# EXPERIENCES OF NURSES OF THE IMPLEMENTATION OF OCCUPATIONAL SPECIFIC DISPENSATION (OSD) IN SELECTED PUBLIC HOSPITALS IN THE UMGUNGUNDLOVU DISTRICT IN KWAZULU-NATAL

by

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**DECLARATION**

I declare that: **EXPERIENCES OF NURSES OF THE IMPLEMENTATION OF OCCUPATIONAL SPECIFIC DISPENSATION (OSD) IN SELECTED PUBLIC HOSPITALS IN THE UMGUNGUNDLOVU DISTRICT IN KWAZULU-NATAL** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

22 September 2013

..... .....

**SIGNATURE** **DATE**

Nompumelelo Annatoria Kunene

# EXPERIENCES OF NURSES OF THE IMPLEMENTATION OF OCCUPATIONAL SPECIFIC DISPENSATION (OSD) IN SELECTED PUBLIC HOSPITALS IN THE UMGUNGUNDLOVU DISTRICT IN KWAZULU-NATAL


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## ABSTRACT


The purpose of the study was to explore the lived experiences of nurses on the implementation of occupational specific dispensation (OSD). Qualitative research using hermeneutic phenomenology was conducted in the three selected public hospitals in the Umgungundlovu district in KwaZulu-Natal (KZN).

Data was collected by means of in-depth interviews with professional nurses, enrolled nurses and nursing assistants and focus group discussions with nurse managers purposively selected at the public hospitals in the Umgungundlovu district. Parse's extraction synthesis analysis of data was done and seven (7) themes emerged from the participants' dialogical conversation exploring the experiences of the implementation of OSD.

The findings suggested that nurses viewed OSD as unfair labour practice because it divided nurses; there are those who grossly benefitted and those who benefitted less. The researcher concluded that the study will assist the authorities in the department of health both nationally and provincially to review OSD for nurses and close the gaps identified during the implementation as they were the pilot group.


## KEY CONCEPTS


Department Public Service and Administration (DPSA), experience, general stream, implementation, Occupational Specific Dispensation (OSD), specialty stream.

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# *Dedication*

*To my husband and three daughters,*

*for their support and belief in me especially during my studies.*

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| | |
|---|---|
| AMN | Assistant Manager Nursing |
| ANC | African National Congress |
| CDC | Communicable Disease Clinic |
| CEO | Chief Executive Officer |
| DC22 | Umgungundlovu district |
| DENOSA | Democratic Nursing Organisation of South Africa |
| DHIS | District Health Information System |
| DNM | Deputy Nursing Manager |
| DoH | Department of Health |
| DPSA | Department Public Service and Administration |
| EN | Enrolled Nurse |
| ENA | Enrolled Nursing Auxiliary |
| HR | Human Resource |
| ICU | Intensive Care Unit |
| KZN | KwaZulu-Natal |
| MTEF | Medium Term Expenditure Framework |
| OSD | Occupational Specific Dispensation |
| PHC | Primary Health Care |
| PHSDSBC | Public Health and Social Development Sectoral Bargaining Council |

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# CHAPTER 1

# ORIENTATION TO THE STUDY

## 1.1 INTRODUCTION

The African National Congress (ANC) led Government introduced initiatives, such as scarce skills and rural allowance which excluded some categories of health professionals and, also the introduction of Occupational Specific Dispensation (OSD) which left many nurses angry, feeling betrayed and dissatisfied (Dolamo 2009:32). OSD means revised salary structures that are unique to each identified occupation in the public service. These salary structures were to be centrally determined through grading structures and broad job profiles. Secondly, they were to develop career path opportunities for public servants based on competences, experience, and performance. Thirdly, they were to provide for pay progression within the salary level and to consolidate certain benefits and all allowances into the salaries of professionals (Department of Health [DOH] 2007b).

OSD is a system put in place to assist with remuneration of professionals. The Department Public Service and Administration (DPSA) aim of the process was to divide nurses into general and specialised streams depending on the qualifications and the area in which one worked. Those with post-registration qualifications and worked in specialised areas were grouped as speciality nursing stream and those working in non-specialised areas were grouped as general nursing stream. Speciality areas according to OSD included operating theatre, intensive care unit (ICU), paediatrics, orthopaedics oncology, primary health care and nursing education. None speciality areas were nursing areas like medical, surgical and outpatient departments (DPSA 2007:4).In the Republic of South Africa (RSA) nurses are generally dissatisfied with remuneration. The result of poor wages has led to nurses migrating to other countries looking for greener pastures. According to Dolamo (2009:32), shortages of nurses have imposed heavy burdens on the frontline in the nation’s health status. Nurses are overworked and many experience burnout.

The RSA government's plan was to cut down on brain drain of skilled professionals to other countries. South Africa invests a lot in training nurses, but once these individuals qualify, they leave the country to work in developed countries as the monetary benefits are alleged to be more than in South Africa. The plan was to increase the salary structures and make it as attractive as possible (Mahlathi 2009:9).

## 1.2 RESEARCH PROBLEM

The source of the problem, the background to the problem, and statement of the problem will be discussed in the text below. A research problem is an area of concern in which there is a gap in the knowledge base which requires research to be conducted so as to generate the necessary knowledge and provide evidence that proves the existence of the problem. These research problems can be developed from the literature, clinical practice, interaction with colleagues, research priorities identified by funding agencies and theory (Burns & Grove 2005:85).

### 1.2.1 Source and background of the problem

It started as a resolution with labour sectors at the Bargaining Council, identifying the need for health professionals to receive priority in terms of a new remuneration dispensation (Mahlathi 2009:3). OSD was to improve the ability of the public service to attract and retain skilled employees as remuneration was identified as a major challenge. The Department of Health (DoH) took proposal to the National Council suggesting that the nursing profession be prioritised; the reason being that every health facility had nurses (Mahlathi 2009:5).

The researcher was stimulated and prompted to research on this topic by problems that were being observed and directly encountered in the clinical area, in the nursing practice. The nursing managers and the nursing division were continuously receiving grievances from professional nurses pertaining to OSD, and apathy from other categories of nurses. Peer interactions also contributed to stimulate the researcher to deal with this topic on OSD. In nurse managers' team briefings, institutional, district and provincial meetings OSD is still a major burning issue. Many nurses felt and still feel they must benefit from OSD, such as nurses working in communicable disease clinic (CDC), tuberculosis (TB) clinic and medical wards due to current disease profile. The

researcher was also encouraged by an experienced researcher who highlighted the good reasons and benefits of the research topic.

The grievances/complaints about OSD were that it was an unfair system with the general nurses now not happy to assist in the speciality units in cases of emergency because ‘they do not benefit from OSD. According to the remuneration policy for professionals (DOH 2010:6-7) there were, however, positive issues about OSD, that post-registration qualifications have been recognised. Salary structure for most, nurses was increased. Future employment targeted skilled and qualified individuals. Movement could only take place within speciality areas which means that people continued practising their skills. According to SANC migration has not stopped, but it seems it has reduced, this is confirmed by SANC verification and transcripts issued since the implementation of OSD in November 2007 as follows: In 2008, 1180 transcript issued, 2009=807, 2010=450, 2011=358, 2012=378, 2013 up to June=165.

One of the duties of the DoH is the provision of health care delivery to the population under its jurisdiction. About 70% of the work force consists mostly of nurses working at different levels of health care. The shortage of staff is caused mainly by attrition of highly skilled work force due to emigration of professional nurses from South Africa to developed countries. OSD was to stop the migration of nurses to other countries.

According to Zamisa (2007:13), following the strike in 2007 by public servants where some of the demands were 12% salary increase, improved housing and medical benefits for all employees and filling of all vacant posts, the former public service minister at that time said that the offer included the OSD that was to reward performance and recognise experience, allowing the salaries of certain public servants to increase substantially. It was also to offer career path opportunities for public servants, which were not automatic salary increases, but a systematic way of improving the salaries of professionals. Further, the minister said that approximately 80% of all public servants would benefit from this dispensation (Zamisa 2007:8; Tota 2008:36). For the first time the employer was going to prioritise nurses as the first occupational group.

According to Magagula (2007:25), all unions signed the resolution, Public Service Coordinating Bargaining Council (PSCBC), Resolution 1 of 2007 that was talking to the OSD for nurses to raise the nurse’s salaries by 7.5% across the board. The second

segment of the nurse's salary improvement was the OSD which is Public Health and Social Development Sectoral Bargaining Council Resolution 3 of 2007(PHSDSBC 2007).This was to (a) recognise experience or years of service, (b) recognise qualifications (c) creation of grade progression and (d) improve on the current pay progression and (e) rewarding of high performance.

The category of nurses that benefited from OSD was professional nurses working in the speciality nursing stream. Professional nurses working in these speciality areas without the speciality qualification received a once-off payment, notch to notch increase only and did not benefit for phase 2 which was considering the years of experience. Maternity professional nurses with advanced midwifery and neonatal nursing science certificate were also considered.

