation of RPL and describes how providers should implement RPL in respect of all qualifications and part-qualifications in South Africa. RPL must take place on an individual, student-by- student basis and must involve an assessment/ professional judgement of prior learning (National Department of Health 2019: 7).

## 2.6 THE GLOBAL HISTORY OF THE ENA

Twigg *et al*. (2016: 192) state that in America, Certified nursing aides (CNAs) operate at the paraprofessional level to help nurses provide patient care. CNAs are at the entry level in terms of education, scope of practice and demonstrated clinical competencies. The training programme was only one semester long and included approximately 75 hours of classroom instruction. The training centres on skills development in hands-on bedside care, such as bathing, feeding, dressing and transferring patients (Twigg *et al*. 2016: 193). CNAs work under the supervision of the licensed professional nurse (LPN), the registered nurse, the physician or physician assistant. The CNA can develop her career by training to become an LPN. The Board of Nursing sets license requirements and practice regulations for nurse aides and nurses. There is a greater ethnic diversity in the workforce among CNAs as opposed to the other categories of nurses. Most of the CNAs are employed in long-term care settings such as nursing homes and assisted-living facilities. CNAs working in acute settings require certification and licensure (Twigg *et al*. 2016: 194). Most of them did not take on these roles due to insufficient wages, inconvenient hours,

job stress and lack of respect. In a study conducted by The Colorado Health Institute (2011: 19), it was found that 26% of CNAs plan to leave their profession in the next 5 years due to job dissatisfaction. Although they can progress by studying towards the next level of LPN, many of them cannot afford to because of poor remuneration. There is a projected shortage of CNAs in America by 34%, mainly due to an ageing workforce. The USA has identified a need to develop CNAs and has given them an opportunity to expand their scope of practice. Additional medication aide training allows them to administer routine medication (Colorado Health Institute 2011: 20).

In Europe, the number of elderly patients requiring care support is increasing as the life expectancy increases. There is a lack of qualified nurses, thus increasing the need for health care assistants (HCAs). (Eurodiaconia 2016: 8). The HCAs followed the same path as South African ENAs, who practiced with on- the-job experience and no formal qualifications. This changed in 1989, when they had to embark on a one-year training programme, consisting of a theoretical and practical module. The HCAs did not belong to a regulatory body up until 2013 when the Francis Report recommended that they belong to the Nursing and Midwifery Council (Eurodiaconia 2016: 9). In 2013, the Cavendish Report recommended that the HCAs complete a “Certificate of Fundamental Care”, which will allow them to practice unsupervised and give them the opportunity to attain a higher qualification. They could progress their careers by training to become assistant practitioners (APs). The Government or employees fund the training of the HCAs (Eurodiaconia 2016: 10).

## 2.7 DESCRIPTION OF THE ENA IN THE VARIOUS COUNTRIES

The South African definition of the ENA is one that is enrolled under section 16 of Act 50 of 1978, as amended. He/ she is an assistant to the other nursing categories or to the midwife (Geyer 2016: 51).

The Nurses and Midwives Whitley Council of England describe the nursing auxiliary as one who does not have a formal nursing or midwifery qualification, is not a nursing student of any kind, but who performs nursing functions under the supervision of a qualified nurse or midwife (Geyer 2016: 51).

The nursing auxiliary is defined as someone who is categorised as a nurse but can perform only specific functions related to patient care. These functions require much less use of judgement than the other categories of nursing personnel. They carry out duties that they are trained to do under supervision (Geyer 2016: 52).

Eurodiaconia (2016: 6) states that nursing assistants are referred to as health care assistants (HCA) across most European countries. HCAs work as structural support to nurses who delegate tasks to them. The core of their training includes care assistance, nutrition, hygiene, basic needs of patients and monitoring of vital signs.

The World Health Organisation (WHO) describes the nursing auxiliary as someone who is a technical worker in a certain field but has less than a full professional qualification (Geyer 2016: 52).

In Canada, the nurse auxiliary is defined as someone who is trained to care for selected convalescent, sub- acutely and chronically ill patients. She works within the nursing team and assists the professional nurse (WHO 2013:16).

In Japan, the nursing auxiliary is specifically defined as a female who has been licensed by the Governor of the Prefecture, and who works under the supervision of a doctor, nurse or dentist. The auxiliary is responsible for providing nursing care to the sick, injured or women in childbed (WHO 2013: 6).

## 2.8 GLOBAL DEVELOPMENTS IN ENA TRAINING

The International Council of Nurses (ICN), together with WHO has recognised nursing as the backbone of most healthcare systems around the world and supported developments in the international scope of nursing. These developments led to a revised training programme and scope of practice for ENAs in certain parts of the world (WHO 2013: 9).

Since 2010, America introduced the CNA level 2 and 3 programmes that allowed CNAs with these qualifications to work in a hospital setting as opposed to mainly long- term care centres. CNAs at level 1 can bridge to level 2 and level 3. Thereafter they have the option to study towards a Licenced Practice Nurse (LPN) and then to a RN (Giorgi 2018: 1).

The year 2013 signalled changes for the national qualifications framework in Europe. The HCAs national qualifications were linked to the European Qualification Framework. This recognition of HCA qualification at a higher level allowed HCAs to become a more significant part of the nursing team. During this time, their roles and responsibilities were clearly defined. At the time of this study, the pathway facilitating the HCAs professional mobility was being discussed (Eurodiaconia 2016: 11).

The ultimate goal of WHO, together with the ICN is ensuring an educated, competent and motivated nursing and midwifery workforce with effective and responsive health systems at all levels and in different settings. With this in mind, there is ongoing developments into the education and roles of all categories of nursing (WHO 2013: 9).

## 2.9 HEALTHCARE CHALLENGES

### 2.9.1 Global healthcare challenges

Deloitte (2014: 56) is of the opinion that there are more global healthcare challenges now than ever before. Global spending on healthcare has increased due to various reasons: ageing population; the rising prevalence of numerous chronic conditions; soaring costs; uneven quality; imbalanced access to care due to workforce shortages and disruptive technologies. Deloitte (2014: 60) further emphasises the increase in life expectancy, which averaged at 73.7 years in 2017. This creates an additional demand on healthcare services as chronic ailments, that require additional healthcare spend increases. Garrett (2013: 33) argues that chronic diseases are the major cause of mortality worldwide and are associated with 63% of deaths. This has led to painful cuts in wages and staffing levels, with the intention of making healthcare services sustainable. Increasing costs of healthcare adversely affect patients, providers and insurers. Deloitte (2014: 60) states that shortages of medical and nursing personnel are a stark reality globally.

Garrett (2014: 26) states that in Africa itself, the HIV/AIDS endemic has placed a large burden on healthcare, especially the nursing sector. This has resulted in a dire shortage due to attrition, increase in workload and perceptions of risk associated with the profession. According to Mahlathi and Dlamini (2017: 8), 20% of South African trained

medical and nursing personnel leave to work abroad. The situation is so dire that the South African Government has made multilateral and bilateral agreements with destination countries to prevent the poaching of key healthcare workers. Globally, workforce shortages are the biggest challenge to healthcare service delivery (Mahlathi and Dlamini 2017: 9).

### 2.9.2 South African healthcare challenges

In 2012, the South African healthcare system used up 8.8% of the country's gross domestic product (Mahlathi and Dlamini 2017: 6). An increasing number of South African nurses are taking their skills and knowledge abroad for the promise of more pay and better working conditions. This has plunged South African healthcare into crisis, which now looks to the lower categories of nurses such as the ENs and ENAs to bridge the gap created by a shortage of RNs (Mahlathi and Dlamini 2017: 19).

Nkatha, Chan and Ford (2016: 3) emphasise that hospitals with low levels of nursing staff, especially those with the incorrect skill mix, have higher rates of poor patient outcomes such as pneumonia, shock, cardiac arrest, urinary tract infections and failure to rescue. The skill mix of nursing staff shifted as hospitals increased the number of ENAs or nurse aides. This gave the RNs more of a supervisory role and removed them from the bedside at a time when patients required more bedside care (Duffield *et al.* 2010: 2242). In an American study by Twigg *et al.* (2016: 190), it was found that changes in skill mix left ENAs feeling overworked and disillusioned because of their becoming completely responsible for bedside care and their limited scope of practice. They also perceived a decrease in the quality of nursing care.

Mackinnon, Butcher and Bruce (2017: 1) are adamant that nursing shortages are a global phenomenon, of which Governments are aware. This has led directly to the development of new staffing models and flexible, expanding scopes of practice to counteract these shortages. According to Valizadeh (2016: 486), the changing models have led to an increase in the use of unregulated healthcare workers and nursing aides and the use of team nursing to ensure the efficiency of human resources.

However, the changing healthcare needs of global citizens and the increased burden of disease have shifted the nursing paradigm from one of grouped nursing care to individualised patient care (Anderson 2013: 62).

## 2.10 SKILL MIX IN NURSING

Skill mix refers to grouping of different categories of nurses that are employed to provide care to patients (Havaei 2016: 49). The increasing demand for health care, shortage of nurses and cost containment drive the need to establish an effective skill mix for nursing. In many developed countries, role-based approaches are used to determine staff mix (Gross *et al.* 2015: 28). This is largely due to the human resource challenge that has put a strain on the delivery of healthcare. Standardised nurse-- patient ratios have long been used to determine staff mix. The most broadly used ratios in acute care hospitals were one (1) licensed nurse to four (4) or five (5) patients (Gross *et al.* 2015: 29).

## 2.11 MODELS OF NURSING CARE DELIVERY

Various types of nursing are implemented in the clinical environments to ensure that the workload is divided and assigned to the correct category of nurse. The type of nursing that is utilised is based on the resources available, the patient mix and environmental factors such as layout.

### 2.11.1 Task-based analysis

Twigg *et al.* (2015: 975) state that the more recent method used to determine skill mix was task-based analysis. This entails shifting tasks safely to the different categories of nursing staff so that quality and efficiency are maintained. It is a process of delegation where tasks are delegated to lower categories of staff. RNs maintain the overall responsibility for the clinical area. This method is mostly used when changes to the skill mix are driven by lack of funds and the availability of professional care providers (Gross *et al.* 2015: 30). This means that the number of RNs in the wards has decreased and the number of lower categories of nurses has increased. This has affected the working environment of all categories of nurses, especially the ENs and ENAs. However, quality,

cost effectiveness and safety are criteria that must be considered in developing a skill mix (Gross *et al.* 2015: 31).

### 2.11.2 Total patient care

Uys and Klopper (2013: 32) defined total patient care as a mode of nursing that uses more registered nurses to care for a group of 4-5 patients. This allows for close patient-nurse relationships and continuity of care. In this mode, there is less communication and coordination between team members, as one person is responsible for the delivery of care. It is also an expensive mode of care and globally, there is a shift away from this type of nursing (Uys and Klopper 2013: 33).

### 2.11.3 Team nursing

In contrast, Armstrong and Rispel (2015: 28) describe team nursing as sharing responsibilities between the various members of the nursing team, with the RN maintaining a supervisory role. There are fewer RNs in this mode of nursing, but a greater responsibility lies on the RN to supervise and coordinate the delivery of care (Armstrong and Rispel 2015: 28). The entire team is responsible for the care provided to the patient and therefore, the levels of communication and coordination between team members are higher. As a result, every member of the team is instrumental in achieving safe, quality care (Armstrong and Rispel 2015: 29). Global healthcare challenges, including staff shortages and financial pressures, have led to this type of nursing as an alternative to counteract these challenges (Havaei 2016: 8).

## 2.12 QUALITY PATIENT CARE

Harding and Walker (2013: 252) emphasised that the aim of any healthcare facility is to provide quality patient care, amidst global challenges and limited human resources.

Robinson (2013: 42) defines healthcare quality as the degree to which health care services increase the likelihood of desired health outcomes. Amidst these growing challenges and rising cost of healthcare, nurses are tasked with providing quality

individualised patient care. As per WHO (2014: 2) there are six concepts that define quality care as follows:

- An effective service must be provided. This service must be based on evidence, which means that scientific evidence must be used to deliver high quality, cost effective nursing care.
- The care provided must be efficient. This translates into care that uses resources effectively with minimal wastage. Care must be delivered within the framework of resources that have been provided.
- Healthcare must be accessible to all those who require it. This is not limited to geographical settings only, but to ensuring that skills and resources are adequate to provide the service.
- Care that is provided must be patient centred which translates to being acceptable and accepted by the patient.
- Care that is delivered must be equitable irrespective of who is providing the care and to whom the care is being provided.
- Care that is delivered must be safe, namely no harm must come to the patient in the delivery of care.

Armstrong *et al*. (2015: 32) concur that the above-mentioned concepts apply to quality healthcare on a global level. Nursing managers play a vital role in ensuring quality, by setting goals and objectives that will directly improve the quality of care delivered. Leadership is crucial in ensuring that quality is a key focus in healthcare. They drive the processes that lead to improved quality (Armstrong *et al*. 2015: 32).

According to Twigg *et al.* (2016: 192), the nursing team is directly responsible for the quality of nursing care. Each category, namely the RN, EN and ENA plays a role in patient care by performing tasks that are aligned to their scope of practice. Together, they complement the service that is delivered. However, The Colorado Institute of Nurses, in a 2011 study, has expressed concerns about the quality of nursing care delivered. The

study found that, despite numerous quality improvement initiatives to improve patient safety, meaningful improvements are very slow. Nurses of all categories do not possess a shared understanding of quality care. They also found that nursing management developed quality improvement initiatives without the input of nurses on the floor. This often led to the goals of quality improvement not being achieved (Colorado Institute of Nurses 2011: 3).

The type of work environment influenced the quality of care delivered by the nursing team. Harding, Walker and Duke (2013: 254) stressed that positive work environments enhanced staff morale and quality of care whereby negative work environments demotivated staff and decreased the quality of care.

## 2.13 NURSING WORK ENVIRONMENTS

Havaei (2016: 30) describes nursing work environments as organisational characteristics of a work setting that facilitate or limit professional nursing practice. Littlejohn *et al.* (2012: 24) stress that healthcare work environments have been restructured since the 1990s due to budget constraints and staff shortages among other factors, thereby negatively affecting the work environment. The factors that make up a nursing work environment are nursing leadership, participation in hospital affairs, nurse-doctor relationships, nursing model of care delivery and staffing and resource adequacy. A study done by Havaei (2016: 31) concluded that ENAs believed that the nursing model of care delivery most affected their work environments (Havaei, 2016: 31).

### 2.13.1 Positive practice environments (PPE)

Duffield *et al*. (2011: 250) state that recently there has been global attention on the importance of building PPEs, which is defined as environments that support excellence and decent work. These environments ensure the health, safety and personal wellbeing of staff who in turn can provide quality patient care. Employees in a PPE are highly motivated and productive (Duffield *et al*. 2011: 251). A study conducted by Ferguson and Cioffi (2017: 10) concluded that PPEs contribute to increased levels of staff motivation and better patient outcomes. Environments that did not foster employee growth,

development and motivation had poor quality patient outcomes and a greater number of adverse events.

With mounting economic pressures on healthcare to control costs while increasing productivity, the Registered Nurses Association of Ontario (2014: 12) developed guidelines for a healthy work environment. The goal of the guidelines was to provide high quality, effective patient care within a sustainable and affordable healthcare system. They believed that a healthy work environment is a setting that fosters staff satisfaction and optimal patient outcomes (Registered Nurses Association of Ontario 2014: 13). An integral part of the framework was the individual level, the organisational level and the cognitive level. The cognitive level looks at factors such as communication skills, technical skills and teamwork. This level is supported as the most important level that glues the individual level and the organisational level together. For the guidelines to be successful, it is suggested that all categories of nurses are motivated to work in a team, complement each other's work and the workload is split equally and effectively according to the nurse's scope of practice. Therefore, the correct skill mix is critical to a healthy work environment (Registered Nurses Association of Ontario 2014: 14).

## 2.14 ROLES AND RESPONSIBILITIES OF THE ENA IN SOUTH AFRICA

At the centre of patient care is the ENA who spends most of his/her work hours at the patient's bedside, delivering basic patient care. The ENA is responsible for carrying out basic tasks as per the nursing care plan that is prescribed by the registered nurse. The ENA, through care and commitment, translates nursing goals into meaningful action that directly affects the quality of care (Twigg *et al*. 2016: 193). The ENA provides hands on care to patients and is responsible for many healthcare contributions. She/he works under the direct or indirect supervision of the registered nurse and plays a significant role in patient outcomes and safety and shapes the quality of nursing care delivered (Prestia and Dyess 2012: 146).

Cavendish (2013: 88) states that nursing tasks are delegated from a licensed practitioner, that is from the registered nurse to the ENA, who is referred to as the delegatee. Communication and the collaborative relationship between the licensed nurse and the

ENA and the scope of practice are essential to ensure that delegation is successful (National Council of States of Board of Nursing 2015: 9). ENAs make up approximately 24% of the South African public health professional posts (Day 2015: 118).