### 1.2.2 Statement of the research problem

Whereas, OSD objective was to improve nurses' salaries, nurses feel it was meant only for some categories and not for all nurses. OSD created a lot of division among nurses and for human resource nurse managers. It is now a problem to allocate a professional nurse from general nursing stream to assist in the speciality nursing stream for example intensive care unit (ICU) when there is crisis because nurses feel they are not paid. The OSD for nurses has not been finalised up to now, nurses are still forwarding concerns to human resources and financial offices. The DoH is still paying nurses OSD because some units like Accident and Emergency were not categorised as speciality and yet they are doing the resuscitative, emergency and specialised function. One may wonder whether the nursing managers had input at the Bargaining Council.

This study was to explore lived experiences of nurses on the implementation of OSD in selected public hospitals in the Umgungundlovu district in KwaZulu-Natal (KZN).

## 1.3 AIM OF THE STUDY

This section discusses the aim of the study. According to Burns and Grove (2005:86), the aim of any study concerns the research purpose and the objectives of the study. The said purpose is a concise, clear statement of the specific goal or aim of the study, indicating the type of study and its variables, population and settings.

### 1.3.1 Research purpose

The purpose of this study was to describe lived experiences of nurses on the implementation of OSD in selected public hospitals in Umgungundlovu district in KZN.

### 1.3.2 Objectives of the study

According to De Vos, Strydom, Fouche and Delport (2005:105), objectives are the end towards which an effort or ambition is directed.

The following objectives guided this study:

- To explore experiences of nurses on the implementation of OSD in selected public hospitals in the Umgungundlovu district.
- To recommend guidelines that can be used to improve the implementation of OSD.

### 1.3.3 Grand question

What are your lived experiences with the implementation of OSD at Umgungundlovu district in KZN?

## 1.4 SIGNIFICANCE OF THE STUDY

The study will give nurses a platform to relate their lived experiences on the implementation of OSD in the Umgungundlovu district in KZN. The study will further assist authorities both provincially and nationally to be aware of the challenges as experienced by the implementation of OSD and outstanding issues related to nurses OSD implementation as they were the pilot. The study will also benefit nurse managers who are sometimes blamed as not doing enough for the nursing staff to be recognised for OSD.

## 1.5 DEFINITION OF KEY CONCEPTS

The following concepts were used regularly in this study:

### District nurse manager

One who gives direction and coordinate Health services within the DoH at a district level. Manages and supervise strategic planning of Health care establishment namely: hospitals, community health care and primary health care centres (DPSA 2007:9).

### Dispensation

A strategy that seeks to enhance the recruitment and retention of critical skills and competencies required for public service delivery that includes the delivery of health services, and provide clear salary and career progression measures based on competencies and performance (Fouche 2007:5).

### Enrolled nurse

Enrolled nurse, also called staff nurse, is a person educated to make independent decisions in the practise of basic nursing care and treatment in the manner and to the level prescribed by SANC in the Republic of South Africa. Since enrolled nurses are registered and licensed under the *Nursing Act, 33 of 2005*, their practise allows them to carry out such nursing care as their enrolment permits “under the direct or indirect supervision or direction of a registered nurse or, where applicable, under direct or indirect supervision of a medical practitioner or a dentist or on his direction or written or verbal prescription” (Government Notice R.1649, as amended by R.480).

### Enrolled nursing assistant

Enrolled nursing assistant, also called Auxiliary nurse, is a person educated to provide elementary nursing care in the manner and to the level prescribed in terms of section 31, of the Nursing Act (South Africa (Republic) 2005:25). According to Government Notice R.1648 as amended by R.482, enrolled nursing assistants “shall carry such nursing care as their enrolment permits under the direct or indirect supervision or

direction of a registered nurse, an enrolled nurse or, where applicable, under the direct or indirect supervision of a medical practitioner or a dentist or on his direction or written or verbal prescription". Their scope of practice does not allow them to administer drugs or engage in any medical intervention procedures (SANC 2005).

**Occupational specific dispensation**

It is a revised salary structure that is unique to each identified occupation in the public service. These salary structures will be centrally determined through grading structures and broad job profiles, develop career path opportunities for public servants based on competences, experience and performance, provide for pay progression within the salary level and consolidate certain benefits and allowances into the salaries of employees (DPSA 2007:2).

According to Mtolo (2007:12), OSD is a salary plan that was initiated between the DoH and its partners in a trade union movement, following a public sector strike relating to wages, aiming at correcting the chronic problems that have plagued the public health workforce over many decades.

**Professional nurse**

A professional nurse is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practise as registered in terms of section 31, of the Nursing Act (South Africa (Republic) 2005:25).

## 1.6 PHILOSOPHICAL FOUNDATION OF THE STUDY (RESEARCH PARADIGM)

The philosophical basis of qualitative research is interpretative, naturalistic and humanistic and is concerned with the understanding of the meaning of social interaction by those involved (Burns & Grove 2005:24). It is interpretative in the sense that it is concerned with studying reality as it is constructed by people when they interpret and give meaning to their lives and experiences from an insider perspective (that is, the perspective of the research participants).

It is naturalistic because it studies phenomena or people in their natural settings with no attempt to exercise control over the settings or variables (Polit & Beck 2008:17). It is humanistic because it emphasises the perspective according to which humans are perceived to continuously construct, develop, and change their everyday interpretation of their worlds in order to make sense of their lives. The researcher describes and understands human experience and emotions holistically as part of the person's total living (Babbie & Mouton 2006:28).

The discussion below addresses the assumptions underlying the study and the theoretical framework.

### 1.6.1 Assumptions

Assumptions are basic principles that are accepted as being true on the basis of logic or reasoning without being verified or proven (Polit & Hungler 1999:640). According to Burns and Grove (2005:39), assumptions are statements taken for granted or considered true, even though they have not been scientifically tested.

#### *1.6.1.1 Methodological assumption*

The study was based on the human becoming theory of Parse phenomelogical hermeneutic research approach. The aim was to uncover the meaning of universal human health experiences by studying descriptions of the participant's experiences (Polit & Beck 2012:497). The researcher is the main instrument in the research process actively involved with the participants and not detached from the study, thereby bringing in the element of intersubjectivity (Babbie & Mouton 2001:29). Non-numerical analysis and interpretation of narrative data was carried out. The research process was inductive, resulting in the generation of new theory. It was noted that truth can be discovered only by imperfectly and in a probabilistic manner (Burns & Grove 2005:23).

#### *1.6.1.2 Epistemological assumption*

Epistemology deals with the nature of knowledge and knowing by specifying according to which rules knowledge should be produced. It is commitment to an ideal, generating results and findings which are as valid or truthful as possible (Babbie & Mouton 2006.8).

The study was based on a linguistic epistemology with the assumption that humans live, think and feel in terms of language. The study was also based on the epistemological position that data are contained within the perspective of the nurses who had lived experiences with the implementation of OSD, thus the researcher engaged the participants in collecting the data.

#### *1.6.1.3 Theoretical framework*

Exploring the experiences of nurses on the implementation of OSD involved looking at workplace behaviour, human relations and whether their initiative had fully or partially addressed the issue of improving the salaries. The researcher decided to base the study on the framework of Adam's Equity theory of work motivation (1965). Its basic tenet was that people are motivated to achieve a condition of equity/fairness in their dealings with other people, and with organisations they work for. Equity theory suggests that employee perceptions of what they contribute to the organisation, what they get in return, and how their return-contribution ratio compares to others inside and outside the organisation, determine how fair they perceive their employment relationship to be (Adams 1965:45; Spector 2008:17).

Similar to other employees, nurses also make judgements or comparisons between their own inputs at work, such as their qualifications, experience and effort, and outcomes they receive, pay and fringe benefits, status and working conditions. They then assign weights to these inputs and outputs according to their relevance and importance to themselves. The summed total produces an output/input ratio, which is the key issue in terms of motivation. If a person's output/input ratio is equal to that of another person, equity exists. Perceptions of inequity cause employees to take actions to restore equity such as reduction of effort, lack of cooperation, quitting which is not helpful to the organisation (Baron & Byrne 1991:36).

The equity helped to provide the basis for studying the motivational implications of perceived unfairness and injustice in the workplace. It also laid the foundation for more recent theories on distributive (how much is allocated to each person) and procedural justice (how rewards and job requirements are determined) (Cropanzano & Folger 1996:3). In a meta-analysis of many of these theories, Cohen-Charash and Spector (2001:321) found that both distributive and procedural justices were related to job

performance, job satisfaction and the intention to quit. The equity theory has served to direct attention to the importance of treating employees fairly and the consequences of failing to do so (Spector 2008:12).

## 1.7 RESEARCH DESIGN AND METHOD

This study used a qualitative, exploratory, Hermeneutic and contextual research based on phenomenological approach, with an aim and attempting to capture the human experience, within the context of those who experienced the phenomenon (Polit & Hungler 1999:25). Qualitative research involves the systematic collection and analysis of subjective narrative data and identifies the characteristics and the significance of human experiences. It takes into account human beings' participation in a situation by using the raw data of informants in written and oral descriptions (Polit &Hungler 1999:32).

The researcher chose a qualitative research approach because it was the most appropriate design to answer the aim and purpose of the study, as well as the research question and objectives.

Research methods refer to specific research techniques which involve sample selection, data collection and data analysis techniques (Silverman 2000:79).

### 1.7.1 Population and sample

The population for the study were all permanently employed categories of nurses in the three selected public hospitals in Umgungundlovu district. Accessible population are those that conform to the legibility criteria (Polit & Hungler 1999:230) as described under 2.3.1.3 in chapter 2. And a sample refers to the subset of units or elements (humans) that compose the population (Polit & Hungler 1999:140).

A non-probability, purposive sampling design was used to select informants in this study. Those informants met the eligibility criteria as described under 2.3.1.3 in chapter 2.

### 1.7.2 Data collection approach

A narrative description in an essay format and open-ended unstructured interview with field notes were the data collection strategies. The narrative essays and the open-ended unstructured interviews provided participants the opportunity to explain their experience of the phenomena of interest (refer to chapter 2).

### 1.7.3 Data analysis

Data analysis started soon after the first narrative essays of focus group discussion and in-depth interviews. This is described under 2.4.1.3 in chapter 2.

## 1.8 TRUSTWORTHINESS

The goal in a qualitative study is to accurately represent the participants' experience. Lincoln and Guba (1985:112) suggested four criteria to support trustworthiness. These criteria are credibility, dependability, confirmability and transferability (Streubert Speziale & Carpenter 2003:28; Polit & Hungler 1999:362). These criteria and strategies were implemented in the study to establish trustworthiness and are fully discussed in chapter 2.

## 1.9 ETHICAL CONSIDERATIONS

A study should comply with the ethical principles of beneficence, respect for persons and justice, protecting the rights of the informants and the institution as well as the scientific integrity of the research. The researcher consequently took the following ethical measures into consideration: informed consent, confidentiality and anonymity, privacy and the right of participants as discussed below.

### 1.9.1 Protecting the rights of the participants

To ensure that the principle of respect for human dignity (the right to self-determination) is maintained, the researcher allowed participants to exercise their right to participate in the study or not without coercion. The participants also exercised their right to answer or

withdraw from the study at any time without a penalty or prejudice. With the right to full disclosure, the researcher ensured that all aspects of the study were disclosed to all participants.

### 1.9.2 Protecting the rights of the institutions

The researcher ensured that no disruption occurred in the study field to services rendered by the participating institutions. The researcher collected data during lunch breaks to those who preferred that and also arranged with respondents to meet with them when off duty as others opted.

### 1.9.3 Principle of justice

The researcher attempted in making sure that every participant received fair and equal treatment. Virtues such as courtesy, trustworthiness, patience and tolerance were aimed as cornerstone of the study. The participants' right to privacy were ensured by selecting convenient venues agreed upon by all parties.

### 1.9.4 Principle of beneficence

Freedom from harm was undertaken by ensuring that all issues pertaining to the study and sensitive on participant's responses were handled with utmost care so that no actions on the part of the researcher caused psychological or emotional harm. Participants were free to report to the researcher any feeling of insecurity of which it emerged during the course of data collection, the researcher did hesitate to address them or call off the exercise.

The main purpose of the study was to understand and describe the lived experiences of nurses following the implementation of OSD. This was assumed as of benefit to all nurses in practice, and to make authorities in the DoH to be aware of challenges and problems as experienced by the implementation of OSD. The study did not involve clinical trial. It was therefore, non-therapeutic and no potential risks were envisaged to participants.

### 1.9.5 Scientific integrity of the research

The researcher demonstrated respect for participants by protecting the integrity of scientific knowledge. The researcher endeavoured to be honest in pursuing the study, no fabrication or forging of the report, but reflected what was done and said during data collection. The researcher did not manipulate the data, all data gathered was used in the report. The researcher used own laptop to transmit and store information to avoid hackers to access and read data.

Before the start of data collection, the researcher obtained ethical clearance from the Research and Ethics Committee, Department of Health Studies, University of South Africa(annexure A), Health Research and Knowledge Management (KZN Provincial DoH) (annexure B) and Umgungundlovu district (annexure C). Further permission was also requested and obtained from the Chief Executive Officers of the selected hospitals of Umgungundlovu district, namely, Greys hospital (annexure D), Northdale hospital (annexure E) and Edendale hospital (annexure F).

Informed consent is at heart of this study, because informed consent is a moral issue which recognises the rights of the study participants. Informed consent was obtained from the informants prior to the interviews (annexure G).

Confidentiality and anonymity were guaranteed by ensuring that the data obtained could not be linked to the source. No names were attached to the information obtained and anonymous labelling was employed. The participants were informed that they were free to withdraw from the study at any time without prejudice.

## 1.10 SCOPE AND LIMITATIONS OFTHE STUDY

The limitations of the study refer to the restrictions on, or in, the study that may decrease the generalisability or transferability of the findings (Burns & Grove 2005:487). There are two types of limitations, conceptual and methodological. Conceptual limitations restrict the abstract generalisability or transferability of the findings while methodological limitations restrict population to which findings can be generalised or transferred.

In this study participants were drawn from the Umgungundlovu district only and not the whole of KZN, thus limiting the transferability of the findings. The use of interviews to discuss sensitive issues with regards to salaries may evoke emotions and could be a setback to this study by restricting the depth of the information to be obtained.

## 1.11 OUTLINE OF THE STUDY

The following table 1.1 gives the outline on the organisation of the chapters.

**Table 1.1 Organisation of chapters**

| | |
|---|---|
| Chapter 1 | Orientation to the study |
| Chapter 2 | Research design and methodology |
| Chapter 3 | Data analysis and literature control |
| Chapter 4 | Conceptual frame work |
| Chapter 5 | Summary of findings, limitations, recommendations and conclusion |

## 1.12 CONCLUSION

This chapter introduced the study by outlining the research problem, its source and the background to the problem. The aim of the study which included the research purpose and objectives was also outlined. The significance of the study, its philosophical foundations and definitions of key concepts were also covered. The research design and methodology, measures to ensure trustworthiness as well as ethical considerations were also discussed. Limitations to the study, and lastly the general outline of the study report.

The research design and methodology follows in chapter 2.

# CHAPTER 2

# RESEARCH DESIGN AND METHODOLOGY

## 2.1 INTRODUCTION

Chapter 1 furnished an orientation to the study. This chapter outlines the research design adopted and the research methodology employed in the investigation. A description of participants and the data gathering technique employed is provided, explaining how the data were gathered and analysed.

## 2.2 RESEARCH DESIGN

A research design could be explained as being the blueprint of the study or entire strategy followed from identification of the problem to final plans for data collection (Burns & Grove 2005:211). In order to fulfil the purpose of the research an exploratory, hermeneutic (human becoming), phenomenological, contextual and qualitative study was conducted.

### 2.2.1 Qualitative research design

Talbot (1995:415) describes qualitative research as research with, rather than on people. Qualitative studies focus on people's perceptions, expressed opinions, feelings and experiences, and the unique context in which they occur, rather than on numbers (Creswell 2009:178). Qualitative research paradigm takes its departure point that of the insider perspective on social action. The original context of the experiences is unique and rich knowledge and insight can be generated in depth to present a lively picture of the participants' reality and social context. Holloway (2005:4) asserts that these events and circumstances are important to the researcher. Creswell (2009:162) describes the characteristics of qualitative research as, the focus on the process and outcome of a phenomenon, and emergent rather than tightly prefigured, taking place in a natural world and fundamentally interpretive.

While objectivity and truthfulness is the core of both quantitative and a qualitative research method, the qualitative approach seeks believability, based on coherence, insight and instrumental utility (Streubert Speziale & Carpenter 2003:18). Qualitative research involves the systematic collection and analysis of data provided by involved people about the phenomenon, including how they interpret the experiences and meaning attached to the experience (Creswell 2009:179). The researcher saw it appropriate to choose the qualitative research approach to answer to the purpose of the study which involved real-life experiences.

Qualitative research is naturalistic since it studies phenomena or people in their natural setting, applying low control designs. The researcher visited the sites of the research, which were, three selected public hospitals in the Umgungundlovu district, to meet with the participants. The research was conducted in a manner that did not disturb the context of the phenomena studied (Streubert Speziale & Carpenter 2003:18).

According to Marshall and Rossman (1995:98) qualitative research studies focus on the context which is flexible and emergent rather than tightly prefigured. It takes place in a natural world and fundamentally interpretive. This enables the researcher to adapt the inquiry as understanding deepened or the situation changes. In this study nurses managed to describe their experiences in their own words and conveyed their feelings through verbal and non-verbal communication.

### 2.2.2 Exploratory research design

Exploratory studies are aimed at gaining insight and understanding into a new interest, designed to shed light on various ways in which a phenomenon is manifested and on underlying processes. They are conducted in order to satisfy the researcher's curiosity and desire for a better understanding and to explicate the central concepts and constructs of the study (Polit & Beck 2012:18). The researcher wanted to explore and gain insight and comprehension into the experiences of nurses on the implementation of OSD. This was achieved by means of focus group discussions as well as in-depth interviews of the informants.

### 2.2.3 Hermeneutic research design

Hermeneutic research design was formulated by Parse based on human becoming theory also called man-living-health theory. The aim of this theory is to uncover the meaning of universal human health experiences by studying descriptions of participant's experiences (Polit & Beck 2012:497). According to Burns and Grove (2009:530), hermeneutic design involves dialogical engagement in which the researcher and the respondent participate in an unstructured discussion about a lived experience. This study aimed to describe the experiences of nurses on the implementation of OSD in the selected public hospitals in the Umgungundlovu district in KZN. The lived experiences of the participants were described within the research setting.