## 2.15 ROLES AND RESPONSIBILITIES OF THE ENA GLOBALLY

As per Eurodiaconia (2016: 3), the HCAs in Europe are responsible for the following tasks:

- Making beds
- Helping patients to eat and bath
- Recording patient's glucose levels, temperature, pulse and respirations
- Weighing patients
- Simple dressings
- Escorting patients to theatre

Cavendish (2013: 54) found that the HCAs often work out of their roles due to shortage of nursing staff. These tasks include intravenous cannulation, female catheterisation, complex dressings and setting up infusion feeds, doing ECG's, taking blood samples and updating care plans. The Royal College of Nursing held an annual National Nursing Assistants' Week from 19- 23 May 2019. This week focused on the working conditions of HCAs and brought the relevant stakeholders together in a bid to improve working conditions and discuss pertinent issues (Royal College of Nursing, 2019). There are ongoing efforts to formalise the training, role and responsibilities of the HCAs. The HCAs have a formalised code of conduct that they are expected to follow. European countries accept HCAs from other countries, as the labour is cheaper (Eurodiaconia 2016: 4). HCAs are employed in the following settings:

- Nursing homes for the elderly
- Home- based care
- Institutions for disabled persons
- Hospices
- Rehabilitation facilities
- Outpatient care

In America, nursing assistants work predominantly in nursing homes, providing basic assistance to residents. There are three (3) times more nursing assistants employed in nursing homes as opposed to other categories of staff. A small percentage work in hospitals, under the direct supervision of the RN (Duffield *et al.* 2014: 44).

According to Duffield *et al*. (2014: 45), nursing assistants are responsible for the following tasks:

- Assistance with bathing, dressing, eating and ambulating
- Supporting residents to participate in social activities such as religious services.
- They provide an average of 2.4 hours of hands-on care per resident per day and are expected to detect changes in condition and report these changes to licensed nursing staff.
- Hands-on bedside care such as feeding, bathing and transferring patients.

A study by Liu (2013: 42) concluded that nursing assistants also play an important role in pain management of patients. Since they spend a considerable of time on hands-on care at the patient's bedside, they were the first to respond to patients' complaints of pain; they were reportees of pain; they administered the prescribed medication that was "dished" up by the RN and carried out non-pharmacological interventions for pain (Liu 2013: 42).

The ENA is expected to be a competent practitioner as per the training received and the scope of practice. Aued *et al*. (2015: 90) undertook a research study to identify the clinical competence of nursing assistants in a private hospital in Brazil. They found that the years of experience as a nursing assistant led to higher level of competencies. The competencies were mainly gained by interaction with other professionals, the daily routine of nursing practice, life experiences and formal learning (Aued *et al*. 2015: 92). The majority of nursing assistants stated that they learn most of their competencies from interactions with other nursing professionals. This exposure, over time, increased their levels of competence but also exposed them to tasks and responsibilities that fell outside their scope of practice. The study found that it took 5-6 years for nursing assistants to develop competencies in the workplace. It is important to note that this category of nursing assistants performed tasks that they were not trained for (Aued *et a*l. 2015: 93).

Twigg *et al.* (2016: 172) concur that this, in turn, led to various challenges and issues that ENAs experienced while trying to integrate themselves into the nursing team.

## 2.16 CHALLENGES EXPERIENCED BY ENAs IN SOUTH AFRICA

Lubbe and Roets (2013: 59) emphasise that the assessment of patients is the first step of the nursing process and forms the framework on which all individualised, patient-specific care is planned. In the South African healthcare context, the RN is responsible for this task. Abroad, nurses with a 4-year university education are responsible for this task. However, Lubbe and Roets (2013: 60), in their study of nurses' scope of practice, found that ENAs were conducting patient assessments. It is not possible for all nurses to practice within their scope because of the critical shortage of registered nurses. (Littlejohn *et al*. 2012: 34).

In a study conducted by Haskins *et al*. (2014: 37), focus groups were held with all categories of nursing staff to determine their attitudes toward patient care. The ENAs in the study revealed that they were treated poorly by senior personnel, who often shouted at them in front of patients, without knowing the full story of what went wrong. This demotivated them to such an extent that it affected the type of care they rendered to their patients. This led to decreased productivity and an unpleasant work environment (Haskins *et al*. 2014: 38).

## 2.17 CHALLENGES EXPERIENCED BY ENAS GLOBALLY

Corazzini (2013: 320) asserted that internationally ENAs are also prone to workforce injuries due to caring for the elderly, most of whom have disabilities. They tend to work part-time because of low salaries. More than 90% are female and 26% fall in the age group of 25-34. There is a high rate of poverty among nursing assistants and nearly 40% rely on some form of public assistance. The turnover rates for nursing assistants are high, resulting in many unfilled vacancies in nursing homes (Corazzini 2013: 321).

According to Spilsbury *et al.* (2011: 51), the National Health Service (NHS) in the United Kingdom spends 70% of its budget on staffing costs. In a bid to reduce these costs, they decided to make more efficient use of their human resources. The assistant practitioner

(AP) post was created to assist in the redesign of services to improve quality and efficiency and to alleviate the burden of an ageing healthcare workforce. APs are higher level support workers who undertake a work-related competence-based qualification or a 2-year degree level qualification (Spilsbury *et al*. 2011: 50). The research sought to examine the challenges and opportunities associated with the introduction of the AP. It was found that the nurse aides were demotivated as their place in the nursing hierarchy was usurped by the APs. The staff found that the AP role was poorly communicated and there was lack of a clear job description. The introduction of the AP had a negative effect on nurse aides' motivation and productivity (Spilsbury 2015: 52).

The study done by Spilsbury in 2015 also found that, for nurse aides to work harmoniously with APs, a certain level of trust was required. APs were not allowed to administer medication, although many of them involved in the study felt that they could administer medication successfully. The RNs, who felt overwhelmed with the task of administering medication and carrying out the rest of their duties, allowed the APs to administer medication. This type of preferential treatment had many nurse aides up in arms. They were perceived by fellow staff as a cheaper source of labour. Nurse aides felt isolated in their roles. The study also raised concerns about the lack of continuous development opportunities for nurse aides. They also reported a lack of mentorship and guidance from senior members of staff. The study concluded that the transition into accepting the AP role was a difficult one and formal policy initiatives should be developed to allow the role of the nurse aide to complement the role of the AP (Spilsbury *et al*. 2011: 52).

In a study conducted by Danielson (2014: 6), nursing aides perceived that their responsibilities were unspecified. This caused them to become frustrated. However, they felt that experience in the field developed certain capabilities and skills. Nursing assistants did not always feel supported by registered nurses as they were asked to attend to numerous tasks, which included being treated as porters and cleaners. The study by Danielson (2014: 7) also revealed that the nursing assistants felt that they were not trusted in the team and sometimes felt invisible, although the RNs in the study stated that ENAs were an integral part of the team. High staff turnover and lack of resources were

also perceived as challenges that affected the nursing assistants' work outputs (Danielson 2014: 7).

The study conducted by Puerto et al. (2017: 6) revealed that nursing assistants attributed their work stressors to not knowing where in the nursing team they were positioned. They felt that the rest of the team were frustrated with them as they were limited in what they could do. They were told to report patient abnormalities to senior nursing personnel, but when they did, the RNs would express their frustration because the nursing assistant did not do more to help them with the patient. The nursing assistants interviewed were cognisant of their limitations and felt that expanding their scope of practice would allow them to be a valuable part of the nursing team (Puerto et al. 2017: 7).

## 2.18 ARGUMENTS FOR AND AGAINST THE ENA AS A PART OF THE NURSING TEAM

### 2.18.1 Arguments for the ENA as part of the nursing team

In South Africa, ENA's are a part of the nursing team and form part of the nursing skills mix. A study by Ritchie and Gilmore (2013: 32) concluded that ENAs are a vital part of the nursing workforce. The RNs interviewed in the study indicated that they are heavily reliant on the ENA to be their eyes and ears in the unit. They felt that the ENA made a valuable contribution to the environment because they were there to run errands and get to the tasks that the RN could not get to; however, they did state that the ENA did some tasks that were out of their scope of practice. This was mainly due to staff shortages but also the RNs in the study felt that certain ENAs showed potential to be able to perform tasks out of their scope of practice (Ritchie and Gilmore 2013: 32).

The study conducted by Haakestad (2012: 88) explored the role of ENs in the nursing environment. When asked about their relationships with the ENAs, most of them felt that ENAs were valuable to the nursing team. They were able to provide care and comfort to patients, spent a considerable amount of their time with patients and complemented the nursing team positively. They also felt that the PNs were exempt from doing the menial tasks like answering of patients' call bells, while ENAs gladly accepted this as part of their responsibility (Haakestad, 2012: 92).

### 2.18.2 Arguments against the ENA as part of the nursing team

In contrast, another study conducted by the Registered Nurses Association of Ontario (2014: 62) revealed that RNs were unhappy that they worked with a greater number of ENAs than they should. They acknowledged that ENAs worked with minimal supervision and worked out of their regulated scopes of practice; however, direct supervision was not realistic in their working environments. They believed that ENAs were risking their jobs by not opposing delegated tasks that were out of their scope of practice (Registered Nurses Association of Ontario 2014: 63). Many of the ENAs they worked with wanted to prove that they could do more than their scope allowed. The RNs believed that it became dangerous to clinical care when the ratios of ENAs were too high. The probability of adverse events increased as ENAs did not possess the clinical knowledge to make appropriate decisions. The Registered Nurses' Association of Ontario elaborates that the role and responsibilities of the RN are overwhelming when working with junior staff that require direct supervision.

Mabunda's (1995: 103) study reiterated the mixed feelings RNs and other categories of staff have about ENAs working in the nursing environment. The majority of the RNs interviewed felt that ENAs always required supervision and needed to check the most basic of nursing actions with them. With medical wards being high activity areas, it will be easier to work with levels of staff that had more clinical knowledge and could make decisions that are more independent. The minority of RNs interviewed felt that ENAs were an asset, provided they stuck to their scope of practice.

In a study by Valizadeh (2016: 486), ten (10) RNs were interviewed to find out their experiences with working with more ENAs and unregulated care workers. RNs felt that assessment and prioritisation of patient care were their primary functions but the shortage of RNs in the ward prevented them from executing these important tasks. Administrative duties such as allocating staff to the different shifts also kept them away from important bedside duties (Valizadeh 2016: 490). They valued the work of the nursing aides and care workers but felt that they were very restricted in what they could do. This placed an overwhelming burden on the RN who was ultimately responsible for the patient. RNs felt

that an expanded scope of practice for the nursing aides would help them overcome their challenges and improve the quality of care for the patient (Valizadeh 2016: 501).

## 2.19 THEORETICAL FRAMEWORK

### 2.19.1 Mead's 1934 Role Theory

Mead's role theory (1934) as quoted by Harnisch (2011: 53), is a conceptual framework that defines how individuals, such as nurses, behave in social situations and how these behaviours are perceived by external observers, allowing for the exploration of attitudes and perceptions of individuals, such as ENAs who interact within healthcare organisations. Role theory concerns one of the most important features of social life, characteristic behaviour patterns or roles. Roles are explained by presuming that people are members of social positions and hold expectations for their own behaviours and those of others (Van der Horst (2016: 1). The primary focus in this theory is the social interactions in which people cooperate to achieve a goal or outcome (Harnisch (2011:54). The role theory evolved from two schools of thought, namely structural and interactional.

### 2.19.2 Roles as structure

According to Van der Horst (2016: 1), structuralism is associated with status, position and office. Roles are culturally defined norms such as rights, duties, expectations, and standards of behaviour associated with a given social position. The social position that one has influences one's behaviour. The emphasis of this approach is on the rules and norms that govern certain roles (Van der Horst 2016: 2). Role competence refers to success in carrying out a role. There are societal pressures associated with fulfilling roles and sanctions can be applied for non-conformance to roles. Role captivity refers to the unwanted participation in the role, mostly brought on by societal pressures (Carter and Fuller 2015: 11).

### 2.19.3 Roles as Interaction

Carter and Fuller (2015: 12) describe the interactional approach to role theory as the relationships between what a person does and what others do around them. Communication, both verbal and non-verbal, is central to the process. Individuals also take on the roles of others in order to anticipate their actions and perspectives. This is referred to as role taking. As an outcome of interactions, individuals identify themselves and are identified by others as holding particular social statuses or positions. Van der Horst (2016: 3) emphasises that role occupants have specific expectations and behaviours that are required of them. Role senders, however, have their own expectation and anticipation of the role occupant's response to their role expectation.

### 2.19.4 Accumulating and changing roles

Both Carter and Fuller (2015: 12) agree that individuals accumulate different roles in any given stage of their lives. During the lifespan, individuals transfer into and out of roles. Certain roles are kept and others are discarded and referred to as *role transitions.* Multiple roles are associated with both positive and negative consequences. Van der Horst (2016: 4) also notes that, when the role occupant and the role sender are in conflict over the role to be performed, role ambiguity, role conflict, role overload and role incongruity may occur. The author also explains the following role transitions as:

- *Role conflict* refers to the incongruity between the expectations of one role and those of another.
- *Role overload* refers to the experience of lacking the resources, including time and energy, needed to meet the demands of all roles.
- *Role ambiguity* is a condition in which expectations are incomplete or insufficient to guide behaviour.
- *Role incongruity* however is a term adopted from the work of Proctor and Davis (1994: 31) and refers to difference between people's expectations of what types of individuals either normally perform certain roles or are ideally suited to perform certain roles or are best qualified or suited to perform certain jobs and those who are not.

These roles, as explained above, lead to the role occupant's inability to complete tasks and meet expectations due to limitations of time, skill level or education. This is referred to as *role stress*, where role obligations are vague, irritating, difficult, conflicting or difficult to meet. If role stress is not addressed it will lead to role strain (Van der Horst 2016: 3).

*Role strain* refers to feelings of frustration, tension and anxiety that arise because of conflicting roles.

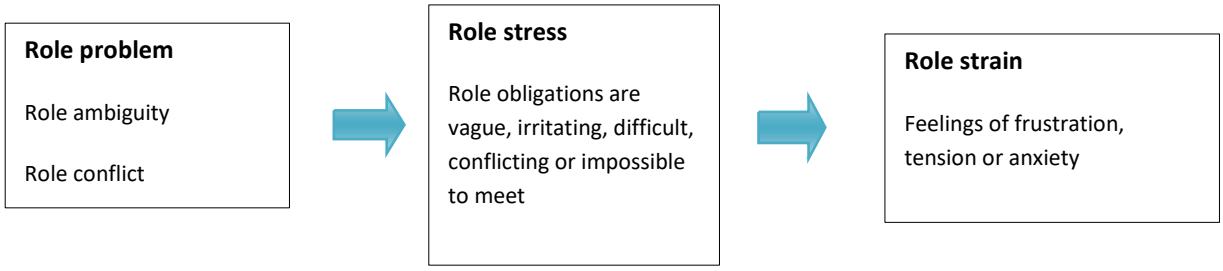


**Figure 2. 1 Mead's role theory (Van Der Horst, 2016)**

## 2.20 RESEARCH PARADIGM

### 2.20.1 Application of the role theory to topic of enquiry

In the context of this research, the ENA is a member of the nursing team that includes RNs and ENs, who share a common goal to deliver quality nursing care. Each member of the team has an expected role to play, which is dictated by the training that they receive, as well as the scope of practice that is stipulated by the SANC. The role senders are the RNs or ENs that supervise and delegate the tasks performed by the ENA in the clinical environment. Although ENAs are trained to fulfil a specific role, namely provide basic nursing care, various environmental factors lead to their performing multiple and sometimes complex roles that they are not trained to perform. These factors include, but are not limited to, staff shortages, incorrect skill mix and lack of equipment which can lead to RNs and ENs delegating tasks to ENAs that they have not trained for. This can result in their experiencing role conflict, role overload, role ambiguity and role incongruity. If this situation persists, role stress is experienced, which eventually leads to role strain. The ultimate result is decreased levels of motivation, productivity and burnout. In the context

of the proposed study, the role theory will serve as a plausible and useful framework to facilitate the understanding of the role perception of ENAs in a contemporary healthcare setting and will further assist in describing models of nursing care and advanced strategies for decreasing role conflict and role burden in the professional workplace of the nurse. An understanding of the role arises from an appreciation of the activities of the role holder, which meet the expectations of teams, colleagues, patients and other stakeholders.

## 2.21 CHAPTER SUMMARY

The ENA, governed by a scope of practice, plays a vital role in the nursing team. They spend most of their time at the patient's bedside delivering basic care that patients come to expect from nurses. They are expected to work under the direct supervision of the RN or EN; although certain factors make it difficult for them to receive optimal supervision. Various healthcare challenges influence the work environment of the ENAs, including the ability to develop professionally, which limits their career pathing. There are mixed feelings about the role and value of the ENA in the healthcare setting. as Although they are regarded as valuable members of the nursing team, the frustration lies in their limited scope of practice and their growing numbers in the nursing environment.

# CHAPTER 3: RESEARCH METHODOLOGY

## 3.1 INTRODUCTION

This chapter presents a description of the study design, the setting, population, sampling frame, approach and technique, sample size, data collection method, data processing and analysis used in this study. An in-depth explanation of how research rigor, trustworthiness and ethical considerations were maintained throughout the study is also presented.

## 3.2 RESEARCH DESIGN

According to Grove, Burn and Gray (2013: 692), a research design is the structural framework of the study and a blueprint for conducting the study. They also state that every study required a plan, which is referred to as the research design. Within this design, the researcher must remain objective and the approach to knowledge must be systematic so that validity is enhanced (Polit and Beck 2012: 237). An exploratory descriptive design, utilising a qualitative approach, was used to explore the working environment of the ENAs in private hospitals in the eThekwini District.

### 3.2.1 Qualitative Designs

According to Grove, Burns and Gray (2013: 23), qualitative research is appropriate when the researcher wants to examine the experiences of human beings in their natural environment. Qualitative research uses a subjective approach to define life experiences and add meaning to them. Exploratory research is designed to increase the knowledge of a field of study (Grove *et al.* 2013: 25). In addition, a descriptive design is included when the researcher wants to develop theory, identify problems with current practice and make judgements (Brink, Van Der Walt and Van Rensburg 2012: 162). This method was deemed most suitable because it allowed the researcher to obtain information from participants who were working in the environment of interest. The study provided an overview of the working environment of ENAs in private healthcare institutions using the

perceptions of ENAs, RNs and UMs. The study was conducted in a real world setting and in a natural setting where the participants worked. The experiences of participants were described in the participants' own words.