### 2.2.4 Contextual research design

A study is contextual when the phenomenon is studied for its intrinsic and immediate contextual significance (Mouton 1998:133). Contextual studies focus on specific events in "naturalistic settings". Naturalistic settings are uncontrolled real-life situations sometimes referred to as field settings (Burns & Grove 1998:331). This study focused on the experiences of nurses on the implementation of OSD and was undertaken in relation to the clinical areas of the three selected public hospitals.

For the purpose of this study, the naturalistic setting was the three government hospitals within the Umgungundlovu district in KZN where nurses were employed.

Umgungundlovu health district is located in the Midlands of the KZN province. The natural flow of communities from the surrounding districts into this district has an impact on service delivery and resource utilisation. Umgungundlovu health district covers an area of 9,190kilometres, consists of seven local municipalities, the biggest being Umsunduzi municipality. The centre of the district is Pietermaritzburg, the City of Choice. The district is traversed by the N3 which provides for economic opportunities but also the big potential for road accidents for which the district has reasonable three public and four private hospital services, mainly situated in Pietermaritzburg. Figure 2.1 shows the KZN health districts.

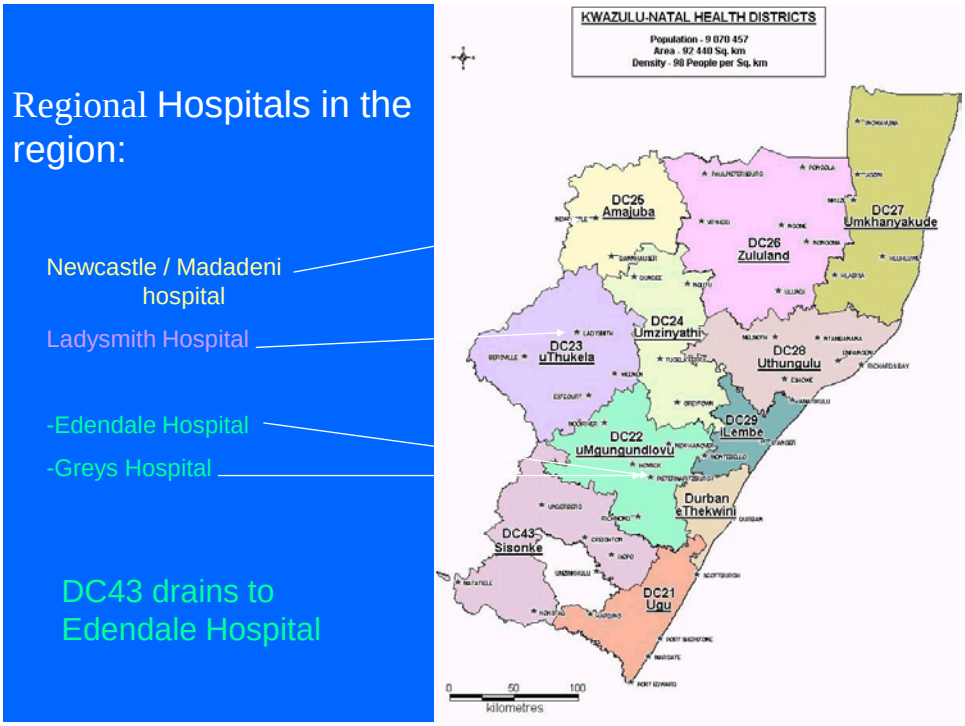


**Figure 2.1 The KZN health districts**

(DoH 2010)

### 2.2.5 Phenomenological approach

This is a phenomenological study which means it is systematic, interactive and subjective in approach, so as to describe and give meaning to life experiences. The aim of a phenomenological approach to qualitative research is to describe accurately the lived experience of the people concerned and not to generate theories or models of phenomenon being studied (Leininger in Burns & Grove 2005:23). A phenomenological study seeks to understand people's experiences, perceptions, perspective and understanding of a particular situation (Leedy & Ormrod 2005:139). It searches for in-depth, contextualised understanding of phenomena, leading to gaining insight and comprehension using in-depth interviews and focus group discussion with participants.

To understand the experiences of nurses on the implementation of OSD a phenomenological study was used to gain insider perspective on the phenomena in a naturalistic setting with enough flexibility, being as non- intrusive as possible. The primary source of data was the life world (Welman & Kruger 1999:189)

## 2.3 RESEARCH METHODOLOGY

In this study methodology refers to how the research was done and its logical sequence. The focus of this study was exploration and human becoming of the experiences of nurses on the implementation of OSD, therefore the research approach was qualitative.

The following aspects were covered in this section: population, sampling, inclusion and exclusion criteria, data collection as well as data analysis and ethical considerations adhered to during the research process.

### 2.3.1 Population and sample

A study population is that theoretically specified aggregation of elements from which the sample is actually selected. Sampling is the process of selecting a group of people, events, behaviours or other elements with which to conduct a study. An element is that unit about which information is collected and which provides the basis of analysis. A sample which consists of elements is selected from a target population by means of probability or non probability methods (Babbie & Mouton 2006:173).

#### *2.3.1.1 Population*

To match the research objectives the study population included all categories of nurses namely, deputy nurse managers, assistant nursing managers, operational managers, professional nurses in speciality and general wards, enrolled nurses and enrolled nurse auxiliary working in selected public hospitals in the Umgungundlovu district. These categories were selected to get the feeling in the work situation. Student nurses and pupil nurses were excluded from the OSD salary structure. Since these were the source of the key participants, the persons were thoughtfully and purposefully selected because they were considered to be knowledgeable and information rich with regards to the subject of enquiry (Leininger & McFarland 2002:93).

#### *2.3.1.2 Sampling technique*

A cluster multistage sampling approach was done as it was convenient and administratively necessary (Uys & Basson 1999:92). The population was divided into clusters of assistant nursing managers, operational managers, professional nurses, enrolled nurses and enrolled nursing assistants. The researcher considered and started with the largest inclusive sampling population that is, the assistant nursing managers and the operational managers for focus group discussions. The researcher then moved to the next most inclusive sampling (Brink 2008:131) of professional nurses, enrolled nurses and enrolled nursing assistants who presented themselves for participating in the study willingly for in-depth interviews in each of the three selected hospitals in the Umgungundlovu district.

The study utilised a non random purposive sampling scheme that is, selecting members of the target population who were likely to provide the most valuable data addressing the research objectives (Streubert Speziale & Carpenter 2003:58). All categories of nurses and both speciality and general wards were sampled in a clusters multistage approach. The table below indicate how many nurses were sampled per category in each hospital.

**Table 2.1 Number of nurses per category sampled in each hospital**

| **Institution – level of care** | **Sampling for** | **Category – Rank** | **Total** |
|---|---|---|---|
| Level 3 – tertiary | In-depth interview | Prof nurses | 17 |
| | | Enrolled nurses | 03 |
| | | Enrolled nursing auxiliary | 02 |
| | FGD | Assistant nursing managers | 07 |
| | | Operational managers | 13 |
| Level 2 – regional | In-depth interview | Prof nurses | 10 |
| | | Enrolled nurses | 05 |
| | | Enrolled nursing auxiliary | 05 |
| | FGD | Assistant nursing managers | 11 |
| | | Operational managers | 17 |
| Level 1 – district | In-depth interview | Prof nurses | 14 |
| | | Enrolled nurses | 08 |
| | | Enrolled nursing auxiliary | 05 |
| | FGD | Assistant nursing managers | 05 |
| | | Operational managers | 13 |
| | | **TOTAL** | **135** |

Even though purposive sampling lacks predictive power as no statistical analysis can be performed, and because the sample is not statistically determined, such sampling was used mainly because of its simplicity (Holloway 2005:301). It is based on the assumption that the researcher's knowledge about the population is complete enough to enable her to select cases deemed appropriate to the objectives of the study. Generalisation of results from a purposive sample is limited (Polit & Hungler 1999:284).

#### *2.3.1.3 Inclusion criteria*

Qualitative study on OSD wanted to look at these categories to be included.

##### *2.3.1.3.1 Inclusion criteria for in-depth interviews*

The study checked at the following characteristics:

- Is a professional nurse, enrolled nurse and/or enrolled nurse auxiliary.
- Is employed at Tertiary hospital level 3, Regional hospital level 2, and/or District hospital level 1.
- Has been working at either of these hospitals for five years and more (that is, they were employed on 30 June 2007).

These were selected because the OSD for the three nursing occupations (professional nurse, staff nurse and nursing assistant) was only applicable to employees where there was an inherent job (post) requirement that the incumbent of the job had to maintain registration with the South African Nursing Council (SANC).

##### *2.3.1.3.2 Inclusion criteria for Focus Group Discussion (FGDs)*

For the nurse managers the following criteria was used:

- A nurse manager, assistant nurse manager and /or operational nurse manage
- Employed/working at Tertiary hospital level 3, Regional hospital level 2, and/or District hospital level 1.

- Has been working at either these hospitals for five years or more (that is, they were employed on 30 June 2007).

#### *2.3.1.4 Exclusion criteria*

Student nurses and pupil nurses were excluded from participating.

### 2.3.2 Data collection

Data collection begins with the researcher deciding from where and from whom data will be collected. The researcher is the main research tool or primary instrument (Streubert Speziale & Carpenter 2003:18). The data collection was reflective to give the participants the opportunity to reflectively express their experience.

Following UNISA ethics clearance certificate, permission to conduct the study was granted by the KZN provincial DoH, Umgungundlovu health district and the chief executive officers (CEOs) for the three selected public hospitals. In this study data collection entailed unstructured in-depth interviews for professional nurses, enrolled nurses and enrolled nurse auxiliaries in both general and speciality wards. An in-depth interview is a qualitative research technique that allows face-to-face interactions between an interviewer and an interviewee to understand the interviewee's life experience or situation as expressed in his/her own words (de Vos et al 2005:299). The researcher conducted in-depth interviews at convenient times, when nurses were free either at home or free periods at work. All nurses who gave permission and agreed to be interviewed were scheduled according to the times they were available (Annexure G for informed consent agreement).

The researcher also used focus group discussions with nurse managers from the three selected public hospitals when having district meetings or when conducting their institutional meetings with Assistant Nursing Managers and programme coordinators during lunch hour 45-60 minutes and also during weekends when not committed. Focus group discussion proved to be a highly insightful research technique for engaging a group of participants with an idea or question, providing a more natural setting, allowing participants to share their stories and enabling new strands of thought to emerge (http://www.publicengagement.ac.uk./how/guides/focus-groups). Each focus group

consisted of six to ten members, Questions were asked in an interactive group setting where participants were free to talk with other group members. In each institution two (2) focus group discussions were conducted, that is one with assistant nursing managers and one with operational managers making a total of six focus group discussions.

#### *2.3.2.1 Development of data collection instrument*

An unstructured English interview guide was developed by the researcher with a grand tour question to guide the process of the interview/investigation and possibly prevent any deviation from the study topic. Findings from literature review and in-depth knowledge of the supervisor with regard to nursing challenges guided the researcher in developing the data collection instrument.

#### *2.3.2.2 Pilot study*

The researcher conducted a pilot study in December 2010 in Pietermaritzburg; Bisley Heights with one of the retired nurse manager who was the chairperson of the KZN nurse manager's forum for OSD. The participant signed the informed consent and participated in an in-depth interview which lasted for one hour and was captured by a digital voice recorder. The researcher transcribed the tape recording verbatim. Field notes were completed during and after the interview. The researcher ensured that the environment was quiet with no distractions.

The pilot study helped the researcher to be acquainted with the instrument. Consultation with an expert concluded that the order in which questions were asked was vitally important. The practical aspect of the research study was tested before the actual proposed study. Finally the pilot study helped to determine whether the researcher was going to use appropriate interviewing skills for the different categories of nurses.

#### *2.3.2.3 Data collection process*

The hermeneutic research approach consists of three processes: dialogical engagement, extraction-synthesis and hermeneutic interpretation. Dialogical engagement is the first process in the data gathering process. The dialogical

engagement is not an interview but a unique dialogue where the researcher is a true presence with the participants who are asked to talk about their experiences under study (Polit & Beck 2012:497).

The researcher, in true presence with participants engaged in a dialogue surfacing the remembered and the now issues of OSD. Care was taken to ensure that each dialogue took place in a quiet, private offices or seminar room with no disruptions. The researcher was the main data collection instrument in the study. As the initiator of the dialogue, the researcher played an active role in making certain decisions about the progress of the dialogue. The allocation of numbers instead of names on the tape recorder as well as on the field notes re-assured the participants about the anonymity of the interview data. Each signed consent form was sealed and locked away for safe keeping in a separate container from the transcriptions of the interviews.

The interviews were conducted face to face in a comfortable environment (Streubert Speziale & Carpenter 2003:230). Reflexivity, bracketing and intuiting were continuously reviewed to prevent bias of the researcher (Polit & Hungler 1999:636). A broad, grand open-ended question was used to start the dialogue. Subsequent probing questions followed, depending on the response after grand tour question.

The dialogue was conversational with responses being recorded on audio-tape and field notes taken. Data was collected until no further data pertinent to the categories emerged, **saturation** which was the point where all participants were expressing the same ideas relevant to the developing theory, and nothing new was emerging from observation in the field (Holloway 2005:155). The size of the sample was controlled by saturation of information, which means the point at which repetition or confirmation of previously collected data occurs (Streubert Speziale & Carpenter 2003:25).

The interviewer applied facilitative communication skills such as paraphrasing, probing, clarifying and summarising to ensure that participants were able to describe their experiences. However, while the participants were able and encouraged to respond in any manner they wished as well as to introduce new topics of importance, the interviewer directed the interview so as to remain focused. The interviewer maintained the flow of conversation, kept the questions brief, simple and listened actively.

*2.3.2.3.1 Audio taping*

Permission was requested from the participants to use a digital voice recorder (annexure I). All interviews were captured in their entirety. Each interview was recorded in a separate file and labelled with assigned interview code. As soon as possible after each interview the researcher listened to the recording and made notes transcribing key words, phrases and statements in order to allow the voice of research participants to speak. The researcher made sure that the recording equipment was always in perfect working condition and that batteries were available at all times.

*2.3.2.3.2 Field notes*

The interviewer took field notes during the interviews which were used as a secondary data storage method since the human mind tends to forget quickly (de Vos et al 2005:285). Field notes constitute a step towards data analysis. Writing of field notes during the research process compelled to further clarify each interview setting.

During each interview the interviewer wrote observational notes to describe the underlying theme as well as the dynamics during the interview in order to assist in remembering all aspects of the interview. The field notes were made while watching and listening and included direct quotations of what was said. The collected data was then prepared for analysis using Parse's extraction synthesis process as outlined in Polit and Beck (2012:497) and interpreted.

### 2.3.3 Data analysis

Qualitative data analysis use words rather than numbers as the basis of analysis, moving from concreteness to increasing abstraction inductive reasoning (Burns & Grove 2005:535). Data analysis in qualitative research occurs simultaneously with data collection. In this study the researcher listened to all tape recordings and transcribed verbatim. Field notes taken during focus group discussion and in-depth unstructured interviews were interpreted.

The ideas that emerged from the unique dialogue sessions were then consolidated. A list of all questions and their responses were drawn up and similar topics that arose

from the responses were grouped in columns. Themes and categories were arranged in columns. Codes were allocated to the data according to the topics identified. Data belonging to each category were grouped and analysed and then final remarks on the data analysis were completed (De Vos et al 2005:343).

Qualitative data analysis needs to be conducted with rigour and care (Holloway 2005:276). Rigour in qualitative research refers to striving for excellence and is associated with discipline, adherence and strict accuracy (Burns & Grove 2005:43).

Data analysis requires the researcher to dwell with the data or become immersed in the data. Data analysis is done to preserve the uniqueness of each participant's lived experience while permitting an understanding of the phenomenon under investigation. This begins with listening to participants' verbal descriptions and is followed by reading and rereading the verbatim transcriptions. As the researcher becomes immersed in the data, is able to identify and extract significant statements (Henning 2004:127).

#### *2.3.3.1 The data analysis process*

The data collected was analysed using Parse's six steps of extraction synthesis (1987) as outlined in Polit and Beck (2012:497) and interpreted.

(1) The researcher carefully constructed a story that captured core ideas about the phenomenon from each participant's dialogue.
(2) The researcher extracted and synthesised essences from participant's descriptions and expressions of the core ideas about the phenomenon (participant's language).
(3) The researcher synthesised and extracted essences as conceptualised in the researcher's language at a higher level of abstraction.
(4) The researcher formulated a proposition from each participant's description. This proposition is a nondirectional statement conceptualised by the researcher joining the core ideas of the essences that arose from the participant's description in the researcher's language.
(5) The researcher extracted and synthesised core concepts and ideas from all participants that captured the central meaning of the propositions.

(6) The researcher synthesised a structure of the lived experiences of nurses on the implementation of OSD; the structure answered the research grand question as outlined in chapter 1, 1.3.3 (Polit & Beck 2012:497).

#### *2.3.3.1.1 The dialogical engagement*

The dialogical engagement stage is more critical in qualitative studies. It is the first phase, and data-gathering process. This was not actually an interview but a unique dialogue where the researcher was a true presence with participants in an unstructured discussion asking them to talk about the lived experiences under study. Before the dialogue the researcher dwelled with the meaning of the lived experiences, centering self in to be open to a full discussion of the experiences shared by the participants. The discussion was audio tape-recorded and the dialogue was transcribed for the extraction synthesis (Polit & Beck 2012:497). After transcribing the researcher replayed the tape to correlate the information for accuracy (Streubert Speziale & Carpenter 2003:168). To uncover the meaning of the experiences, the researcher read the interview transcripts several times. The researcher explored personal feelings and experiences that might influence the study and integrated this understanding into the study – this is called reflective thought (Burns & Grove 2009:523).

#### *2.3.3.1.2 Extraction synthesis*

Extraction synthesis is a process of moving the descriptions from the language of the participants up the levels of abstraction to the language of science, themes and emerged (Polit & Beck 2012:497). The researcher contemplated the phenomenon under study while listening to the tape and reading the transcribed dialogue until the researcher was multisensorily immersed in data.