### 3.2.2 Exploratory Studies

Exploratory studies are used to address problems that require a solution for a specific population. They are designed to increase the knowledge in a field of study (Grove, Burns and Gray 2013: 694). In the current study, the researcher explored the working environment of ENAs in private hospitals by asking participants to describe the role and responsibilities of ENAs, their experiences when working as and with ENAs and the challenges that ENAs face in the course of their working day.

### 3.2.3 Descriptive Studies

Descriptive research allows the researcher to observe, describe and document phenomena as they occur in the natural setting (Polit and Beck 2012: 226). It is ideal to use when there is little known about a topic. Descriptive designs are used to develop theory, to determine what others are doing in similar situations, to identify problems with current practice and to justify current practice (Botma *et al.* 2010: 110). In this study, the researcher asked the participants to describe their understanding of their scope of practice and their role and responsibilities which allowed the researcher to identify problems with current practice.

## 3.3 STUDY SETTING

According to Brink et al. (2012:59), a study setting refers to the specific area or place where the research is conducted. The study was conducted in the medical and surgical units of private hospitals in the eThekwini District. Two private hospitals, that employ ENAs, both on a permanent and agency basis, and that have more than one medical and surgical unit each, were included in the study. The medical and surgical units were chosen because the required skill mix for these units are made up of 40% ENAs, 30% RNs and 30% ENs as compared to other types of units which utilise a lower percentage of ENAs in their skill mix. For the purpose of confidentiality, the hospitals were coded as hospital

A and hospital B. Hospital A was the 400-bedded hospital that offered both general and specialist services. Hospital B was the medium sized, 207-bedded hospital that offered general services. These hospitals were chosen because they had the greatest number of varied medical and surgical units and employed the highest number of permanent ENAs.

For hospital A, the sample of RNs, UMs and ENAs was obtained from four (4) medical and five (5) surgical units. These units had between 25-34 beds each and had an average occupancy of 75%- 85% per unit. For hospital B, the sample of nurses for the study was obtained from two (2) medical and two (2) surgical units. These units had a bed capacity of 20-32 beds each and an average occupancy of 68%- 80% per unit.

### 3.4 POPULATION

According to Brink *et al*. (2012: 131), a population is the entire group of individuals that meet the specific criteria that the researcher is interested in. For this study, the population was made up of ENAs, RNs and UMs of medical and surgical wards. At the time of the study, there were fifty-nine (59) ENAs, sixty-five (65) RNs and thirteen (13) UMs permanently employed in the medical and surgical wards of the selected hospitals. The total population was 137 staff members.

For hospital A, there were nine (9) UMs, forty-four (44) RNs and forty (40) ENAs. Hospital B had four (4) UMs, twenty-one (21) RNs and nineteen (19) ENAs.

### 3.5 RECRUITING OF PARTICIPANTS

Ethical clearance, IREC 009/19 was received on the 13 June 2019 from the Institutional Research Ethics Committee (IREC) (Appendix 1a). Thereafter, permission to conduct research at the proposed study sites was requested from the research committee. Once this was received, the researcher obtained permission from the private hospitals under study to arrange for the information giving and recruitment sessions with prospective participants. These sessions were held during working hours, when the UMs, RNs and ENAs were available, without disrupting normal operations. They took place in a private venue where the participants were informed about the study and given an opportunity to read the covering letter and provide written consent to participate in the study. Once

informed consent (Appendix 3) was obtained the dates and times for the interviews were scheduled with each participant based on their availability and convenience but also guided by the different phases of data collection as detailed in the data collection section (3.8).

## 3.6 SAMPLING PROCESS

Purposive sampling was used to recruit participants for this study from the medical and surgical wards. According to Creswell (2013: 88), purposive sampling is used to recruit participants for whom the research topic is relevant, and where the goal of the study is to gather information on their experiences. Purposive sampling was best suited to this study as a limited number of participants namely UMs, RNs and ENAs could serve as primary data sources due to the nature of the research design, aims and objectives. The experiences of the UM, RN and ENA was therefore essential in providing information rich data about the work environment of the ENA in private hospitals in the eThekwini district

The type of purposive sampling used for this study was maximum variation sampling. Creswell (2013: 89) describes maximum variation purposive sample as one that is used to provide a diverse range of cases relevant to a particular phenomenon. The purpose of this kind of sample design is to provide as much insight as possible into the phenomenon under examination. The range of cases (participants) in the current study were the different categories of nurses which included the UMs, the RNs and the ENAs.

### 3.6.1 Sampling of UMs

Each medical and surgical unit has a permanently employed UM that works a day shift in a designated unit from Monday to Friday and may work on a Saturday or Sunday to take charge of the hospital. If they work on a weekend, then they will take their time off on a weekday, depending on operations of the unit. Selection was guided by the following inclusion and exclusion criteria.

*Inclusion criteria:*

- Permanently employed UMs who have been working in the medical or surgical units for a minimum of one year.

*Exclusion criteria:*

- UMs that were away on time off annual leave, sick leave or emergency leave at the time of the interview.

### 3.6.2 Sampling of RNs

The medical and surgical units utilised an average of two or three RNs per shift with some working via a nursing agency and some being permanently employed by the hospital. The following inclusion and exclusion criteria guided the selection:

*Inclusion criteria:*

- Permanently employed RNs or RNs employed by a nursing agency who have been working in the medical or surgical units for a minimum of one year.

*Exclusion criteria:*

- RNs who are rotated to assist in medical and surgical wards for less than a year.

### 3.6.3 Sampling of ENAs

There was an average utilisation of two ENAs per working shift. Selection of these participants was guided by the following inclusion and exclusion criteria:

*Inclusion criteria:*

- Permanently employed ENAs or nursing agency who have been working in the medical or surgical units for a minimum of one year. A period of one year was used as an avid judgement of character and the work environment can be made in this time.

*Exclusion criteria:*

- ENAs that are rotated intermittently to assist in medical and surgical wards for less than a year.

### 3.6.4 Sample size

Qualitative research does not have a fixed sample size. The sample size is determined by the information needs of the research (Polit and Beck 2012: 252). The sample size is guided by the principle of data saturation, which is the point where no new information is obtained from the participants (Grove *et al.* 2013: 371). Thus, the current study was guided by data saturation, which was achieved when there was no new information emerging from participants about the working environment of the ENAs.

The sample sizes for both sites were guided by data saturation, which was monitored concurrently for the two study sites but separately for each nursing staff category. Two additional interviews were held for each category after data saturation had been reached which was after ten ENAs, eight RNs and four UMs. Therefore, in total, 28 interviews were conducted (12 ENAs, 10 RNs and 6 UMs) for the entire study. Table 3.1 presents the sample realisation for this study.

**Table 3. 1 Sample realisation for the study population**

| Study site | UM's | RN's | ENA's |
|---|---|---|---|
| A | 4 | 6 | 8 |
| B | 2 | 4 | 4 |
| Total | 6 | 10 | 12 |

## 3.7 CODE BOOK FOR DATA DEFINITION

All the participants were assigned code numbers to ensure confidentiality and anonymity of data. The two study sites were coded as A and B respectively, while the participants were assigned "P" as a code. The numbering was done in consecutive order per interview session. During the first phase UMs were interviewed and were assigned codes from P1 to P6, followed by RNs in the second phase that were assigned codes from P7 to P16 and lastly the ENAs in the third phase were assigned codes from P17 to P28.

## 3.8 DATA COLLECTION

Data collection was done between the 17th June 2019 and 03rd July 2019. Data collection commenced with the UMs (phase one), followed by the RNs (phase two) and lastly the ENAs (phase three). All interviews were conducted in English by the researcher who had no personal or professional relationships with the participants. The researcher alternated data collection between the two study sites in order to monitor data saturation which was monitored concurrently for the two study sites. During the information giving session, the interview session for each participant who agreed to take part in the study was scheduled for the date, time and venue that was preferred by each participant. All participants opted for having the interview session in the units where they were working. Private rooms to use for the interviews were arranged through the UMs. An arrangement was made that the secretary for each unit was to assist with the flow of participants to the data collection room, as per interview schedule.

At the onset of each interview session, the researcher began by welcoming and orientating the participant regarding the interview process, remind him/her about the aim and objectives of the research, assure him/her that the ethical principles will be maintained. The researcher also verified that informed consent have been signed, request the consent to audio record the interview session and to take some field notes, record the demographic information of the participant and set up the recorder to begin the interview. On average, each interview session lasted approximately 45 minutes. Maximum two interviews were completed per day. These were analysed before conducting the next interview in order to monitor data saturation.

### 3.8.1 Data collection tools

According to Grove *et al.* (2013: 271), a semi-structured interview is a qualitative method of inquiry that combines a pre-determined set of open questions that prompts discussion with the research participants and gives the interviewer the opportunity to further explore themes or responses. The use of two separate semi-structured interview guides (one for ENAs and another for RNs and UMs), in this study, did not limit participants to any set of pre-determined answers. It allowed them the freedom to express their opinion or

understanding of the phenomenon under study, without the restrictions of closed-ended questions or the interviewer's opinion or bias.

The researcher used an interview guide that comprised a demographic section and a question to focus the discussion (Appendices C and D). The central question posed to ENAs was:

*"How would you describe your working environment?"*

The probing questions were:

- Describe your understanding of your scope of practice as an ENA.
- Explain what is currently expected of you as an ENA in the ward.
- Describe the challenges you experience in the workplace.
- Describe the supervision and mentorship you receive.
- Describe what you think will improve your work environment.

The central question to the RNs and UMs was:

*"How would you describe the working environment of the ENA?"*

The probing questions were:

- Explain your understanding of the ENA's scope of practice
- Currently, describe what is expected of the ENA's in the ward
- Explain the challenges you experience when working with ENA's. What causes these challenges? What can be done about it?
- Describe the level of supervision that ENA's receive.
- Tell me how the work environment of the ENA can be improved

Probing questions were asked to elicit detailed information about the working environment of ENAs. Additional probing questions were asked as the need arose to gain more clarity on the participants' responses whenever necessary. The researcher had no prior contact with any of the participants and the interviews were conducted in English, which is the preferred language medium in both participating hospitals.

### 3.8.2 Pilot study

A pilot study was conducted before the commencement of the actual study in order to test appropriateness of the planned processes and the data collection tool. The pilot site was a private hospital in eThekwini District. One medical and one surgical ward was used to sample the pilot participants. Four participants which included; one UM, one RN and two ENAs were randomly sampled. Similar data collection processes and tools to those planned for the main study were employed in conducting the pilot study. The results of the pilot study confirmed that the planned data collection processes were appropriate for the intended enquiry. The pilot indicated a need one modification of the data collection tools. This included rephrasing of one probing question “What do you do in the ward?” to “Explain what is currently expected of you as an ENA in the ward” in order to elicit rich information about their experiences. The pilot site, participants and findings were not included in the main study

## 3.9 DATA ANALYSIS

Polit and Beck (2012: 556) state that the process of data analysis involves organising and providing structure to the data that has been collected. Tesch’s eight step open coding approach (Creswell 2013: 234) was used to analyse the data:

- The data was collected verbatim and the transcripts were read to get a general impression of the data.
- Thoughts arising from the data were documented in the margin.
- Similar topics were clustered together and organised as major, similar or leftover topics.
- Abbreviated topics were written as codes next to the corresponding segments of data.
- The most descriptive wording was used for topics.
- Related topics were grouped together.
- Data that belonged to each category was assembled from which themes emerged.
- The existing data was then recorded.

## 3.10 RESEARCH RIGOR

Trustworthiness, according to Brink *et al.* (2012: 172), is based on the 1995 model of Lincoln and Guba and is an alternative construct for validity and reliability in qualitative research. It is often grouped as part of qualitative validity and is a way of ensuring data quality or rigor in qualitative research. Qualitative validity means that the researcher checks for the accuracy of the findings by employing certain procedures (Polit and Beck 2012: 231). The model identifies five criteria for developing trustworthiness in qualitative research namely: credibility, dependability, confirmability, transferability and authenticity.

### 3.10.1 Credibility

Polit and Beck (2012: 239) define credibility as the confidence in the truth of the data. The researcher ensured credibility by taking a period of two (2) weeks to collect the data. This ensured that the researcher built trust and rapport with the participants. The participants were purposively chosen and the information was collected until data saturation was achieved.

### 3.10.2 Dependability

Dependability refers to the provision of evidence such that if the study were to be repeated with the same or similar participants in the same or similar context, its findings would be similar (Polit and Beck 2012: 239). The researcher ensured dependability by conducting an inquiry audit whereby an external reviewer scrutinised the data and the supporting documentation.

### 3.10.3 Confirmability

Confirmability refers to accurate reporting of the real meaning of data as provided by the participants (Brink, van der Walt and van Rensburg 2012: 171). The interviews for this study were audio-recorded so that the information provided by the participants was accurate and truthful. The researcher developed an audit trail so that an independent auditor could reach conclusions about the data.

### 3.10.4 Transferability

According to Polit and Beck (2012: 239), transferability is the ability to apply the findings of the study in other contexts or to other participants. For this study, the population comprised UMs, PNs and ENAs. These categories of nurses are found in all medical and surgical units of private hospitals.

### 3.10.5 Authenticity

Authenticity refers to the extent to which the researcher faithfully and fairly shows a range of different realities. It emerges in a report when it conveys the feeling of the participants' lives as they lived it (Polit and Beck 2016: 234). The data that was collected in the course of the study was described accurately and depicted the actual experiences of the participants in their real-life settings, enabling readers to develop a heightened sensitivity to the working environment of the ENA in private healthcare institutions.

## 3.11 ETHICAL CONSIDERATIONS

Ethics refers to a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations in interacting with participants (Polit and Beck 2012: 727). The study commenced after the ethics clearance (IREC 009/19) was granted by the DUT Institutional Research Ethics Committee (IREC) (Appendix 1a). Certain ethical principles must be maintained to ensure that the rights of participants are upheld. Polit and Beck (2012: 752) identify the following four principles namely, beneficence, justice, informed consent and confidentiality that are vital for ethical consideration by any researcher.

### 3.11.1 Beneficence

Beneficence is one of the most important ethical principles in research. It outlines the researcher's responsibility to minimise harm or increase benefits for the participants (Polit and Beck 2006: 87). The participant has a right to be protected from any type of harm, such as physical, psychological, emotional, social or legal. If participants show signs of distress during data collection, the researcher must debrief the participant or even offer

counselling services (Brink *et al*. 2012: 36). The researcher ensured that participants understood the benefits of the study by providing detailed explanations. The researcher also ensured that no harm came to participants during the process of data collection by ensuring anonymity of the participants.

### 3.11.2 Principle of justice

Participants should be treated fairly and should be provided with an information leaflet that details the study. There should be no intervention that is not described in the leaflet. Data must be collected with the explicit permission of the participant (Brink *et al*. 2012: 20). The participants' right to privacy must be respected, deciding how much information should be made available to others (Botma *et al.* 2010: 20). The researcher ensured that participants were provided with relevant information about the study. The names of participants were translated into codes and not made accessible to any other party.

### 3.11.3 Informed consent

Participants must be given adequate information regarding the study that is undertaken. The researcher must also ensure that this information is understood and that participation in the study is voluntary. Participants should also be provided with a written consent form that includes the purpose of the study, expectations of the participants, the time involved and the potential costs and benefits (Polit and Beck 2012: 93). According to Brink *et al.* (2012: 38), informed consent also includes giving the participant a choice to participate in the study. The correct protocols and principles must be dealt with when dealing with vulnerable participants. Each participant was given an information leaflet that detailed the relevant areas of the study. Written, voluntary consent was obtained from each participant, with the right to withdraw from the study at any time.

### 3.11.4 Confidentiality

This ethical principle refers to the management of personal information that ensures that only the researchers that are directly involved with the study can access the information. The participant has a right to choose who to share personal information with. The researcher needs to respect this (Botma *et al.* 2010: 16). Confidentiality measures need

to be taken by researchers to ensure that confidentiality is maintained. In order to maintain anonymity, identification numbers, rather than participants' names should be used on study records. (Polit and Beck 2012: 95). Codes, instead of the participants' names, were used on the data collection sheets. This ensured that participants remained anonymous and that their responses could not be linked to individual names.

## 3.12 SUMMARY

The research design of this study, its setting and recruitment and sampling of participants has been clearly detailed in this chapter. This chapter also outlined the ethical considerations which were explained and applied in context of the study. Chapter 5 will present the results of qualitative data utilising Tesch's method of data analysis to further categorise the data into themes and sub themes.

# CHAPTER 4: PRESENTATION OF FINDINGS

## 4.1 INTRODUCTION

Chapter three outlined the methodology that was used in conducting the study. Chapter four will present the findings of the study, highlighting the themes and sub-themes that emerged from the interviews with UMs, RNs and ENAs regarding the working environment of the ENAs in private healthcare hospitals, in the eThekwini District.

## 4.2 DEMOGRAPHIC DATA

### 4.2.1 Phase one: UMs

All the UMs interviewed were between the ages of 32 and 52 years old. All of them were female. The majority of UMs were in their position for 5-10 years and employed at the study site for >10 years.

**Table 4.1 Demographic data of UMs**

| Study site | Participant code | Gender | Age | Category of nurse | Years as UM | Years at study site |
|---|---|---|---|---|---|---|
| A | P1 | Female | 47 | UM | 5-10 | >10 |
| A | P2 | Female | 42 | UM | 1-<5 | 1-<5 |
| A | P3 | Female | 39 | UM | 5-10 | 1-<5 |
| A | P4 | Female | 49 | UM | >10 | >10 |
| B | P5 | Female | 49 | UM | >10 | >10 |
| B | P6 | Female | 40 | UM | 5-10 | >10 |

### 4.2.2 Phase two: RNs

The RNs interviewed were between the ages of 32 and 52 years old. All of them were female. The majority of RNs interviewed were in their position for 1- <5 years and employed at the study site for < 5 years.

**Table 4.2 Demographic data of RNs**

| Study site | Participant code | Gender | Age | Category of nurse | Years as RN | Years at study site |
|---|---|---|---|---|---|---|
| A | P7 | Female | 32 | RN | 5-10 | 5-10 |
| A | P8 | Female | 29 | RN | 1-<5 | 5-10 |
| A | P9 | Female | 52 | RN | >10 | 5-10 |
| A | P10 | Female | 38 | RN | 5-10 | >10 |
| A | P11 | Female | 44 | RN | 5-10 | >10 |
| A | P12 | Female | 32 | RN | 1-<5 | 1-<5 |
| B | P13 | Female | 32 | RN | 5-10 | 1-<5 |
| B | P14 | Female | 36 | RN | 1-<5 | 1-<5 |
| B | P15 | Female | 38 | RN | 1-<5 | 1-<5 |
| B | P16 | Female | 43 | RN | >10 | 1-<5 |

### 4.2.3 Phase three: ENAs

The twelve (12) participants in Phase three comprised ENAs, of which only one was a male ENA. Their ages ranged from 24- 41 years old. Most of them were in the role of ENAs between 5-10 years but were employed at the study site for 1-< 5 years. Table 4.3 illustrates the demographic data for all ENAs who participated in Phase three of data collection.

**Table 4.3 Demographic data for ENAs**

| Study site | Participant code | Gender | Age | Years as ENA | Years at study site |
|---|---|---|---|---|---|
| A | P17 | female | 35 | >10 | >10 |
| A | P18 | female | 36 | >10 | >10 |
| A | P19 | female | 32 | >10 | 5-10 |
| A | P20 | female | 41 | 5-10 | 5-10 |
| A | P21 | female | 27 | 5-10 | 5-10 |
| A | P22 | female | 37 | 5-10 | 5-10 |
| A | P23 | female | 33 | >10 | 1-<5 |
| A | P24 | male | 25 | 5-10 | 1-<5 |
| B | P25 | female | 31 | 5-10 | 1-<5 |
| B | P26 | female | 29 | 5-10 | 1-<5 |
| B | P27 | female | 24 | 1-<5 | 1-<5 |
| B | P28 | female | 35 | 1-<5 | 1-<5 |

## 4.3 OVERVIEW OF THEMES AND SUB-THEMES

Since similar themes and sub-themes emerged from the two data sets, the data is presented concurrently. Added emphasis is placed where the data complements or contradicts each other. In order to facilitate the presentation and discussion of the findings, the UMs are referred to as “Phase one participants”, the RNs are referred to as “Phase two participants” and ENAs as “Phase three participants.”

### 4.3.1 Themes

The five themes, which emerged after analysis of both data sets, were:

- Challenges experienced by the ENA
- Experiences in the work environment
- Supervision of ENAs
- Overcoming challenges
- Improving the work environment

### 4.3.2 Themes and sub-themes

Several sub-themes corresponding to each of the five themes emerged. Table 4.4 illustrates the themes and the corresponding sub-themes.

**Table 4.4 Themes and sub-themes**

| Theme No | Theme | Sub-themes |
|---|---|---|
| Theme one | Challenges experienced by ENAs | 1.1 Lack of communication pertaining to training to the next level of qualification |
| | | 1.2 Financial restrictions |
| | | 1.3 Value add of the ENA |
| | | 1.4 Role stress |
| | | 1.5 Staff shortages |
| Theme two | Experiences in the work environment | 2.1 Working out of scope of practice |
| | | 2.2 Lack of respect and recognition |
| | | 2.3 Close relationships with patients |
| | | 2.4 Job dissatisfaction |
| | | 2.5 Over utilisation of agency staff |
| Theme three | Supervision and mentorship of ENAs | 3.1 Minimal supervision from RNs and ENs. |
| | | 3.2 Expectations of ENAs |
| | | 3.3 Time constraints |
| Theme four | Overcoming challenges | 4.1 Provision of funding for further training opportunities. |
| | | 4.2 Increasing permanent staff numbers of ENAs |
| Theme five | Improving the working environment of the ENA | 5.1 Decrease overall agency utilisation |
| | | 5.2 Reward and recognition programme for ENAs |

## 4.4 PRESENTATION OF FINDINGS

### 4.4.1 Theme One: Challenges experienced by ENAs

During the interviews, a theme that arose was the challenges that ENAs experienced in the course of their work. Five sub-themes associated with challenges were highlighted: Lack of communication pertaining to training to the next level of qualification, financial restrictions, value add of the ENA, role stress and staff shortages.

#### *4.5.1.1 Sub-theme 1.1: Lack of communication pertaining to training to the next level of qualification*

Phase one and two participants, comprising the UMs and RNs agreed that there was no clarity on funding for next level of qualification as well as when this qualification is likely to be available at the private nursing college.

> "...*It's sad that there are no training opportunities for ENA's. The other categories of staff get to do some training but the ENA is always left out. Something should be done about this..." participant 6B*

The phase three participants in the interviews concurred that there was a massive gap in funding of career development opportunities for ENAs. The consensus was that there was no communication provided on when the new nursing qualification would be available at the private nursing college and if the healthcare group would fund this qualification. There have also been delays in providing answers about whether the hospitals will provide funding for the new courses proposed by the SANC. This left ENAs feeling demotivated and overlooked. The following statements from some of the participants can substantiate this:

> *"There is no further information on training available for us and we feel frustrated. We would like to learn more, but we are unable to..." participant 23A*

> *"...It's like we can't grow more. We want to train but there are no opportunities available. It seems unfair..." participant 27B*

*"...I am waiting for so long for an answer. They keep telling us next year and then next year, but nothing is happening. I am frustrated and disappointed but there is nothing I can do. I am an ENA for 12 years. The sisters will tell you how well I can do my job." participant 19A*

#### *4.5.1.2 Sub-theme 1.2: Financial restrictions*

Phase one and two participants acknowledged that many ENAs could not afford to fund their studies in a personal capacity:

"…*although they have the potential to become EN's and even RN's, they don't have the money to leave work and study." (Participant 13B).*

*"Shame, they want to study further but they can't afford it on their own" (Participant 2A).*

All the ENAs that participated in the interviews agreed that financial restrictions prevented them from studying further. Since there was no clarity regarding funding for further studies by the hospitals they worked for, it means that they have to leave permanent employment to study further. This was an unaffordable option as most of them were a substantial source of financial support for their families.

*"...I would love to study further and develop myself. But I don't have the money to pay for my studies..." (Participant 20A).*

*"...I am the sole breadwinner so paying to further myself is out of the question. I can't leave work to study. There's no way I can afford that..." (Participant 26B).*

*"...It is too expensive to study on my own. The Company does not give ENA's money to study. I can't afford to pay myself..." (Participant 18A).*

*"...I got a family to support and 2 kids. I can't leave work to study full time. But I want to study more. The Company pays for the bridging so they must consider us as well." (Participant 19A).*

#### 4.5.1.3 Sub-theme 1.3: Value add of the ENA

Phase one and two participants questioned the value of the ENA in the work environment. Some RNs and UMs felt that the ENA category should be replaced by the EN category, as the EN is able to function more independently and was able to perform tasks that are complex and require less supervision:

*"...The ENA has a very basic scope of practice. Sometimes they tell you they can't do certain things. That's frustrating, and then you think about what value they add at work..." (Participant 4A).*

*"...They are so many things that the ENA can't do. Some are very willing, and you know they can do it, especially the older ones, but their scope doesn't allow for it. In my opinion I would rather use EN's in the unit as they can do many more tasks and adds more value." (Participant 6B).*

All participants agreed that the ENA scope of practice is basic. Phase three participants felt that they had the potential to do much more than their scope allowed but lack of clarity around funding for further training opportunities prevented them from fulfilling their potential. This was mainly due to the number of years working as ENAs:

*"...I feel I can do so much more than my scope allows because I am an ENA for 18 years. I am disappointed that there is no training for us. But the sisters sometimes get irritated when we say we can't do certain things..." (Participant 18A).*

*"...I want to do things like dressings because I watched the sisters do it and I feel I can do it. But our scope of practice doesn't allow us to do even the minor dressings..." (Participant 24A).*

#### *4.5.1.4 Sub-theme 1.4: Role stress*

The tasks that are performed by the ENA daily are considered predictable by all categories of nurses that were interviewed. There is little variation in what is done daily. Their primary function revolves around doing vital signs, bathing patients, doing pressure care, intake and output and answering call bells. They are also expected to run errands such as collecting medications from pharmacy and are responsible for

tasks such as doing patient admissions, with history taking which falls out of their scope of practice, creating conflict around their role.

Phase one and two participants acknowledged that the ENAs role was sometimes vague and conflicting:

*"... Yes, they are willing to help us when we need it. We know it's not ideal for them to perform some tasks like admissions, but they are experts at it now."(Participant 14B).*

*"If we ask them to do a task outside their scope of practice, it is because we have no other choice. They follow our orders and do it. "(Participant 3A).*

ENAs are aware that they are asked to do tasks that conflict with their scope of practice, but they feel obligated to do it.

*"I know that it is not in my scope of practice but the sister asks me to do it. I also want to help them out, so I do it."(Participant 25B).*

*"I have to leave what I am doing and go to the pharmacy to pick up medication for the patient. There are a shortage of porters and they don't respond quickly. So the sister sends me and I have no choice but to go."(Participant 19A).*

#### 4.5.1.5 Sub-theme 1.5: Shortage of staff

Phase one and two participants concurred that staffing shortages are affecting the work environment of the ENA, especially since the healthcare worker was removed from the nursing skill mix and not replaced by another category of staff:

*"...there is a huge emphasis on cost management in nursing. We have 27 beds and use two RN's, two EN's and one ENA. Previously we had care givers who assisted the ENA with their work but we not allowed to use them anymore." (Participant 15B).*

*"...the care worker does not have a nursing qualification and can't do many things. Everyone gets so busy with their work but the ENA also has to do what the care worker used to do. We feel sorry for them but what can we do?" (Participant 13B).*

The general feeling among the participants in Phase three is that staff shortages have contributed to a feeling of being overworked and increasing expectations have been placed on the ENA, especially in light of care workers no longer being used as part of the nursing FTE. Prior to this study, care workers worked in both medical and surgical wards, mainly through nursing agencies. They assisted in delivering basic bedside care, for example, bathing, feeding and grooming patients, making beds and assisting with pressure care.

*"There is less staff now. An extra ENA will help, especially when the ward gets busy but we not allowed to call them." (Participant 22A).*

*"... We used to have the care workers who helped us a lot with our work. Now we are not allowed to use them, and we not allowed to replace them. There's this cost thing that we have to save now. But we must do all the work now. Before the care worker would do the baths with us but now, I must wait for another ENA to help me. It's becoming very stressful." (Participant 17A).*

### 4.5.2 Theme Two: Experiences in the work environment

The second theme to emerge was the experiences of the ENA in the work environment. Though the experiences varied to a certain extent, there were some marked similarities in experiences. The four sub-themes that emerged were:

- Working out of scope of practice
- Lack of respect and recognition
- Close relationships with patients
- Job dissatisfaction

#### *4.5.2.1 Sub-theme 2.1: Working out of scope of practice*

Phase one and two participants agreed that ENAs were working out of their scope of practice because of staff shortages or trust in the abilities of the ENA.

*"...The ENA's in our ward take patients to theatre...the eye cases and the gynae cases and the scope patients. They also bring the patients back when the ward is*

*too busy. We are also short staffed so we ask them to help us. They don't mind..." (Participant 14B).*

*"...The ENA's do take out J loops. If there is a problem with the site, they inform us. The CF's have taught them how to check drip sites." (Participant 7A).*

*"The ENA's take out wound drains as well. They won't remove the chest drains though." (Participant 11A)*

Phase three participants acknowledged that they were working out of their scope of practice. The work that fell out of their scope included doing patient admissions, taking medical and surgical history and initial assessments, handing patients undergoing minor theatre procedures to theatre, receiving these patients from theatre, removing intravenous access and certain drains, being completely responsible for patients' intake and output as well as pressure care and providing health education for patients on their diagnosis and discharge. This was mainly due to staff shortages, high turnover of patients and belief in the more senior ENAs in the unit.

"*.... I do the entire admission for the patient. Then I hand over the file to the sister to call the doctor. I make the patient comfortable and orientate them to the ward. I do the history taking- the surgical and medical history. I complete the whole admission document. I write the first entry in the nursing notes." (Participant 17A).*

*".... The sisters trust us to do admissions because we worked in the ward for so long. We will do a complete admission. We also take the patient's medical and surgical history down and write the first entry in the progress notes...." (Participant 19A).*

*".... We take patients to theatre and hand them over to the theatre staff but this is for the day cases. We don't take patients for big procedures...." (Participant 25B).*

*"I empty the catheter and drains and write the amount in the intake and output chart. I do the intake and output for the patient- that is my responsibility." (Participant 23A).*

#### *4.5.2.2 Sub-theme 2.2: Lack of respect and recognition*

Even though ENAs appear to do more than their scope of practice permits, the consensus is that they are shown a lack of respect and recognition. This is mainly because their work seems to be taken for granted and they are expected to so certain tasks such as answering the call bells and seeing to the elimination needs of patients.

Phase one and two participant's shared similar sentiments as Phase three participants in that the ENAs work was taken for granted and recognition by other staff was poor.

> *".... The ENA does a lot in the ward. They answer the bells, give patients bed baths and bedpans but nobody takes the time to thank them. The ward is very busy so we overlook them most times...." (Participant 10A).*
>
> *"...It seems like a given that the ENA must answer bells and give bedpans. I try to change that and make it everyone's responsibility, but it's hard. They work hard; sometimes we forget to thank them. It just gets so busy." (Participant 14B).*
>
> Some ENAs feel that their work is not considered important as they are often called to do other tasks when they are busy:
>
> *".... It's like what I do is not important. I can be busy with a patient, but the sister will be shouting at me to do an admission. When she screams, you can't say anything; you must just do what she says..." (Participant 21A).*
>
> *".... The ward will be so busy, and I will be with a patient but when the bell rings, I must leave the patient and answer the bell. Nobody thinks what we do is important because we always get interrupted. The staff nurses and sisters are giving medication and can't be disturbed. This is not respecting us...." (Participant 28B).*

#### *4.5.2.3 Sub-theme 2.3: Close relationships with patients*

Despite the ENA spending the most time caring for patients at the bedside, it was concluded by the other categories of nursing staff, who were interviewed, that the EN formed the closest relationships with patients. This was mainly due to the time that the EN spent dispensing medication, doing dressings and intravenous related care for the

patient. It allowed the EN opportunities to have conversations with the patient while performing the task.

*".... The EN forms the closest relationships with the patients because they have time during their medication rounds to make conversation. I heard them speaking to patients about work, family and personal things. Patients like that..." (Participant 15B).*

*"...I would say the EN's spend more time at the patient's bedside. Some of them do medication rounds for a long time and have time to speak to patients". (Participant 5B).*

However, some ENAs did feel that they bonded most with patients:

*"...We give the patient a bath, take the patient to the toilet or give the patient a bedpan. But we are rushed and there is no time to talk to the patient as much as we would like to...." (Participant 18A).*

*"Patients often put our names down on the comment cards. They also tell us that we work hard and that they notice we are the ones running around. That makes me feel good." (Participant 22A).*

#### *4.5.2.4 Sub-theme 2.4: Job dissatisfaction*

Phase one and two participants concurred with Phase three participants that job dissatisfaction was experienced mainly because of lack of clarity around funding for further training opportunities. ENAs were identified as having the potential to become much more but lacked the opportunity to do so.

*"They would like to train further but there's no opportunity. They are waiting for so long for an answer. You can see them becoming disappointed and demotivated." (Participant 8A).*

*"... I know ENA's in my ward that would do much better than the EN's that we have now. They have the potential to do so much more but they don't have the opportunities to develop further..." (Participant 14B).*

Phase 3 participants felt dissatisfied with their jobs because many of them were ENAs for a number of years. They have the potential to become ENs but were not aware if the hospital would provide funding for them to study towards the next level of qualification. Job dissatisfaction also arose from doing work that was taken for granted by peers:

> *"... I like my job a lot. I'm grateful for the pay. But I feel I can do so much more. I've been an ENA for so long now but I got nowhere to go. That demotivates me because I want to grow myself..." (Participant 26B).*

> *"... I see what the EN's do and I can do that because I watched them. But I'm not allowed because I don't have that training. Some things I'm allowed to so but dressings and stuff I'm not allowed. Yes I feel unhappy and frustrated because I know I can do it..." (Participant 24A).*

#### *4.5.2.5 Sub-theme 2.5: Over utilisation of agency staff*

All categories of nurses interviewed agreed that too many agency staff were utilised in the nursing units. In certain instances, there was a high turnover of agency staff which added an extra burden to the permanent staff that were responsible for teaching and orientating them to the nursing units.

Phase one and two participants felt it was stressful to deal with a high turnover of agency staff, as they had to check constantly if the work was being done.

> *"... We work with a lot of agency staff. Some of them are new they don't know much about the ward. It's our job to show them around and tell them what to do. That takes so much of my time and energy." (Participant 21A).*

Phase three participants felt that it was left up to them to teach the new agency staff the routine and orientate them to the ward.