#### *2.3.3.1.3 Heuristic interpretation*

The heuristic interpretation entails structural transposition and conceptual integration. The structure of the description of the experiences was moved to a higher level of abstraction (Polit & Beck 2012:497-498). The actual words used by participants to describe their experiences on the OSD implementation were used in reporting the findings. The researcher identified themes and categories found in the data and used

them to develop a structural explanation of the findings. Interpretation focused on the usefulness of findings for clinical practice or moved toward theorising.

## 2.4 MEASURES TO ENSURE TRUSTWORTHINESS

In qualitative research it is important to ensure trustworthiness. Trustworthiness was ensured by using Lincoln and Guba's (1985:112) model criteria as follows:

### 2.4.1 Credibility

Credibility is demonstrated when participants recognise the research findings as their own experiences (Streubert Speziale & Carpenter 2003:38). Credibility criteria involve establishing that the results of qualitative research are believable, from the perspective of the participants involved in the research. Credibility is high when compatibility exists between the constructed realities that exist in the mind of the participants and those that are attributed to them. This research has achieved credibility through the following strategies:

#### *2.4.1.1 Prolonged engagement*

Prolonged engagement is the investment of sufficient time to achieve certain purposes, learning the culture, testing for misinformation introduced by distortions either of the self or of the participants and building trust (Lincoln & Guba 1985:302). It is imperative therefore that the researcher spends enough time becoming orientated to the situation.

Prolonged engagement is one of the strategies that increased credibility of this study. The researcher works in one of the three selected public hospitals. This reflects the researcher's prolonged engagement with participants of the phenomenon under study. Enough time was spent with the participants to develop a trusting relationship with them during the interviews and member checks (Holloway 2005:175).

#### *2.4.1.2 Persistent observation*

The purpose of persistent observation is to identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and to

focus on them in detail. Focusing on the issues also implies sorting out irrelevancies – the things that do not count (Lincoln & Guba 1985:304)

To satisfy this criterion of trustworthiness, the researcher tentatively identified the participants' behaviour during the performing of duties and witnessed clinical problems associated with the implementation of OSD. This enabled the researcher to sort the irrelevancies.

#### *2.4.1.3 Reflexivity*

The researcher is part of and not divorced from the phenomenon under study and, in the study, was constantly taking the position of a main research tool. The researcher explored personal feelings and experiences that might influence the study and integrated this understanding into the study to promote objectivity (Burns & Grove 2009:545). The analysis of the researcher's experience made the researcher aware of possible biases and preconceived ideas. Bracketing was implemented throughout the study and each phase of the research was carefully approached using bracketing (to lay aside what is known) and intuiting (looking at the phenomenon) to avoid bias and approach the phenomenon with an open mind.

#### *2.4.1.4 Peer and participants briefing*

Peer debriefing exposes the researcher to the searching questions of others who are experienced in the methods of enquiry, the phenomenon or both (Lincoln & Guba 1985:308). One nurse manager who was not the participant in the study and trusted by the researcher was requested to give constructive criticism.

#### *2.4.1.5 Member checks*

The member checks, whereby data, analytical categories, interpretations and conclusions are tested with members of those stake-holding groups from whom the data were originally collected, is the most crucial technique for establishing credibility (Lincoln & Guba 1985:432). Member checks were done both informal and formal and continuously. This immediate informal checking provided the researcher with an opportunity to assess what the participant intended by providing certain information.

### 2.4.2 Transferability

Transferability refers to the extent to which the findings can be applied to other contexts or with regards to other respondents. The researcher ensured thick descriptions of findings with sufficient detail and precision regarding the context and research process in order to ensure transferability. Purposive sampling was used to make sure that the informants who differed from one another were selected in order to maximise the range of specific information that could be obtained from and about the context (Babbie & Mouton 2006:277).

### 2.4.3 Dependability

Dependability ensures that the study would yield similar results if repeated with the same or similar participants in the same or similar context. It refers to the stability of the data over time and conditions. It emphasises the need for the researcher to account for the ever changing context within which research occurs. According to Guba and Lincoln (1985), there is no credibility without dependability; in as much as there can be no validity without reliability. Therefore, the researcher employed the same measures as for credibility to ensure dependability (Babbie & Mouton 2006:27).

### 2.4.4 Confirmability

Confirmability is a neutral criterion for measuring the trustworthiness of qualitative research. If the study demonstrates credibility and fittingness, the study is also said to possess confirmability (Lincoln & Guba 1985:331; Streubert Speziale & Carpenter 2003:38). Confirmability is the degree to which the findings are the product of the focus of the enquiry and not of the biases of the researcher. A confirmability audit trail was conducted involving the reviewing of the raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, instrument development information and materials relating to intentions and dispositions. An audit trail ensured that the conclusions and interpretations could be traced to the source and were a true reflection of them. An audit trail can determine both dependability and confirmability at the same time (Babbie & Mouton 2006:278).

## 2.6 CONCLUSION

This chapter discussed in detail the research design and methodology as well as ethical considerations. It also covered the strategies employed to ensure trustworthiness. The next chapter will address the issues of data analysis and literature control.

# CHAPTER 3

# DATA ANALYSIS AND LITERATURE CONTROL

## 3.1 INTRODUCTION

Chapter two discussed the research design and methodology of this study of which data analysis was discussed as part of methodology. In this chapter data analysis and literature control is described in details. As mentioned before, data analysis is a process of bringing order, structure and meaning to the data collected so that they can be synthesised, interpreted and communicated in a research report (Marshall & Rossman 1995 148; Polit & Hungler 1999:716).

The in-depth interview was collected from the three categories of nurses at three selected public hospitals in the Umgungundlovu district in KZN. The qualitative data collection was meant to obtain in-depth information on experiences from all categories of nurses in relation to OSD irrespective of whether one received it or not.

The purpose of this study was to describe lived experiences of nurses on the implementation of OSD in the three selected public hospitals in the Umgungundlovu district. The following objectives guided this study:

- Explore the experiences of nurses on the implementation of OSD in the three public hospitals in the Umgungundlovu district.
- To recommend guidelines that can be used to improve the implementation of OSD.

## 3.2 RESEARCH METHODS

The data collection and analysis to address the objectives mentioned above, the researcher used in-depth interviews and focus group discussions which the participants answered in their own words, thus yielding narrative data for qualitative non numerical analysis. The main question was asked at the beginning of the interview sessions which

was followed by probing questions. The data were collected over a period of five weeks from all categories of nurses excluding student nurses at three selected public hospitals in the Umgungundlovu district in KZN. The analysis of findings was done following Parses hermeneutic approach of qualitative data analysis as described in chapter two.

Study population were all the categories of nurses working at Umgungundlovu district for a period from 30 June 2007 and backwards. These nurses had experienced the OSD implementation at the same district. In this study analysis began with repeated listening to the participant's verbal description on the tape recorder. All tape recordings were listened to and transcribed from 62 interviews and six (6) focus group discussions and also listening to the tape recording, themes were identified and classified into major categories.

The results of data analysis were moved to the higher level of abstraction and finally interpreted in terms of the principles of the Parse theory as indicated in Polit & Beck. Seven major themes emerged from the data analysis process. The researcher begins with furnishing the demographic profile of the participants.

The study utilised purposive sampling scheme by selecting members of the target population who were likely to provide the most valuable data to address the research objectives (Streubert Speziale & Carpenter 2003:58).

## 3.3 BIOGRAPHICAL PROFILE OF NURSES

### 3.3.1 Data collection

The researcher used dialogical engagement, one-on-one approach (face-to-face encounter) in order to understand the participants' life experiences and situations in their own words. To meet the objectives of the study the researcher interviewed 39 professional nurses, 14 staff nurses and 9 nursing auxiliary during their breaks at work and at their homes after hours and during days off as arranged. Six focus group discussions were conducted. The ages of the participants were between 25 and 60 years, mostly females and only 4 males. Participants were from all four race groups namely Whites, Blacks, Coloured and Indians. Interviews were conducted in English to

cover all race groups but, participants were allowed to use isiZulu to make them feel better and KZN is dominated by Zulu speaking citizens.

The researcher involved enrolled nurses and nursing auxillary nurses because they were excluded by rural allowance. It was of great interest to find out their views on the implementation of OSD that included them for the **first** time in the salary structure. They were also not categorised as specialty or general nursing streams but graded as 1, 2 and 3.