> *"...we don't always use familiar agency staff. Sometimes our familiar ones get permanent jobs elsewhere cos we can't give them jobs because of the costs and all. It's very stressful to deal with new staff who don't know the unit. The ENA usually has to show them everything." (Participant 15B).*

### 4.5.3 Theme Three: Supervision received by ENAs

The expectation is that ENAs work under the direct supervision of the RN or EN, as per the scope of practice. However, participants interviewed concurred that there was minimal to no supervision of the ENAs because of the trust in experienced ENAs, staff shortages and workload. The two sub-themes that emerged were:

- Minimal supervision of ENAs by RNs and ENs
- Expectations of the ENAs.
- Time constraints.

#### *4.5.3.1 Sub-theme 3.1: Minimal supervision of ENAs from RNs and ENs*

There is minimal to no supervision received by ENAs in the units that they work. Lack of resources and workload appear to be the main contributing factors, as identified by both Phase one and two participants. The other reason that was identified by participants was that the more experienced ENAs know what to do and how to do it; therefore, they did not require supervision. The UMs and RNs, at both study sites, confirmed minimal to no supervision of ENAs with the following statements:

> *"...the ward is so busy. Patients are coming in, going to theatre. Some are getting discharged. We can't do everything ourselves so we need the ENA's to help. There is no time to supervise them...." (Participant 15B).*

> *"...We would like to supervise them in certain tasks but there is no time to do that. They get on with the work. Our more experienced ENA's know their work like the back of their hand. I am confident in their abilities so there's really no need to supervise them." (Participant 2A).*

Phase three participants agreed that they received minimal to no supervision, mainly because of time constraints:

> *".... To be honest the sisters and staff nurses don't supervise us. We take out patients drips when they are going home. We are not trained but we do it. The sisters are too busy to supervise us but we do it correctly..." (Participant 27B).*

#### *4.5.3.2 Sub-theme 3.2: Expectations of ENAs*

The general feeling of Phase one and two participants is that the experienced ENAs do not require supervision, as they know what is required of them. There is also a high level of confidence in the ability of the more experienced ENAs:

"...*The ENA's in my ward have been working here for years. They know what to do so we don't supervise them. They are quite capable..." (Participant 12A).*

*"... The sister just tells me what to do and I can do it. I think it's because she knows me for so long. She knows what I can do. She won't ask a new ENA to do what she asks me to do..." (Participant 17A).*

Phase three participants agreed that the RNs have a high level of confidence in their ability to carry out their tasks:

*"...I show the new ENA's around and tell them what to do. The sister doesn't have time to do that. I worked in the ward for so long; I know how things are done..." (Participant 18A).*

#### *4.5.3.3 Sub-theme 3.3: Time constraints*

With the current staffing structure and constraints, the general perception is that there is inadequate time to provide adequate supervision of ENAs. Participants in all categories concurred that the workload has increased and staffing levels are not adequate to deal with the workload, even though different methods of nursing are employed.

*"...honestly, there is no time to supervise the other staff. I'm ok when we have our permanent staff but when there's agency, it becomes very difficult. Our doctors start rounds from 7 o clock and they do like 3 rounds in a day. So we carry out the orders and do medication and make sure everything is running smoothly. The day is gone like that." (Participant 13B).*

*"...I try my best to supervise but I can tell you that the day is very busy. Some days are busier than others and Mondays and Wednesdays are the worse. There is no time, as much as I would like to supervise the junior staff." (Participant 10A).*

*"There's only two RN's, two EN's and two ENA's and we have 30 beds in the ward. We recently divided the ward into 15 each so there is 1RN, 1EN and 1 ENA on each side. But the activity is a lot and everyone is overwhelmed with their work. There is no time to watch over others."(Participant 14B).*

*"...the sister is busy with doctor's rounds and giving medication- they have no time to supervise us. The staff nurses too are busy with medication and doctors rounds. We understand everyone is busy; it's a very busy ward. Mondays is the worse day, they can be like 20 admissions. There is no time for supervision. I do the entire admission and the sister will call the doctor for orders." (Participant 20A)*

### 4.5.4 Theme Four: Overcoming challenges experienced by ENAs

The UMs, RNs and ENAs were asked for suggestions on how the challenges that ENAs experienced could be overcome. The common theme in the responses received from all three nursing categories was to provide funding for further training opportunities for ENAs and increase the permanent staff complement.

#### *4.5.4.1 Sub-theme 4.1: Provision of funding for further training for ENAs*

Most participants were of the opinion that provision of further training opportunities would assist in overcoming most of the challenges experienced by ENAs. If ENAs were provided with funding to further their studies, then they would progress to the next level of nursing which was the EN category. Their scope of practice would change to allow them to legally perform some of the tasks they are currently doing. Their job satisfaction levels will increase because most ENAs feel they are ready to embrace new challenges and develop their careers.

"*If ENAs were also provided with funds to train further, then they will think of the organisation as being fair. Also, there are ENAs that have the potential can become ENs." (Participant 4A).*

"We*, as RNs get chances to study and so does the EN. They shouldn't be left out. This is what is making them so unhappy."(Participant 16B).*

*"I would love to be given the opportunity to become an EN. Then I can practice safely. But it also will give me so many chances to improve myself. And when the sister asks me to do a dressing, I can do it properly."(Participant 9A).*

*"I have been an ENA for so many years. I'm ready to grow, develop, and learn more. We help the sisters and staff nurses out so much with their work as well. The hospital should provide funds for us to study as well."(Participant 17A).*

#### *4.5.4.2 Sub-theme 4.2: Increase the permanent staff complement of ENAs*

The general perception among all three categories of participants was that the workload of the ENA increased when the private healthcare group under study removed the healthcare worker (HCW) from the skills mix. This gap should be bridged by employing ENAs to fill the position of the HCW.

"*When they said that the healthcare worker can no longer work with us, they didn't increase the number of ENAs in the team. So the ENA had to do their work as well as the work of the healthcare worker. This was unfair. They need to bring in more ENAs to replace the healthcare worker."(Participant 10A).*

"*The HCW was removed from the skill mix but we were not allowed to replace them with ENAs. Our existing ENAs had to do the HCW jobs as well as their own. The hospital must replace the HCW with the ENA to prevent them from burnout."(Participant 1A).*

"*At least the healthcare worker used to help us with our tasks. They used to help us bath the patients, change the linen and feed patients. Now that they can no longer work with us, all these tasks have to be done by us. There is only 2 of us on the shift and our ward has 30 beds." (Participant 26B).*

### 4.5.5 Theme Five: Improving the work environment of the ENA

The fifth theme that emerged was suggestions that would improve the work environment of the ENA. The common sub themes that emerged from all three categories of participants was to decrease the amount of total nursing agency utilisation in the private hospital group and develop a reward and recognition program, specifically for the ENA category.

#### *4.5.5.1 Sub-theme 5.1: Decrease overall nursing agency utilisation*

The general perception is that the percentage of nurses used from the nursing agencies are too high. There is a high turnover of agency nurses leading to unfamiliar nurses placed in the nursing units. There is insufficient time available to complete unit orientations and attend to the workload. Increasing the number of permanent nurses in all categories will lead to sufficient numbers of familiar staff doing the work they are required to do. This will prevent the RN from asking ENAs to perform tasks that fall out of their scope of practice.

> *"Almost every day there are new faces from the agency in the unit. They are unfamiliar with the ward routine and we can't leave them on their own to work. We need to have more of our permanent staff, people who are competent and knows how the unit functions. Sometimes, I would rather do without that agency staff member because its more tiring to constantly check up on them. " (Participant 14B).*

> *"We need more permanent staff for the wards. The agencies don't always send the same people, so we end up spending so much time orientating the new staff. Some of them are slow to complete their work. And we can't always be with them."(Participant 4A).*

> *"We need more of our own staff. We work with too much of agency staff. When our sister is off sick, then we have to work with an agency sister that doesn't know much about the ward. The doctors get upset and we end up doing the sisters job, which we know is wrong. But we don't have a choice" (Participant 18A).*

#### *4.5.5.2 Sub-theme 5.2: Develop a reward and recognition program for the ENA*

It was previously stated in major theme two that ENAs were not respected or recognised for the work that they performed; yet they played an important role in nursing care delivery. UMs and RNs stated that there was a formal recognition program in place for RNs who met the stipulated criteria from the private hospital group, but there was nothing in place for the ENA category. A formal reward and recognition program will not only increase job satisfaction but will also serve to highlight the contribution of the ENA to nursing.

"*The RNs have a special awards ceremony, where certain RNs are recognised for their work. But the ENAs who do so much in the unit doesn't have anything like this. They should consider having something like this for them as well." (Participant 16B).*

"*The ENAs also need to be recognised for their hard work. We should consider some form of recognition for them."(Participant 6B).*

*"There are rewards for the other staff, like sending them to study. We also need some recognition for the work we do. We not asking for money but for some form of appreciation."(Participant 21A).*

## 4.6 CHAPTER SUMMARY

In Chapter 4, the results of qualitative data using thematic analysis were presented. Tesch's method was utilised to analyse the information gathered from the interviews with the selected participants to identify certain themes and sub-themes. In the next chapter, the findings of the study in relation to the role and functioning of the ENA will be discussed, by reviewing and interpreting data obtained.

# CHAPTER 5: DISCUSSION OF FINDINGS

## 5.1 INTRODUCTION

The previous chapter highlighted several themes and sub-themes that emerged from the interviews with the study participants. This chapter presents the results of the study, which were obtained from 28 in-depth interviews across the different categories of nurses that participated in the study. The qualitative data obtained aimed to achieve the three objectives of the study, namely:

- Explore and describe the working environment of ENAs in private healthcare institutions as perceived by ENAs in relation to their role and functioning.
- Explore the working environment, the role and function of ENAs in private healthcare institutions as perceived by the RNs and UMs.
- Determine if the working environment, role and functions of the ENA in private healthcare institutions foster safe clinical practice.

The following interview questions from the different categories of participating nurses had to be answered to achieve these objectives:

### 5.1.1 Interview Questions for Unit Managers and Registered Nurses

- Explain your understanding of the ENA's scope of practice
- Currently, describe what is expected of the ENA's in the ward
- Explain the challenges you experience when working with ENAs.
- What causes these challenges? What can be done about it?
- Describe the level of supervision that ENA's receive.
- Tell me how the work environment of the ENA can be improved.

### 5.1.2 Interview Questions for the ENAs

- Describe your understanding of your scope of practice as an ENA.
- Explain what is currently expected of you as an ENA in the ward.
- Describe the challenges you experience in the workplace.
- Describe the supervision you receive.
- Describe what you think will improve your work environment

## 5.2 OVERVIEW OF THE DISCUSSION OF FINDINGS

The findings of this study will be discussed as follows:

- The demographic information of participants in relation to the current study.
- The discussion of themes in relation to the objectives of the study.

## 5.3 DEMOGRAPHIC INFORMATION IN RELATION TO THE CURRENT STUDY

The participants were selected across all nursing departments so that a broader perspective of the topic could be obtained. The demographic data collected from participants included age, gender, number of years employed at the hospital and number of years qualified as a nurse.

The ages of ENAs range between 24 to 41 years with the average age being 32 years. Only one (1) ENA from the sample was male, reiterating the opinion of Nkatha *et al*. (2016: 6) that nursing is still predominantly a female profession. Most of these participants were in the role of an ENA for 5-10 years and > 10 years. Six of the ENAs (50%) sampled were working at the study sites for 5-10 years. Econex (2013: 31) states that, often, the length of service of an employee is a determinant of the level of commitment of employees. The healthcare group under study utilised an average of 45% nursing agency staff in the ENA category which could possibly account for half (50%) of the ENAs working at the study sites for only 1-<5 years.

## 5.4 DISCUSSION OF FINDINGS BASED ON THE THEMES AND SUB-THEMES THAT EMERGED FROM THE FINDINGS

The five themes and corresponding sub-themes are discussed in this section, supported with reference to the relevant literature. As presented in the previous chapter, the five main themes that emerged included challenges experienced by the ENA, experiences in the work environment, supervision of ENAs, overcoming challenges and improving the work environment. Each of these are discussed together with the corresponding sub-themes supported by Mead's Role Theory that was used to guide the current study.

### *5.4.1.* Theme 1: Challenges experienced by the ENAs

The first theme that emerged was the challenges experienced by ENAs in the medical and surgical units of private hospitals in the eThekwini District. According to Prestia and Dyess (2012: 145), ENAs work in a challenging environment where they are primarily responsible for rendering basic patient care. However, a concern highlighted by Prestia and Dyess (2012: 145) is that ENAs work out of their scope of practice due to challenges that are beyond their control. Some of these challenges are inadequate skill mixes being used in the clinical environment, lack of financial resources to employ the correct category of nurses and financial constraints in organisations. Duffield *et al*. (2012: 2244) emphasise that their peers or management does often not acknowledge the work of the ENA, resulting in feelings of dissatisfaction and apathy. Similarly, in the current study, five sub-themes emerged as the challenges experienced by ENAs. These included lack of communication pertaining to training to the next level of qualification, financial restrictions, value add of the ENA, role stress and staff shortages.

#### *5.4.1.1 Sub-theme 1.1: Lack of communication pertaining to training to the next level of qualification*

All categories of nurses interviewed, highlighted the lack of communication from the private healthcare group as to when the diploma in general nursing would be available at the nursing college, and whether the healthcare group would fund this qualification. ENAs that want to study further will have to leave their permanent employment and

fund their own studies at a nursing college that has been granted SANC accreditation to offer this qualification. Rispel (2015: 72) stated that the next phase of training for existing ENAs would resume in 2020, leaving existing ENAs in a state of limbo as to career progression. The ENAs in the study expressed feelings of frustration and demotivation because of the delay in acquiring concrete answers to their questions around availability and funding for further study. Rispel (2015: 73) further emphasised the importance to provide a developmental ladder for present ENAs so that they can integrate with the employees that complete the new advanced certificate in basic nursing. According to the South African National Department of Health (2019: 9), this has been accomplished by providing a RPL pathway that provides an opportunity for current ENAs to study further.

According to Harding *et al*. (2013: 254), training and development opportunities are essential for a well-motivated and successful workforce. Training that is geared to employees' specific needs add value not only to the employee, but also to the organisation. The authors further emphasise that training and development opportunities should not be limited to selected employees as it has the potential to cause staff dissatisfaction and work-related grievances.

#### *5.4.1.2 Sub-theme 1.2: Financial restrictions*

All categories of nurses interviewed agreed that although a formal qualification for career development exists, many of the ENAs would not be able to fund their private studies because of the lower salaries they earn and the financial commitments they have. Many of the ENAs interviewed stated that they are the breadwinners in their households and had a family to support. Hence, paying for full time studies was not affordable or a realistic option for them. Booysen and Erasmus (2012: 84) confirmed that ENAs are the lowest paid category of nurses in South Africa, mainly because of their limited training and basic skills that they acquired during their formal training. According to Econex (2013: 45) the rising cost of living and inflation has severely affected the ability of the lower classes to make ends meet in a tough South African economy. The authors also stressed that a large group of South Africans in the lower income groups are not able to meet financial obligations, let alone pay for expenses unrelated to the daily running of a household.

The general feeling by all categories of participants was that, since the hospitals under study pay for employees that pursue post-basic nursing courses as well as the bridging course to RN, they should also fund further studies for the ENA. Twigg *et al*. (2015: 980) confirmed that if employees perceive they are being treated unfairly, their levels of motivation and productivity decreases which has a direct impact on the quality of the service that is delivered.

#### ***5.4.1.3 Sub-theme 3: Value add of the ENA***

All categories of participants agreed that the ENA has a clearly defined scope of practice, which permits them to perform only basic nursing care. The South African National Department of Health (2013: 3) defines the scope of practice of ENAs as being responsible for basic nursing care under the direct supervision of the EN or RN. The majority of ENAs felt capable of doing tasks and functions that fell outside their scope of practice, especially since they have been ENAs for many years. However, their scope of practice prevented them from doing more than basic tasks. Lubbe and Roets (2013: 59) admit that experience does foster new skill development, even though the recipient may not have learned the theory behind the skill but they also guard against the practice of these skills in the clinical setting, mainly because of the lack of theoretical and practical integration. The majority of RNs and UMs felt frustrated that ENAs could only perform basic functions, leading them to question the value of ENAs as part of the full-time nursing establishment. The health group under study utilised a 40% ENA complement in their skills mix, causing senior participants to agree that ENs whose scope of practice allowed for more independent functioning should replace ENAs. This is in line with the findings of Liittlejohn *et al*. (2012: 42) study on nursing staff shortages, where RNs and ENs agreed that the ENA category should be replaced by the EN category because of the increasing workload and their inability to do more than just render basic nursing duties.

#### ***5.4.1.4 Sub-theme 4: Role stress***

Role stress refers to role obligations that are vague, irritating, difficult, conflicting or difficult to meet (Van der Horst 2016: 3). Many of the RNs and UMs interviewed in this study concede that the role of the ENA is vague, conflicting and difficult to meet. It is evident that they are given multiple tasks to perform simultaneously, have frequent

interruptions, are deliberately disturbed from tasks they are occupied with to answer patient call bells and not recognised for their contributions to patient care. All categories of nursing staff interviewed were aware of the ENA's scope of practice and responsibilities, but this was not considered in the delegation of tasks.

The tasks that ENAs performed were taking of vital signs, reporting abnormalities in vital signs readings to senior staff, bed bathing patients, answering call bells, attending to patients' elimination, pressure care and monitoring and recording patients' intake and output. ENAs generally felt that, although they loved their jobs, they were ready for the challenges that came with professional development and felt bored doing their current tasks. They wanted to perform tasks that were more challenging but these tasks were out of their scope of practice. Ferguson and Cioffi (2017: 6) emphasised that routine work and an unstimulating work environment leads to poor employee performance, and decreased attention to detail which negatively affects the quality of care that is being rendered.

Some participants experienced role overload to a high degree. The ENAs were expected to complete certain tasks but were constantly interrupted while doing these tasks. At the end of the working day, many of their tasks were incomplete and they had to work longer hours to complete their record keeping. Many of them felt overwhelmed and felt that their competency was questioned because of their not completing tasks timeously. Fernandez *et al.* (2012: 326) agree that lower categories of nursing staff often experienced work overload as their senior counterparts felt they were not responsible for menial tasks associated with assisting patients with hygiene and elimination needs. According to Laschinger (2014: 286), role overload directly leads to feelings of frustration, tension and a decreased desire to attend work regularly.

Furthermore, ENAs interviewed were largely unhappy that tasks such as answering the patients call bells became their sole responsibility and the other nursing categories felt that they were exempt from this function. Many felt that, though they answered the bells, they were still dependent on the other nursing categories to meet the patients' needs such as giving patients pain medication. A study by Twigg *et al.* (2016: 192) concluded that nurse aides felt angered and demeaned by being solely responsible

for menial tasks like answering bells. This led to fractured teams and lowered levels of customer satisfaction. The major concern highlighted by Twigg *et al*. (2016: 192) was the low morale exhibited by nurse aides, which had a direct negative impact on patients' clinical outcomes.

#### *5.4.1.5 Sub-theme 5: Staff shortages*

All three categories of nurses commented that staff shortages do occur regularly, especially considering the many cost saving initiatives the private healthcare group under study is undertaking. One of the identified issues was the removal of healthcare workers (HCWs) from the nursing full time establishment (FTE) in recent times that formed 30% of the FTE in the medical and surgical units. According to Aylward (2015: 83) the HCWs are not nurses and therefore, not suitable to work in an acute nursing environment because of their limited and inadequate levels of training by unaccredited schools. Contrary to this, the HCWs were a part of the nursing team and were considered as partners with the ENAs. They often teamed up in the units to perform duties like pressure care, making beds and attending to patients' basic care needs. The participants agreed that the HCW's position was not replaced by the ENA category, leaving many of the surgical and medical wards understaffed. All categories of participants also agreed that the ENA was left with a greater workload and no assistance was provided in meeting the increased work demands. Although UMs and RNs were sympathetic to the plight of the ENA, they felt there was nothing they could do to remedy the situation at this time, especially considering the cost saving strategies that were being implemented.

Because of the removal of the HCW from the FTE, role ambiguity was experienced by ENAs. It was clear from participants that there was confusion as to what was expected of ENAs in the working environment. While HCWs were removed from the FTE, there appeared to be confusion by ENAs as to whether this resource would be replaced or whether they were expected to do their jobs as well as that of the HCWs. However, the RNs and UMs interviewed knew that this category was removed from the nursing FTE but was not to be replaced with an ENA. Aiken *et al.* (2013:146) stressed that role ambiguity leads to confusion that causes lack of productivity from employees.

Managers often view employees as incompetent, when in fact the rules of engagement have not been made clear.

### *5.4.2 Theme 2: Experiences in the work environment*

The second theme that emerged was the experiences of the ENA in the work environment, which was the medical and surgical units of private hospitals. According to Prestia and Dyess (2012: 143), the work environment includes social interactions between individuals that can be complex and dynamic. The five sub-themes that arose were working out of scope of practice, lack of respect and recognition for ENAs, close relationships with patients, job dissatisfaction and use of agency staff.

#### *5.4.2.1 Sub-theme 2.1: Working out of scope of practice*

According to Prestia and Dyess (2012: 145), ENAs work in a challenging environment where they are primarily responsible for rendering basic patient care. However, a concern highlighted by the same study, is that ENAs work out of their scope of practice due to challenges that are beyond their control. Some of these challenges are inadequate skill mixes being used in the clinical environment, lack of financial resources to employ the correct category of nurses and financial constraints in organisations Although participants were aware of the ENA scope of practice, they agreed that ENAs were working out of their scope of practice by handing patients undergoing minor surgery to theatre and receiving these patients from theatre, taking complete responsibility for patients' intake and output, removing intravenous accesses and wound drains, doing complete patient assessments and providing patients with health education on discharge. A study conducted by Colorado Health Institute (2011: 54) found that nurse aides in America, which are the equivalents of ENAs in South Africa, did tasks out of their scope of practice, which resulted in an increase in the number of adverse events. Participants in the current study also shared the same view and emphasised that ENAs did not work out of their scope of practice intentionally, but rather out of a need to meet the increasing patient demands in the working environment. RNs and UMs felt that they bore the greatest responsibility for patient care and tasks like doing multiple doctors' rounds, inserting and imitating intravenous therapy, doing complex dressings and administering intravenous medication, among

other tasks, limited the time actually spent on bedside nursing care and supervision of junior staff.

The issue of role-conflict was also highlighted by ENAs in this study. It was noted that, despite RNs being aware that ENAs were unable to perform certain functions, such as handing patients over to theatre, taking confirmation of consents from patients and receiving patients from theatre, they were allowed to do it. It was also revealed that ENAs were not given a choice and were expected to perform the tasks out of their scope of practice out of respect for authority. Failure to do so would render them incompetent, unwilling and lean towards insubordination. Thus, role conflict emerged. MacPhee *et al.* (2014: 22) emphasised that junior nurses often felt conflicted between what they should do and what they were expected to do. The desire to be competent and a team player meant that they had to appear willing.

#### *5.4.2.2 Sub-theme 2.2: Lack of respect and recognition*

It is clear from the majority of the ENAs responses that they were not respected in the work environment and not recognised for the work that they do, even though the majority of RNs and UMs felt that they respected and recognised the ENA. Anderson (2013: 3) pointed out that, often, people perceive that they are being respectful, when in fact they are not. There are also different standards for reward and recognition and what may be recognition for one is not perceived as recognition by another. He further suggested that talking openly about issues that occur between the various categories of nurses leads to a higher level of problem solving and contentment among colleagues. The issue that caused major discontent among the ENAs interviewed was that they are constantly interrupted by the other categories of nursing staff while they are busy with patient centred tasks like pressure care. They felt that their work was not viewed as important or adding value to the work environment, therefore interruptions to their work was viewed as the norm by the other categories of nurses who viewed their own work as being essential to patient care. Duffield *et al*. (2011: 2244) emphasised that peers or management often does not acknowledge the work of the ENA, resulting in feelings of dissatisfaction and apathy. Considering this, it was essential to establish how ENAs perceived their working environment.

They were also subjected to being spoken to abruptly at times by senior staff and were often expected to multitask. This lack of respect and disregard disappointed them, but many of them merely accepted it as the norm. Lubbe and Roets (2013: 62) confirmed that employees in junior ranks are often used to perform menial tasks that senior staff feel are beyond them. This creates disharmony among team members, which affects work outcomes and employee productivity. The authors further stated that breakdown in teams and work dissatisfaction filtered to patients and members of the multi-disciplinary teams who were able to sense the team discord.

#### *5.4.2.3 Sub-theme 2.3: Close relationships with patients*

There were diverse opinions among participants regarding who formed the closest relationships with patients. The RNs and UMs felt that the ENs formed the closest relationships with patients since they appeared to spend a large amount of time at the patient's bedside engaged in activities such as administering medication to patients. Although ENAs attended to the basic needs of patients like doing pressure care, most patients requiring pressure care were not in the frame of mind to make conversation or remember the nurse. ENAs, on the other hand, felt that they formed the closest relationships with patients as a result of their spending more time at the patient's bedside seeing to basic needs like making beds, filling water carafes and answering patient call bells. They were notably the nursing category who were often recognised in-patient comment cards and customer satisfaction surveys as providing outstanding nursing services. Aylward's (2015: 62) study on HCWs concurred with the ENAs' perceptions that ENAs, together with HCWs, formed closest relationships with patients and that sound patient relationship was the cornerstone of nursing which resulted in increased customer satisfaction. She further emphasised that patient satisfaction is mainly measured by gentle gestures such as smiles, politeness and friendly faces as opposed to time-orientated tasks like medication being administered on time. Thus, the impact that ENAs have on the patient experience remains to be invaluable by virtue of the type of interactions they have with patients.

#### *5.4.2.4 Sub-theme 2.4: Job dissatisfaction*

Job dissatisfaction of ENAs arose from uncertainty about funding for further training programmes, being the nursing category that fulfils the role of the HCW, lack of

recognition for their contribution to patient care and being disrespected by senior staff. The study by Haakestad (2014: 56) revealed that lower categories of nurses commonly experienced job dissatisfaction and the factor most responsible for this was the disrespect shown to them by higher ranking nursing staff. The common finding in her study was a lack of teamwork that affected patient clinical outcomes. Blegen *et al.* (2011: 410) contends that poor patient clinical outcomes can be attributed to inferior levels of nursing care and the impact of the nursing team working as a cohesive unit can never be underestimated.

#### *5.4.2.5 Sub-theme 2.5: Over utilisation of agency staff*

All categories of nurses interviewed concurred that there was a large number of staff from the various nursing agencies, specifically in the ENA category, used in the medical and surgical units. According to Rispel *et al.* (2014: 34), nursing agency staff are used mainly in private hospitals in a flexible capacity when the activity of the hospital increases. These staff are sourced through nursing agencies and are not permanent employees of the hospital. Participants also stated that the more familiar agency staff were leaving the healthcare group under study to find permanent employment elsewhere, resulting in a high turnover of agency staff. The newly recruited agency staff require a lot of supervision, as they are unfamiliar with the workplace. The permanent ENAs were mainly responsible for orientating the newly recruited agency ENAs to the ward, teaching them the routine, informing them of their expectations and supervising them. The RNs found permanent ENAs to be far more dependable than the higher categories of agency staff. This was one of the reasons they delegated tasks to ENAs that was out of their scope of practice. Most of the participants indicated that they were overwhelmed and burdened as they still had their own tasks to do. This led to feelings of dissatisfaction and unhappiness. Armstrong *et al*. (2015: 13) reiterated that managers of the nursing units are responsible for the orientation of new staff, irrespective of their category. They were adamant that the responsibility of running an orientation programme was not a task that should be delegated, especially to the lower categories of staff.

Role strain referred to feelings of frustration, tension and anxiety that arise because of conflicting roles (Van der Horst, 2016: 3). ENAs did indicate that they were frustrated

with certain issues in the clinical environment. The general feeling among ENAs was that teamwork was lacking largely, with their category being overloaded with tasks that other categories could do but were very reluctant to do, such as answering a patient call bell. They became anxious when tasks were not completed timeously mainly due to work overload and interruptions. Senior staff reprimanded and disrespected ENAs for incomplete without attempting to understand the reasons for this. According to Duffield *et al.* (2010: 2246) role strain is a direct cause of decreased employee productivity and an increase in the number of adverse events in a healthcare setting. Staff that experience role strain requires urgent intervention.

### 5.4.3 Theme 3: Supervision of ENAs

The third theme that was highlighted in the study was the supervision received by the ENA from the senior categories of nurses, namely the EN and RN. Armstrong *et al*. (2015: 15) stressed that supervision of junior members of the nursing team such as ENAs is imperative to ensure quality clinical outcomes and safe practice. The three sub-themes that arose were the supervision from RNs and UMs, the expectations of the ENAs in respect of supervision and time constraints related to supervision.

#### *5.4.3.1 Sub-theme 3.1: Supervision from RNs and UMs*

The majority of RNs and UMs interviewed, admitted that there was minimal to no supervision given to ENAs. The ENAs also conceded that they received no supervision from the RN or UM. Littlejohn *et al.* (2012: 24) argue that supervision of junior staff is imperative to ensure staff incompetence and inferior levels of nursing care do not compromise that patients' well-being. They also state that nurses are custodians of nursing care and as such have a responsibility to maintain the supervision of junior nursing staff. The SANC (2014a: 3) is clear about the role of supervision over junior staff by senior staff and states that the RN is in breach of legal requirements for patient care if he/she does not provide either direct or indirect supervision of junior staff.

#### *5.4.3.2 Sub-theme 3.2: Expectations of ENAs*

The general feeling of RNs and UMs was that permanent ENAs who worked in the unit for years required no supervision. They knew the clinical environment well, were

aware of what tasks needed to be done and were competent in doing their tasks. In addition, it was apparent that the number of years of experience as ENAs was directly proportional to their competency levels. Permanent ENAs were trusted by senior nursing staff to complete patient admissions and other tasks that were out of their scope of practice. Hudspeth (2013: 375) agrees that although years of experience doing the same job increased competency levels, it did not replace formal training, as the theoretical component was a learned skill that requires formal training. The permanent ENAs who were interviewed also felt that there was no need for supervision, even when they performed tasks out of their scope of practice. This was due to their doing these tasks for many years and becoming proficient.

Participants' responses allude to role incongruity experienced by ENAs who are trained specifically to deliver basic nursing care under the supervision of the RN or EN. Various factors like staff shortages, incorrect skill mix and staff attitudes have led to ENAs performing tasks they are not qualified to perform. While some of the ENAs feel that being allowed to do tasks outside their scope of practice empowers and grows them, a number of them stated that they do not have a choice as senior staff delegate certain tasks to them. Aylward (2015:132), in her study on the role of HCWs, concluded that junior nursing staff are often left powerless to dispute their roles and functions and often just adapt to stressful work environments.

#### *5.4.3.3 Sub-theme 3.3: Time constraints*

The main reason provided by RNs and UMs for lack of supervision was time constraints as the majority of them felt that they carried the most responsibility for patient care, and that the current staff restructuring and cost containment led to fewer staff being used to perform nursing care in the units. The general feeling was that they wanted to supervise the lower categories of staff and accepted that they had a responsibility to do so; however, the current demands of the job left them with no time or very little time to provide supervision of junior nursing staff. A study conducted by Gross *et al.* (2015: 30) on the RN working environment found that RNs in private healthcare were inundated with tasks like multiple doctors' rounds, acquiring patient authorisation for hospital procedures and liaising with diagnostic departments such as

laboratories and X-Ray departments, which allowed very little time to supervise junior nursing staff.

### 5.4.4 Theme Four: Overcoming challenges

The fourth theme that emerged was suggestions to overcome the challenges experienced by the ENAs. Two sub-themes emerged, namely provision of funding for further training opportunities and increasing permanent staff numbers of ENAs.

#### *5.4.4.1 Sub-theme 4.1: Provision of funding for further training opportunities*

One of the main reasons highlighted for ENA dissatisfaction with the working environment was that once the legacy qualification from ENA to EN was stopped by the SANC, the private healthcare group remained quiet about whether funding would be available for the new nursing qualification. Participants interpreted the lack of communication as alluding to no funding would be made available and their chances to develop their careers will be hampered. Based on this, it was strongly suggested that funding be provided for ENAs to study towards the next level of qualification. Gallup (2017: 52) stated that investing in staff's professional development is vital for retention to the point that 94% of employees would stay at a company longer if it invested in their career development.

#### *5.4.4.2 Sub-theme 4.2: Increase permanent staff numbers of ENAs*

The removal of the HCW from the nursing skills mix meant that the ENA had to bear their workload as well as that of the HCW. This led to role stress and role overload. Participants were firm in their opinion that the HCW position in the skills mix should be filled by an ENA. Using ENAs from the nursing agency to fill this gap when the unit is busier is not the solution to the problem as there is a high turnover of agency staff in this category. The best solution to maintain quality care is to employ a greater number of permanent ENAs. Saville *et al*. (2018: 4) states that achieving sufficient nurse staffing levels is important to patient outcomes and safety.

### 5.4.5 Theme Five: Improving the working environment of the ENA

The fifth theme that emerged was ways in which the working environment can be improved. The sub-themes that was prominent was decreasing the overall utilisation of agency staff and developing a reward and recognition programme for ENAs.

#### *5.4.5.1 Sub-theme 5.1: Decreasing the overall utilisation of agency staff*

The percentage of agency staff used at the private hospital at the time of the study was on average 40% of total monthly nursing hours. Issues that arise with high agency utilisation are high turnover of unfamiliar staff in units, time wasted on orientating new staff, filling the gap left by agency staff lack of knowledge. A study conducted by Gilroy (2019: 15) concluded that heavy reliance on temporary staff was associated with a higher risk of patients dying. The study by Gulland (2018: 23) found that heavy use of agency staff was linked to worse patient and staff experiences.

#### *5.4.5.2 Sub-theme 5.2: Reward and recognition programme*

All categories of participants agreed that a reward and recognition programme for the ENA would boost morale and improve job satisfaction. With no form of reward and recognition in place, the importance of the role the ENA played in healthcare was overlooked. Providing funding for further studies was considered a reward for the ENAs under study. Havaei (2016: 17) found that appreciation is an essential human need and employees respond positively to appreciation. Furthermore, praise and recognition are fundamental elements in creating a thriving workplace.

## 5.5 CHAPTER SUMMARY

In this chapter, a discussion of the findings of the study, taking into consideration the perceptions of RNs and ENAs, was presented. The discussion was guided by the theoretical framework and supported by relevant literature. The discussion also focussed on the related themes and sub-themes aligned to the objectives of the study.

In chapter 6, a summary of the study findings and conclusions, the limitations of the study and recommendations through inductive and deductive reasoning resulting from data findings, will be presented.