For confidentiality, the following codes have been used to indicate the hospitals referred to and their levels of care:

THL3: Tertiary Hospital Level 3
RHL2: Regional Hospital Level 2
DHL1: District Hospital Level 1

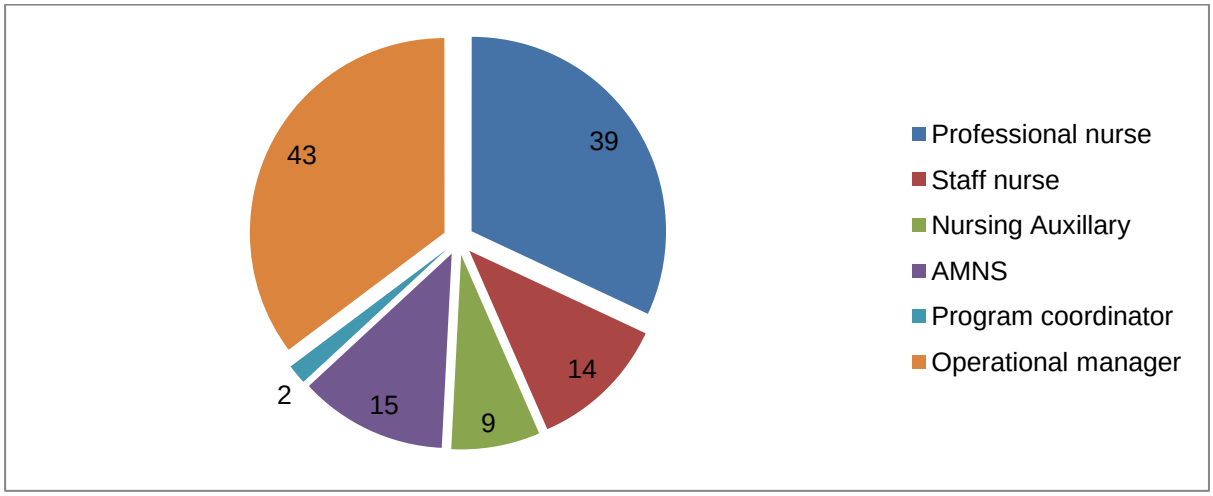


**Figure 3.1 Combined data for hospitals TH, RH and DH**

### *3.3.1.1 Summary of the table*

In each institution two focus group discussions were conducted, that is one (1) with nurse managers together with programme coordinators and one with operational managers making a total of six focus group discussion. Sixty two (62) interviews were done over a period of six weeks. The categories of nurses who were interviewed were from the three selected hospitals in the Umgungundlovu district. They were already employed on 30 June 2007. Registration with South African Nursing Council (SANC)

was the inherent requirement of the post. The nurses were phased in the dispensations for the occupations professional nurse, staff nurse and nursing assistant in the public service as follows:

**OSD for professional nurse**. General Nursing Stream, Specialty Nursing Stream, Primary Health Care Nursing Stream and Nursing Education stream.

**OSD for staff nurses and nursing assistants** were not classified into streams but into grades 1, 2 and 3 (DPSA 2007:8).

### 3.3.2 Data analysis

Although this is a messy, ambiguous and time consuming process, it is creative and fascinating in the end (Marshall & Rossman 1995:150). Data analysis was done to preserve the uniqueness of each participant's lived experience while allowing an understanding of the phenomenon under study using Parse's extraction synthesis as indicated in Polit & Beck (2012:497) du-ring which the descriptions were moved out of participant's language into the language of science.

## 3.4 THEMES AND CATEGORIES

Data collection and analysis of information collected from the categories of nurses namely nurse managers, programme coordinators, operational managers, professional nurses, enrolled nurses and nursing auxiliary on the implementation of OSD revealed seven major themes namely:

- OSD "unfair" labour practise
- Lack of involvement of nurse managers and other nurse categories in OSD decisions
- Development of speciality nursing stream versus general nursing stream
- OSD as a solution
- Disparities in the allocation of OSD
- Benefits of OSD
- OSD challenges

From these seven major themes, categories emerged, which were classified under each relevant theme. A summary of the themes and categories is illustrated below.

**Table 3.1 Themes and categories of data**

| THEME | CATEGORY |
|---|---|
| **Theme 1**<br>OSD "unfair" labour practise | 1.1 Excluded other categories of nurses<br>1.2 Exclusion of some nursing specialties and qualifications<br>1.3 Experience not recognised in phase 2 |
| **Theme 2**<br>Lack of involvement of nurse managers and other nurse categories in OSD decisions | 2.1 Poor communication between the DoH and nurse managers<br>2.2 Conflicts/contradictions between human resource and nurse managers<br>2.3 Poor representation of nurses in labour organisations and bargaining forums |
| **Theme 3**<br>Development of specialty and general nursing streams | 3.1 Nursing care not quantifiable<br>3.2 Dissatisfaction of nurses classified as general stream<br>3.3 Short courses not considered for OSD |
| **Theme 4**<br>OSD as a solution | 4.1 OSD a solution to migration<br>4.2 OSD a solution to moonlighting<br>4.3 OSD a solution to profession development (career path) |
| **Theme 5**<br>Disparities in the allocation of OSD | 5.1 Gross inequality in salaries<br>5.2 Different salary packages<br>5.3 Exclusion from OSD |
| **Theme 6**<br>Benefits of OSD | 6.1 OSD stopped migration of nurses<br>6.2 OSD has recognised other post-basic qualifications<br>6.3 Future employment targeted skilled qualified individuals<br>6.4 OSD does not allow rotation of staff<br>6.5 Increased salaries of all nurses |
| **Theme 7**<br>OSD challenges | 7.1 Challenges related to differences of inter-pretation<br>7.2 Critical units left out by OSD<br>7.3 Changing of titles of nurse managers<br>7.4 Ethics and professionalism deteriorated within the nursing profession<br>7.5 OSD not supportive of DoH Recruitment and Retention Strategy |

### 3.4.1 Theme 1: OSD “unfair” labour practise

During the process of dialogical engagement and when the grand question was asked by the researcher most participants would verbalise that the OSD was unfairly implemented surfacing the remembered, the now (feelings) and not yet all at once. Three categories emerged from this theme:

#### *3.4.1.1 Category 1.1: Excluded other categories of nurses*

Certain interventions in the form of the scarce skills and rural allowance had been introduced previously, but part of the challenge with the scarce skills was that the major beneficiaries were those in the medical profession and a few categories within nursing. These allowances were in essence a short to medium-term stop-gap measure aimed at stemming the exodus of key skills from the public health sector (DoH 2010:6).

The OSD aimed at improving the conditions of service and remuneration for public sector health professionals. The then Minister of health, Dr Manto Tshabalala-Msimang verbalised her excitement by saying that:

> “I am very excited to announce to our nurses that as a result of the agreement we have signed today, 14 September 2007, the entry level salaries for staff nurses will increase by 20%, the entry level salaries for Nursing Assistants and professional nurses in general nursing will be both increase by 24%. Nurses are going to get increment of between 20 and 80 percent” (Tshabalala-Msimang 2007:1).

The nurses were so thrilled to hear the then Minister of Health announcing the above statement as revealed by narratives below:

> “At last and in the first time in history our government considered nurses as the first priority. We anxiously waited for the implementation day”.

> “Awu Nkosi impilo izoke ibengcono kunini Umuntu ehlupheka. Umuntu uzoke akhokhe nezikweletu, usefile omashonisa.{Oh Lord our living conditions are going to improve, “we have been underprivileged/suffering for so long. We will eventually pay our debts, loans and stokfels have ripped us off}”.

> "The implementation day arrived, very few nurses were excited, and instead most of us were disappointed, sad, crying and angry".

> "Ithemba alibulali, waze wadlala ngathi uhulumeni. Asitholi rural allowance, no OSD awusinikanga lutho. Senzeni kangaka? Kwaze kwabuhlungu ukungafundi ube usister. {Hope against hope, the Government has treated us unfairly. We are not getting rural allowance, now OSD is excluding us, what have we done to deserve such? It is hard not being a professional nurse}.

> "As a staff nurse, I take charge of the ward especially at night if the professional has taken any other form of leave, I perform all duties, I am the workforce and the engine of patient bedside nursing even when the professional is present. I feel we should have been picked up a little bit looking at the economic status of the country".

> "It was unfairly implemented, it undermined the staff nurses and Nursing Assistants, and we felt useless. They concentrated in one category; we are part of the team, and work harder than those who got OSD".

It was clear that OSD came with unfair labour practices to the nurses across the board. In most instances all categories of nurses were bitterly disappointed and angry with the manner in which OSD had been implemented.

According to the Remunerative Policy for Professionals Employed in Public Health Sector (2010:6), the motivation was that it was not appropriate to remunerate health professionals in the same way and level that general staff were remunerated.

#### *3.4.1.2 Category 1. 2: Exclusion of some nursing specialties and qualifications*

Posts in a nursing specialty referred to those posts on the establishment of a health care institution where as a regular demand of the post, a post-basic qualification as registered with SANC is a pre-requisite to perform the duties attached to such a post (DPSA 2007:5). Participants were aware of the role of SANC towards the nurses, health care services (HCS) and the public as stipulated in the Nursing Act, 33 of 2005. The DPSA (2007:6) states that SANC can make recommendations to the government on the right/ relevant leadership in HCS by providing general support, networking, liaison

customer care and negotiations. The SANC is also expected to make recommendations, advise and provide information in the form of reports, letters and assist in decision making process (DPSA 2007:6). The participants from the FGDs indicated that the SANC did not come to their rescue with regard to OSD implementation as revealed by the narratives below:

> "There was not enough knowledge for the division of the nursing categories and their functions with regard to scope of practice. Even the classification of their qualification was not known. Hence implementation gave huge problems".

> "My concern is about the exclusion of post-basic qualification in Nursing Management/Administration which was not considered. Personally I feel that nursing administration is a specialty and a requirement for nursing management post".