# CHAPTER 6: SUMMARY, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

## 6.1 INTRODUCTION

The previous chapter presented a discussion on the study findings based on the analysis of the information received from the participants. This chapter presents the summary, conclusion, recommendations and limitations of the current study.

## 6.2 OVERVIEW OF THE STUDY

The study emanated from the anecdotal evidence of the researcher confirmed by authors like Haakestad (2012: 42) that due to the shortage of skilled nurses in the country, brain drain and cost containment in the private health sector, the dynamic healthcare environment resulted in ENAs endangering their professional status by functioning out of their scope of practice and performing a role for which they were never intended or academically prepared. Similar to the findings by Prestia and Dyess (2012: 145), the researcher had also observed that the level of supervision given by the RN or EN to the ENA was also decreasing as a result of dwindling healthcare resources, allowing the ENA to work as an independent practitioner with minimal or no supervision which not only endanger their jobs, but also lead to adverse events that are detrimental to patients wellbeing', and damage the reputation of the healthcare provider.

The aim of the study was to explore the working environment of ENAs, related to their role and functioning, in private hospitals in the eThekwini District. The three objectives of the study were: to explore and describe the working environment of ENAs in private healthcare institutions as perceived by ENAs related to their role and functioning; explore the working environment, role and function of ENAs in private healthcare institutions as perceived by the RNs and UMs and to determine if the working environment, role and functions of the ENA in private healthcare institutions foster safe clinical practice. The main questions that the researcher asked to achieve these three objectives were:

- Explain your understanding of the ENAs scope of practice.
- Currently, describe what is expected of the ENA's in the ward.
- Explain the challenges you experience when working with ENAs.
- What causes these challenges?
- What can be done about it?
- Describe the level of supervision that ENAs receive.

To gain a deeper understanding of the topic under study, the researcher adopted Mead's Role Theory. Mead's Role Theory is a conceptual framework that defines how individuals behave in social situations and how these behaviours are perceived by external observers, allowing for the exploration of attitudes and perceptions of individuals, such as ENAs who interact within healthcare organisations. The Role Theory served as a plausible and useful framework to facilitate the understanding of the role perception of ENAs in a contemporary healthcare setting which further assisted in describing models of nursing care and advance strategies for decreasing role conflict and role burden in the professional workplace of the nurse.

An exploratory descriptive design, utilising a qualitative approach was used to explore the working environment of the ENAs in private hospitals in the eThekwini District. Data was collected in three phases from six (6) UMs, ten (10) RNs and 12 ENAs working at both sites, referred to as Hospital A and B. The sample size was guided by the principle of data saturation. Tesch's eight-step open coding approach (Creswell 2013: 234) was used to analyse the data.

## 6.3 SUMMARY OF FINDINGS

### 6.3.1 The working environment of ENAs as perceived by ENAs

The ENAs had a sound understanding of their scope of practice but conceded to doing tasks outside of their scope and largely unsupervised by the senior staff. One of the most significant challenges that was currently experienced was the lack of clear communication regarding funding for training to the next level of qualification, which hampered their goals of career development. The ENAs were largely unrecognised for their contributions to healthcare service delivery, with much of what they do taken for granted by their peers. Their work was routine and predictable, with many

interruptions experienced from other categories of staff who did not take responsibility for the more menial and basic tasks surrounding patient care. The workload has increased because of the removal of the HCW from the skills mix and it is the responsibility of the ENA to fill this role.

### 6.3.2 The working environment of ENAs as perceived by UMs and RNs

The more experienced ENAs were competent in their roles; however, they had a huge workload to contend with. Although the RN was aware of the limitations of the scope of practice, they did delegate tasks that were out of their scope of practice. This was not intentional but mainly due to staff shortages and high utilisation of nursing agency staff. The ENA did play a role in healthcare delivery to a certain extent, but the EN category would be more valuable as they are more independent practitioners. Largely, ENAs are not recognised for their work and are used as porters among increasing workloads. The lack of communication regarding funding to the next level of qualification for the ENA has caused dissatisfaction and decreased motivation among this group of nurses. At the time of the study, the private healthcare group had not communicated any plans to the nursing management and staff about funding opportunities for the RPL to the diploma programme.

### 6.3.3 Does the role and function of the ENA in private healthcare institutions foster safe clinical practice?

The current role and functions of the ENA in the private healthcare institutions under study do not foster safe clinical practice. Tasks such as writing out confirmation of informed consents, doing complete admissions for patients, including recording the patients' medical and surgical history, writing out chronic medication, providing health education to patients on discharge and on their diagnosis and removing urinary catheters and wound drains, have not been covered in their one-year training programme. The healthcare environment is highly litigious and adverse events can easily arise from ENAs doing complex tasks that they were not trained to perform.

## 6.4 CONCLUSION

The working environment of the ENA in private healthcare in South Africa has not been studied previously. This study revealed that the working environment of the ENA is both challenging and sometimes overwhelming as the ENA is the primary provider of basic bedside patient care and fills other roles that are not directly related to patient care. Their work is viewed as unimportant by senior members of the nursing team as their duties are often interrupted and they are asked to perform tasks that other categories of nurses do not want to perform, such as answering patients' call bells. Furthermore, the findings from the current study revealed that the role and functions of the ENA in private healthcare institutions did not foster safe clinical practice. The ENAs receive minimal to no supervision and practice independently of the professional or enrolled nurse. Most ENAs perform tasks that are out of their scope of practice because of staff shortages and an increasing workload. Their levels of job satisfaction are low, partly due to lack of recognition in the workplace but mainly because of the lack of communication regarding funding for training to the next level of qualification.

## 6.5 LIMITATION OF THE STUDY

The study was conducted in one private healthcare group only and therefore the findings cannot be generalised to all private healthcare groups.

## 6.6 RECOMMENDATIONS OF THE STUDY

Recommendations are presented with special reference to provision of funding for further training for the ENA, decreasing agency utilisation, developing a formal reward and recognition programme and further research.

### 6.6.1 Provision of funding for further training for the ENA

The private healthcare group under study should make financial provisions for the ENA to embark on the RPL to diploma in general nursing programme. ENAs under study perceived that they were being treated unfairly because the other categories of nurses were given funding to progress to the next level of qualification. This decreased their levels of job satisfaction. Funding for further training will not only allow competent staff to progress in their careers but will also lead to greater job satisfaction. The result will

be a more productive workforce. According to Hudspeth (2013: 365), a suitably qualified workforce will lead to safe practice and superior patient outcomes.

### 6.6.2 Reward and recognition programmes

All categories of respondents highlighted the point that ENAs worked hard and contributed sufficiently to ensure smooth workflow but were not recognised for their efforts. A formal reward and recognition program should be developed with key criteria to appreciate those ENAs who provide an exceptional service. According to Nkatha *et al* (2016: 8), a reward and recognition programme not only serves to reward outstanding employees but also sets the standards of achievement for other employees. There is already a formal recognition program in place for RNs, which heightened the perceived sense of unfairness felt by the ENAs. The development of a reward and recognition programme that includes ENAs and ENs will assist in creating a harmonious working environment, which will in turn improve productivity and job satisfaction.

### 6.6.3 Decrease the percentage of nursing agency utilisation

The percentage of nursing agency staff hours used in the hospitals on a monthly basis should be decreased to less than 25% of the total nursing hours to foster continuity in quality care. According to Blegen *et al* (2011: 409), high utilisation of nursing agency staff compromises the quality of care delivered to patients. This is mostly through a high turnover of agency staff who are not familiar with work routines. A greater percentage of permanent staff complement will decrease valuable time spent on orientating, teaching and supervising new agency staff. This will lead to a reduction in role stress that ENAs experience and will also prevent the RN from delegating tasks to the ENA that are out of their scope of practice. This will ensure a safe working environment for all categories of nursing staff.

### 6.6.4 Future research

The study should be extended to other private hospital groups to acquire a better understanding of the working environment of the ENA in private healthcare.

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# APPENDICES

## Appendix 1a: DUT Ethics clearance- full approval

**Institutional Research Ethics Committee**
Research and Postgraduate Support Directorate
2nd Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

**www.dut.ac.za**

13 June 2019

Mrs V Ramiah
20 Shinford Place
Sunford
Phoenix

Dear Mrs Ramiah

**Exploring the working environment of enrolled nursing auxiliaries in private hospitals in the eThekwini District**
**Ethical Clearance number IREC 009/19**

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

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

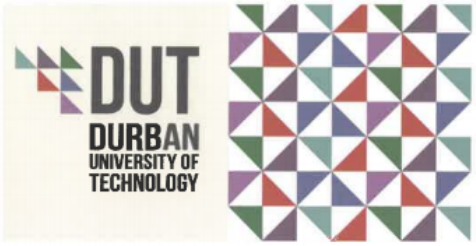
Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

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

Yours Sincerely

Professor J K Adam
Chairperson: IREC

## Appendix 1b DUT ethics clearance- partial approval

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**www.dut.ac.za**

7 March 2019

Mrs V Ramiah
20 Shinford Place
Sunford
Phoenix

Dear Mrs Ramiah

**Exploring the working environment of enrolled nursing auxiliaries in private hospitals in the eThekwini District**

I am pleased to inform you that **PROVISIONAL APPROVAL** has been granted to your proposal subject to:

- Obtaining and submitting the necessary gatekeeper permission/s to Institutional Research Ethics Committee (IREC).

PLEASE NOTE THAT THIS IS NOT A FINAL APPROVAL LETTER. KINDLY SUBMIT THE ABOVE MENTIONED DOCUMENTS WITHIN THREE MONTHS TO THE IREC OFFICE. DATA COLLECTION CAN ONLY COMMENCE WHEN IREC ISSUES FULL APPROVAL

The Proposal has been allocated the following Ethical Clearance number **IREC 009/19**. 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.

Yours Sincerely

Professor J K Adam
Chairperson: IREC

## Appendix 2a- Permission letter to private healthcare group to conduct research

20 Shinford Place,
Sunford
Phoenix, Durban
4068

The Nursing Executive
Life Healthcare Hospital Group
Oxford Manor
21 Chaplin Road
Illovo
3 September 2018

Dear Sir/Madam

**REQUEST FOR PERMISSION TO CONDUCT RESEARCH**

I am a registered Master of Health Sciences: Nursing student in the Department of Nursing at the Durban University of Technology.

The proposed topic of my research is*: Exploring the working environment of enrolled nursing auxiliaries in private hospitals in the eThekwini District*

**Purpose of the study**

The purpose of the study is to explore the working environment of enrolled nursing auxiliaries in the private health care setting in the eThekwini District.

**Objectives of the study:**

The objectives of the study are to:

- Explore the working environment of ENA's in private hospitals as perceived by ENA's.
- Explore the working environment of ENA's in private hospitals as perceived by the RN's and UMs in the medical and surgical units.
- Identify and describe how the work environment of the ENA's in private hospitals can be enhanced.

A total of two private hospitals in the group that utilise ENA's, both on a permanent and agency basis and that have more than one medical and surgical unit each will be included in the study. A large and a medium sized hospital will be chosen because their medical and surgical units use the largest percentage of ENA's as compared to other types of general units and it best represents all the hospitals in the private healthcare group and the findings can be generalised to all private hospitals.

I am hereby seeking your consent to conduct research in these hospitals and I am providing you with the following:

- A copy of an ethical clearance certificate issued by the university;
- A copy of the research proposal.

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows:

Tel: 0836518861 Naickerlisa737@gmail.com, Dr TSP Ngxongo (Supervisor) Tel: 031 373 2606 thembelihlen@dut.ac.za

Upon completion of the study, I undertake to provide you with a bound copy of the dissertation. Your permission to conduct this study will be greatly appreciated.

Sincerely yours

……

V Ramiah

## Appendix 2b- Approval letter from private healthcare group to conduct research

Life Healthcare Head Office
Oxford Manor, 21 Chaplin Road, Illovo 2196
Private Bag X13, Northlands 2116, South Africa
Telephone: +27 11 219 9000
Telefax: +27 11 219 9001
www.lifehealthcare.co.za

National Health Research Ethics Committee registration: **REC 251015-048**

**REF: 05232019/3**

23 May 2019

Dear Vanitha Ramiah

**RE: APPLICATION TO CONDUCT RESEARCH:**

**Title of study: Exploring the working environment of enrolled nursing auxiliaries in private hospitals in the eThekwini District**

The Research & Scientific Committee of Life Healthcare Group hereby grants permission with no conditions for your study to be conducted at **Life Chatsmed and Entabeni Hospitals.**

1. If patient or institutional confidentiality is breached, Life Healthcare is entitled to withdraw this permission immediately. The Higher Education institution under which the research is taking place will be notified, and Life Healthcare reserves the right to take legal action against you, should the company feel that this is warranted.
2. An electronic copy of the research report must be submitted to the Life Healthcare Research Ethics Committee prior to publication. Failure to do this may result in permission to continue to examination being withdrawn. The Higher Learning institution will be notified of this withdrawal.
3. No direct reference may be made to Life Healthcare, its subsidiaries or any of its facilities or institutions in the research report or any publications thereafter. The Company and its facilities, patients and staff must be de-identified in the study, and remain so for any other studies which may utilise this information.
4. The research must be completed within the time allotted by the Higher Learning institution. If the research is being done in an individual capacity by an employee of the life Group, the research must be conducted within one year of permission being given by the Company, OR the proposed time period must be specified in the proposal, and approved. Permission may be withdrawn if the research extends beyond the approved time period.
5. Life Healthcare will not take responsibility for any unforeseen circumstances within its institutions which may materially change the context and potential outcomes of a student's research. Should this occur, the student will be required to approach their Higher Learning institution for guidance around alternatives.
6. Placement of the electronic research report and any publications on the Company's research register after approval by the associated Higher Education Institution.
7. Life Healthcare will not be liable for any costs incurred during or related to this study.

Yours sincerely,

On behalf of the Life Healthcare Health Research Ethics Committee

Life Healthcare Group Proprietary Limited
Reg. no. 2003/024367/07 Registered address Oxford Manor, 21 Chaplin Road, Illovo 2196, Private Bag X13, Northlands 2116
Directors: CI Koekemoer, AM Pyle, PF Theron, PP van der Westhuizen, SB Viranna, KA Wylie

## Appendix 3- Letter of information and consent to participants


**LETTER OF INFORMATION**

**Title of the Research Study: Exploring the working environment of enrolled nursing auxiliaries in private healthcare in the eThekwini District.**

**Principal Investigator/s/researcher:** (Vanitha Ramiah, BCur Nursing)

**Co-Investigator/s/supervisor/s:** (Dr Vasanthrie Naidoo, D Nursing; Dr T Ngxongo, D Nursing))

**Brief Introduction and Purpose of the Study:** Healthcare challenges such as staff shortages, a greater burden of disease on the country and a turbulent economic climate are increasing and this has placed an additional burden on healthcare and nursing efforts in the 21st century. Although Enrolled nursing auxiliaries are well integrated into the patient care team, there are concerns that exist about their evolving role despite their limited training programmes. The proposed study sets out to explore the working environment of enrolled nursing auxiliaries in the private hospitals in the eThekwini District.

**Outline of the Procedures:** An in-depth single interview session, lasting approximately 40 minutes will be held with you to explore the working environment of the ENA. The interview will be held in a private room during your normal working hours. The responses that you provide will be audio recorded and will remain confidential.

**Risks or Discomforts to the Participant:** There are no foreseeable risks or discomfort that will be incurred while participating in this study.

**Benefits:** The findings are hoped to find ways of creating a safe and motivating work environment for the ENA, who is an integral part of the nursing team.

**Reason/s why the Participant May Be Withdrawn from the Study:** Your participation is completely voluntary and you are under no obligation to participate, and may withdraw from the study at any time without penalty or prejudice

**Remuneration:** There will be no remuneration, be it monetary or any other kind from participation in this study.

**Costs of the Study:** You will not be expected to cover any costs towards the study.

**Confidentiality:** All data collected will be strictly private and confidential and will only be used for the purpose of the study. No information will be linked to your identity as a numerical code will be used instead of your name.

**Research-related Injury:** The study does not pose any risk of injury to you.

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

Please contact the supervisor Dr Ngxongo, on 031-373 2606 or the researcher Vanitha Ramiah on (031) 5374202, or the Institutional Research Ethics Administrator on (031) 3732375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof C E Napier on 0313732577orcarinn@dut.ac.za


**CONSENT**

**Statement of Agreement to Participate in the Research Study:**

- I hereby confirm that I have been informed by the researcher, Vanitha Ramiah , about the nature, conduct, benefits and risks of this study-Research Ethics Clearance Number: IREC 009/19.
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis 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 computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my 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.

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| **Full Name of Participant** | **Date** | **Time** | **Signature / Right Thumbprint** |

I, Vanitha Ramiah herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

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| **Full Name of Researcher** | **Date** | **Signature** |
| **Full Name of Witness (If applicable)** | **Date** | **Signature** |

**Appendix 4a- Interview guide for ENA's**

**Section A: Demographic data**

**Please mark the appropriate box with an X**

- Age: _____

- Gender: male ☐ female ☐

- Years employed in this role:

  1-<5 years ☐ 5-10 years ☐ >10 years ☐

- Years employed in this hospital:

  1-<5 years ☐ 5-10 years ☐ >10 years ☐

**Section B**:

Interview questions for ENA's

**Grand tour question:** How would you describe your working environment?

Probing questions:

- Describe your understanding of your scope of practice as an ENA.
- Explain what is currently expected of you as an ENA in the ward.
- Describe the challenges you experience in the workplace.
- Describe the supervision you receive.
- Describe what you think will improve your work environment.

## Appendix 4b- Interview guide for RN's and UM's

### Section A: Demographic data

**Please mark the appropriate box with an X**

1Age: _____

2 Gender: male ☐ female ☐

3 Years employed in this role:

1-<5 years ☐ 5-10 years ☐ >10 years ☐

4 Years employed in this hospital:

1-<5 years ☐ 5-10 years ☐ >10 years ☐

5 Category of nurse:

Registered nurse ☐ unit manager ☐

### Section B

Interview questions for RN's and UMs

**Grand tour question:** How would you describe the working environment of the ENA?

Probing questions:

6 Explain your understanding of the ENA's scope of practice

7 Currently, describe what is expected of the ENA's in the ward

8 Explain the challenges you experience when working with ENA's. What causes these challenges? What can be done about it?

9 Describe the level of supervision that ENA's receive.

14 Tell me how the work environment of the ENA can be improved.

## Appendix 5: Certificate of proof reading from a professional editor

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**EDITING CERTIFICATE**

**Exploring the working environment of enrolled nursing auxiliaries in private hospitals in the eThekwini District / Vanitha Ramiah (21853110)**

I am a freelance editor specialising in proofreading and editing academic documents. I confirm that I have edited this dissertation and the references for clarity, language and layout. I used the track changes/review option in Microsoft Word. I returned the document to the author:

- Ensuring that spelling, grammar, punctuation, line spacing, and font is consistent and correct.
- Checking the List of References for consistency and style and checking entries against online databases to check accuracy of spelling and reference detail.
- Ensuring that all references in the text appear in the List of References and vice versa.

Resolving and accepting the changes in the text and references is the responsibility of the author.

**My Qualifications and Experience:**

- 30 years' experience as a research librarian at the University of KwaZulu-Natal and the Durban University of Technology.
- 16 years' experience in editing theses, research reports, teaching materials, journal articles, newsletters.
- Scribing, recording and transcriptions for workshops, seminars, debates.
- Facilitating and lecturing at Workers' College and Durban University of Technology.
- Master's in Library & Information Science, University of KwaZulu-Natal.
- B.Bibl.(Hons) in Library & Information Science, University of South Africa
- Higher Diploma in Education, University of South Africa.
- B.A. University of Durban-Westville

**Thara Devi Shah (Director)** 21 October 2019

**Appendix 6a- Sample of a transcript from a PN interview**

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| Interviewer | Good morning to you. How are you doing? Thank you so much for agreeing to be part of this interview session |
| Participant | Good morning. I am good. I'm happy to be here |
| Interviewer | That's great. As I discussed with you earlier, this interview is for the purpose of my master's study. All the information that we discuss will be confidential and used only for the purpose of the study. Did you manage to read the information letter I gave to you earlier. |
| Participant | Yes, I managed to go through it |
| Interviewer | That's great. There is a consent form that I would like you to sign that outlines the research. Are you okay to sign the consent |
| Participant | Yes sure |
| Interviewer | Thanks for that. Do you have any questions for me before we start with the interview proper |
| Participant | Umm, I think I'm good for the moment |
| Interviewer | You can stop me at any time if anything comes to mind. Oh, before I forget I need to ask for your permission to record the interview. The purpose for this is to have the information available later on when I analyse the information. Is this okay with you? |
| Participant | Yes, sure no problem |
| Interviewer | I will start by asking you some demographic information. Can you tell me which category of nurse you fall under. |
| Participant | I'm a registered nurse |
| Interviewer | Please can you tell me how many years you are a registered nurse for? |
| Participant | Umm 6 years now |

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| Interviewer | How many years have you been a registered nurse at this particular hospital |
| Participant | Umm it's almost 3 years now |
| Interviewer | Thank you. What is your age? |
| Participant | (smiles) I just turned 34 in April |
| Interviewer | Wow. Happy belated birthday. Now I will move onto questions that focus on the working environment of the ENA. Just to remind you again that there are no names attached to your responses so please feel free to be honest. |
| Participant | Yes sure |
| Interviewer | Can you describe your understanding of the ENA's scope of practice |
| Participant | Umm they can do basic nursing tasks. They do vital signs monitoring and reporting abnormalities, assist with admissions. RN's have to oversee that as the history taken from the patient correlates with the diagnosis. They assist with feeding, bathing, getting patients out of bed, sitting on a chair, take patients out of the ward to the coffee shop. They have alot of personal contact with the patients but are limited when it comes to admissions. They do vitals- BP, pulse and temperature but not allowed to do GM monitoring. They get patients prepared for theatre- makes sure they have no nail polish, jewellery. They are also responsible for the environment- check safety of patients, bed brakes are on, and cotsides are up. |
| Interviewer | Thank you for that. Can you describe what the ENA's that work in your ward are expected to do? |
| Participant | They do vital signs, observations, assist with feeding, preparing patients for theatre, do pressure care and all the things mentioned above. There are sometimes so many surgical and theatre cases but ENA's are not allowed to fetch patients from scope room and theatre but sometimes we ask them to do it when the ward is short staffed. Everyone has to answer bells; whoever is closest answers the bell but I notice that staff often call the ENA's to answer the bells. Everyone is allocated to cubicles to do all the nursing tasks. |
| Interviewer | In your opinion, does the ENA do work tasks that are out of their scope of practice? |

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| Participant | Yes they do entire admissions and bring it to the RN who will phone the doctor. They remove drips and if there is a problem with the site, they will inform the RN. Most often the ENA communicates most frequently with the patients than the RN's. They get to the patients problems first and are able to problem solve. 1 out of 4 can't problem solve but the ENA's that have worked in the ward for a long time can problem solve. Patients are reassured when they attend to them. Theycalm patients down and patients are happier. The ENA's in our ward take patients to theatre...the eye cases and the gynae cases and the scope patients. They also bring the patients back when the ward is too busy. We are also short staffed so we ask them to help us. They don't mind. |
| Interviewer | Do you feel that the ENA is a valuable part of the nursing workforce? |
| Participant | Yes, they are valuable to a certain extent. How do they add value? They do vital signs, take patients pre op to theatre, assist when patients are ambulating. The RN and EN are busy with doctor's rounds then the ENA answers the bells and assist the patients with what they need. They don't need too much of assistance- they know the expectations especially those that have worked in the ward longer. They can oversee certain areas that are not in their scope e.g. a patient that gets admitted for a flexi sig and haemorrhoidectomy- the ENA starts off with vital signs and will tell the RN or EN that the patient needs a fleet enema. They are aware of the requirements and remind us of things when we are too busy e.g. a bridging student may not know the doctors preferences but the ENA will tell them what the preferences are. |
| Interviewer | Can you describe the challenges that you experience working with ENA's. |
| Participant | Sometimes there are problems with their attitude- they are sometimes reluctant to do things like feed patients because they feel they must complete their vital signs first. At breakfast and supper time, they will still be doing vital signs while patients are waiting to be fed. The ward attendant ends up feeding the patients. They can only do basic nursing care which is a problem when the ward is very busy. The biggest challenge is working with agency ENA's who are not familiar with the wards. They need to be shown everything and it is time consuming to do our own work and check up on them. Their scope is very limited and it is too much for the RN. Overall the RN has to see |

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| | to everything and it gets overwhelming to oversee the ENA as well. We need an extra ENA allocated if there are high acuity patients. They are so many things that the ENA can't do. Some are very willing and you know they can do it, especially the older ones, but their scope doesn't allow for it. In my opinion I would rather use EN's in the unit as they can do many more tasks and adds more value. |
| Interviewer | Why do you think this is so? |
| Participant | I was an ENA as well and I was focussed on trying to get the BP's done and feeding patients. No one helps you so it's like 'now I need you to know how I feel. Meal times are busy. ENA's are not respected and recognised for their work. They work hard and we don't acknowledge them. We don't realise how much they really do. I know they are bored. There are instances when some of them want to do more and ask "Can I help you?" or "Can I do this?" but you can't allow it because of their scope. It's not that they can't do it but it's not allowed. |
| Interviewer | Can you describe the challenges that ENA's experience in the workplace |
| Participant | Umm they do have a large workload especially now that we are not allowed to use the careworker, so the tasks of the careworker fall on the ENA. We feel sorry for them but there is nothing we can do- there is cost cutting going on in the Company. |
| Interviewer | As far as training goes, is there opportunities for the ENA to train further? |
| Participant | It's sad that there are no training opportunities for ENA's. The other categories of staff get to do some training but the ENA is always left out. Something should be done about . There are ENA's that I work with that will make good staff nurses, even sisters. |
| Interviewer | How do you judge this? |
| Participant | When a patient rings the bell and is in pain, some of the ENA's come to you and tells you the patient is in pain. They will bring the script to the RN and tell them what pain medication the patient had and what the patients need. They have the ability to go beyond their scope, attending to the patients needs if the patient remains in pain. They give feedback to the patients as well. |

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| Interviewer | How much of supervision are you able to give the ENA's that you work with? |
| Participant | ENA's that have worked for a long time don't need much supervision. With the admission pack, they take the beaker to do the urine test without being told. Certain things you don't tell them. Very rarely you have to tell them that the patient doesn't have a name band. They think before they do stuff. The agency ENA's – that's another story (laughs). |
| Interviewer | How do you think the working environment of the ENA can be improved? |
| Participant | It's good to acknowledge people when they work so hard. We must let them know that we know they work hard. I feel that ENA's feel that nobody notices their hard work. They must be given study opportunities as EN's and RN's have. They are scared because we make them feel that they can only be ENA's. The ENA's that I work with will be good RN's not even EN's. They have the potential and are very good. After they do something and you go through it, you realise that you may not have done it that well yourself. |
| Interviewer | Thank you. Is there anything else you would like to add |
| Participant | No thank you. I think I have said all I wanted to say |
| Interviewer | Thank you once again for your time |
| Participant | Thank you |

## Appendix 6B Sample of a transcript of an ENA interview

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| **I**nterviewer | Good day and welcome to our interview session. How are you doing? |
| Participant | Good day, I am well. |
| **I**nterviewer | That's good. Firstly, I would like to thank you for agreeing to participate in this interview. As I discussed with you earlier, the information that is exchanged is confidential and will only be used for the purpose of the research. I will require you to sign a consent form that states that you are participating in this research voluntarily. Are you okay with this? |
| Participant | That's fine |
| Interviewer | Did you manage to read the letter of information that I gave you earlier? |
| Participant | Yes, I managed read a little bit of it. |
| Interviewer | The information letter outlines the study. We can have a look at it together and please feel free to ask me any questions you may have. |
| Participant | Okay, that's fine |
| Interviewer | Please can you take a minute to sign the consent form for me |
| Participant | Yes okay |
| Interviewer | Do you have any questions about the study? |
| Participant | No, I am fine |
| Interviewer | Thank you. I would like to use an audio recorder to record our conversations if it's okay with you. This is strictly so that I can give you my full attention but I will have to analyse the information at a later stage. Are you okay with that? |
| Participant | Yes no problem |

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| Interviewer | I am going to start by asking you the demographic questions that form the first part of the survey. Can you tell me your age? |
| Participant | I am 42 years old |
| Interviewer | Thank you. Can you tell me the position you hold in the unit you work in? |
| Participant | I am an ENA |
| Interviewer | Can you tell me how many years you are qualified as an ENA |
| Participant | Ummm it's about 11 years now |

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| **I**nterviewer | How many years have you been working as this particular hospital |
| Participant | Ummm from May 2013, about 6 years at this hospital |
| Interviewer | Thank you for that. I am going to ask you some questions about your role and functions as an ENA. I would like to stress that the interview is confidential and anonymous. |
| Participant | (giggles)… that's good |
| Interviewer | Can you explain to me in your own words what you understand by your scope of practice? |
| Participant | Ummm, our scope tells us that we are allowed to do basic nursing care like giving patients bedbaths, assisting patients to the toilet, doing intake and output, feeding patients and doing things like pressure care for patients. |
| Interviewer | Can you tell me more about the work that you do in the ward |
| Participant | Ok. (pause), We come on duty and there is an allocation that is done. But our work is the same everyday. I know what must be done every day. I don't even have to look at the |

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| | allocation because it's the same thing everyday. I do vital signs for patients, give bedbaths to those patients that need it. Then I assist the patients to eat- just those patients that can't eat by themselves. We do the intake and output for patients, check their GM's too. We also do the admissions that come into the ward and take patients to theatre. We do pressure care for the patients that need it and answer patients callbells. Ummm we also help patients to the bathroom. (laughs) I can't think right now |
| Interviewer | That's fine. We can come back to it if you remember anything else. I would like to clarify a few things you just said. What do you mean be doing admissions? |
| Participant | Oh okay. Admissions are new patients that get admitted to the ward. We do their admissions. |
| Interviewer | Thanks for that. What exactly do you do for a new admission? |
| Participant | We bring the patient to their room and orientate them to the ward. We take the medical and surgical history, ask the patient why they came to hospital and ummm write down chronic medication they are on. I also do the first assessment entry. Then I take the file to the sister or staff nurse and they call the doctor for orders. |
| Interviewer | Thank you for clearing that up for me. You also mentioned you take patients to theatre. What do you mean by that? |
| Participant | We work in a surgical ward so lots of the patients need to go to theatre for surgery. We take patients to theatre and hand them over to the theatre staff but this is for the day cases. We don't take patients for big procedures- the sisters or staff nurses take those patients. We know this is not our job (smiles) but what can we do. Sometimes there are like 15 patients that need to go to |

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| | theatre and the sisters are busy with other things. |
| Interviewer | Thank you. Just one more question. You said you did the intake and output for patients. What exactly do you do there? |
| Participant | (smiles) Oh there is a chart we must fill in for all the things the patient eats and drinks- it must be recorded on the chart. When the patients passes urine, we must also write it in. Patients also have drains and catheters- when we empty this in the afternoon, we write how much we emptied in the chart. Then we must total everything till 6 o'clock. |
| Interviewer | Thanks for that. You mentioned that patients have catheters and drains and that you empty these? Is that correct? |
| Participant | Yes we do. It's our job the intake and output |
| Interviewer | Can you describe the challenges you experience in the workplace? |
| Participant | Ummm the ward can get extremely busy. Sometimes on a Monday and Wednesday we can get 20 admissions. I am the only permanent ENA on the shift so I have to do all the admissions. It's a lot of work and the agency ENA's don't know what to do (shakes head). They try but most of them don't know the unit. |
| Interviewer | Thank you. Can you tell me what you mean by "they don't know the unit"? |
| Participant | We don't use the same agency staff all the time. They go and get permanent jobs so they don't work with us anymore. Then the agency brings in new staff that don't know the unit and we must orientate them and show them what to do. It's very frustrating cos we have our own work to do. |

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| Interviewer | Thanks for that valuable information. You can go on describing the challenges you face. |
| Participant | Yes ummm we also don't have any opportunities to train further. I would love to become an EN cos I have been an ENA for so many years but there is no opportunity. They keep telling us next year and then next year but nothing is happening. I am frustrated and disappointed but there's nothing I can do. |
| Interviewer | What do you mean that there is no opportunity to train further? |
| Participant | They stopped the programme that takes you from ENA to EN so now we don't have a chance to study further. We can start the new course but I don't have money to pay for that. The hospital should pay for us cos they pay for the bridging courses. |
| Interviewer | I can see why you concerned about that. Do you have other challenges you want to speak about. |
| Participant | We used to have the care workers who helped us alot with our work. Now we are not allowed to use them and we not allowed to replace them. There's this cost thing that we have to save now. But we have to do all the work now. Before the care worker would do the baths with us but now I must wait for another ENA to help me. It's becoming very stressful. Umm, yes there are lots. You know we will be busy with our work and then we will be called to do other things. Its like our work is not important. |
| Interviewer | Can you tell me more about this? Who interrupts your work and why? |
| Participant | The ward will be so busy and I will be with a patient but when the bell rings, I must leave the patient and answer the bell. Nobody thinks what we do is important because we always get interrupted. The staff nurses and sisters are giving medication and can't be |

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| | disturbed. This is not respecting us. I will be busy with an admission and a patient will ring the call bell. |
| Interviewer | Do you feel rewarded for the work you do? |
| Participant | Not really. Umm there are sisters that say thank you but most of them don't.Some even scream at you when they want something but you have to understand we work in a stressful place. They also get busy with their work so they try to help where they can. |
| Interviewer | Yes, it does sound that way. Can you describe the supervision and mentorship you receive from the senior staff? |
| Participant | Me? No I don't get supervision. As I said, the sisters are too busy with their work to supervise us. But I don't need it. I have been an ENA for so many years. The sisters, they trust me to do the work properly. They know I know what I'm doing. I try and watch them when they doing certain dressings and things so I can learn. |
| Interviewer | Can you tell me what you think will improve your working environment? |
| Participant | Umm. I have to say that we need teamwork. If everybody takes responsibility for the patient then things will be better. Like answering the callbells- the person who sees it must answer it instead of calling the ENA who is busy. The same goes for giving patients bedpans. Even of the sisters or staff nurses give the bedpans, we will take it out and clean the patient but they don't even give it to the patient. They call us to give it. They must also realise we have a lot of work to do. Sometimes my record keeping is delayed and when the sister is handing over the ward to the night staff and she sees this, she is unhappy with me. If they can understand that we don't do this intentionally then the ward will be a happier place. I stay after 7 anyway to complete my work. I enjoy my work a lot |

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| | and love being with the patients and everyone will tell you I always do my best. |
| Interviewer | You also mentioned training was a problem. Is there anything that can be done there to assist you? |
| Participant | Umm yes that's where it needs to be urgent. We need training. How many more years will we just be ENA's? The other staff don't respect ENA's- they look down at us. I want to be an EN so badly. |
| Interviewer | Is there anything else you would like to add? |
| Participant | No, I am fine thank you |