The statement above was in contrary with the recent circular from the provincial DoH, circular No 78 of 2012 dated 15. November 2012; advertisement of assistant nursing manager posts: nursing personnel, stated that **prior** to the introduction of OSD on 1/7/2007; the posts of assistant nursing manager were advertised with Nursing Administration as a requirement for appointment. A directive from DPSA as per attached letter affirms that nursing administration cannot be included as a requirement when posts of assistant nursing manager are advertised on the basis that it is **not** prescribed as a requirement in the OSD for nursing personnel. Advertisement of OSD posts should be strictly in line with the prescribed OSD appointment requirements.

> "I took time and effort to study the nursing degree and Honours, yet my academic qualifications were not recognised and reimbursed by OSD. I am applying knowledge gained from my studies to improve quality patient care but not recognised, this is mere exploitation".

> "The SANC is only interested to the public not us. Their concern is to discipline the nurses when there is ill practice. I expected SANC to intervene regarding discriminatory salaries related to the OSD by clarifying the confusion regarding the specialty offer in the new OSD salary structure. SANC should have provided clear and documented delineation of all the one-year post-basic qualifications in order to

qualify for the OSD as a specialty qualification because nurses possess certificates for these qualifications".

"I am totally discouraged by the OSD.I have a post-basic qualification in ophthalmology and now because I am working on night duty as a supervisor I did not benefit. No one knew that one day this monster will come and discriminate us".

According to DPSA (2007:5) Government Notice R48 and R212 of the SANC which was followed by DoH, the DPSA, the bargaining council and other parties involved in bargaining did not include all the listed post-basic courses.

#### *3.4.1.3 Category 1.3: Experience not recognised in phase 2*

With regard to nurses OSD, it was agreed that there would be two phases to the salary adjustment namely: phase 1 involved notch to notch translation from occupations professional nurse, staff nurse and nursing assistants to OSD salary structure. Phase 2 was to determine whether the nursing employee is eligible for a higher notch on the relevant scale attached to the grade or for translation to a higher production grade based on the recognition of appropriate experience after registration in the relevant nursing category (DPSA 2007:5).

The data analysis revealed that participants were still desperate for salaries commensurable with their years of experience. OSD seemed to have excluded professional nurses with long experience and service. Phase two implementation affected many senior experienced nurses and nurse managers as revealed by narratives below:

"I am not happy, my twenty years of experience as a nurse in maternity was not considered, I just forfeited my service. Rather stop OSD and go back to rank promotion. The old system of salary increase used to cater for all nurses".

"It is very sad; my experience is close to twenty five years, but earning the same salary as the newly qualified professional nurses from the 4 year course. I am mentoring these junior nurses and expected to supervise them. My experience was thrown in the bin".

> "As a nurse manager, I'm still confused why most managers did not qualify for phase 2 (experience) because OSD document unpack what is appropriate experience- if this has not been recognised why mention experience, as the document talks about experience after registration with the South African Nursing Council".
>
> "I suggest that the experience should be considered for all categories of nurses. We have served the government for so long, this could be our incentive after five years as the authorities promised to review OSD at this period".
>
> "It is very sad to talk about OSD. I have worked for more than 10 years in the orthopedic ward and had already indicated that I wanted to do the orthopedic course. Because of the allocation, I was taken out to work in the surgical ward. The reason from my matron was that she needed somebody with experience and according to her I was going to go back to the orthopedic ward once she gets more skilled staff. Then OSD came, I lost out on everything, money and post-basic qualification".
>
> "It is very painful; when the operational manager is off duty I supervise these junior professional nurses who are earning higher salaries than I do. They have no experience, but because they happened to be in the right place at the right time their salaries increased a lot. Thus they do no respect us".

Nurse managers (Task Team Meeting on OSD for nurses 2007:2) were informed that the employer was clear in the process leading to signing of the relevant agreement, that recognition of experience could not be applied to posts in management cadres of nursing as would resulted in the department exceeded the allocated budget.

### 3.4.2 Theme 2: Lack of involvement of nurse managers and other nurse categories in OSD decisions

In 2007, the then Minister of Health announced that it gave her great pleasure to be part of the signing of a collective agreement on OSD of nurses with all five admitted unions in the PHSDSBC namely, Democratic Nursing Organisation of South Africa (DENOSA), National Education Health and Allied Workers Union (NEHAWU), Public Servants Association (PSA), Health and Other Service Personnel Trade Union of South Africa(HOSPERSA), and National Union of Public Service and Allied Workers

(NUPSAW) (Tshabalala-Msimang 2007:1). It emerged from focus group discussions with nurse mangers that they were not part of this signing of a collection agreement on OSD for nurses.

#### *3.4.2.1 Category 2.1: Poor communication between the DoH and nurse managers*

Participants reported that there was also no initiative taken by the DoH, unions or even institutional management to elicit the reaction of the nurses to the proposed method (OSD). There was no explaining of reasons for the selection of the two streams and why the RSA government decided to settle for this strategy. The narratives below indicate that nurse managers were frustrated by its implementation as revealed by narratives below:

> "We were not involved throughout the OSD negotiation; we were only called to a provincial meeting where we were informed about the final decision on the implementation of OSD. Nurse Managers were to go back and fill annexure forms for nurses with post-basic qualifications that are recognised by SANC as listed in Government notices R48 or R212

> "Looking at the number of nurse's grievances and issues related to OSD it confirms that there was no one giving input on behalf of clinical people, our fate was decided by the Nurse Educators".

During dialogue most professional nurses and nurse managers kept on raising the issue of being represented by delegates from the KZN College of Nursing. The researcher made a follow up on this issue; it was confirmed that no nursing manager from the province of KZN formed part of the delegation to the National DoH for the OSD negotiations. Thus they ended up forming a nurse manager's task team to discuss OSD related problems encountered in their respective institutions.

The provincial human resource only invited the college principal and few human resource (HR) managers from few districts to attend OSD negotiations at national. Only one workshop was conducted at Inkosi Albert Luthuli Central Hospital Durban (IALCH) on 3 October 2007 for the implementation of nurses' OSD in the KZN and it was

emphasised that each district office, hospital or institution was limited to a maximum of two (2) delegates (DoH 2007a:1).

#### *3.4.2.2 Category 2.2: Conflicts/contradictions between human resource and nurse managers*

According to the Remunerative Policy (DoH 2010:6) the development of OSD for health professionals was to be understood in relation to the transformation of the human resources for health environment and the need to have a more sustainable remuneration and career profession dispensation for public service employees. In the KZN province only one session, which was not enough, took place for training of HR managers for the institutions in preparation for the implementation of nurses OSD in November 2007. Thus, there were many contradictions between HR and nurse managers as revealed by narratives below

> "I am very much concerned about too many circulars that came out from the provincial H R department. The provincial HR manager kept on phoning the institutions giving instructions to translate certain individuals after having been contacted by unions. It looked like these authorities were covering themselves, and not following the national guidelines for OSD implementation".

> "As an assistant nursing manager I am unable to give answers to the nurses grievances related to OSD. I do try and give answers where I can but I do not give satisfactory answers on questions posed such, why medical and surgical departments were left out by OSD. I do not have sufficient information. I usually refer their concerns to the Deputy Nursing Manager (DNM) and HR department with a supporting letter, but no concrete answers are given to the nurses, especially by HR practitioners and this is frustrating as I feel I am not giving enough support to the nurses".

> "I feel that the Department of Health did not have enough people in terms of training with expert knowledge of OSD implementation, HR was unable to explain the criteria for benefiting from OSD thus I feel very robbed".

The comments above revealed problems of communication. The Batho Pele White Paper on transformation emphasises that finding the right person to speak in a national,

provincial or institutional department particularly someone who can give friendly advice can be very trying, leaving the individual citizen feeling helpless, frustrated and uncertain (South Africa (Republic) 1997:14). HR departments denied participants the Batho Pele Principle of Access, Information and Transparency. Nurses seem to have been left in an apparent state of confusion regarding the new salary structure and why certain personnel benefitted.

Mabasa (2010:268) claimed that HR has the same staffs who continue to mess things up, unable to implement what they are supposed to do due to non-payments, under payments and common corrected overpayments. The DoH did not learn from previous mistakes, feared to repeat the chaos in implementing the OSD for 100 000 nurses.

#### *3.4.2.3 Category 2.3: Poor representation of nurses in labour organisations and bargaining forums*

In 2004 a process was started at the PHSDSBC to address remuneration of health professionals. The emphasis was on the appropriateness, responsiveness, sustainability and affordability of whatever system would be put in place (Resolution 3) (PHSDSBS 2007:5). The discussions with labour organisations centered on mechanisms of improving conditions for health professionals so that they could be retained in public health facilities. From the participants' narratives below it appeared that there was discord and misinformation among labour organizations:

> "There was a lot of confusion and misunderstanding between labour organizations, some told us that it was going to be a flat rate across the board".

> "As nurses we were not involved throughout the OSD negotiations or informed, we were just told about the decision".

> "We are very unfortunate as nurses at ground level; people are always taking decisions on our behalf, not asking for our inputs".

According to the Freedom Charter (ANC1955:3), in the RSA, workers are free to elect their officers and to make wage agreements with their employers. In contrast, decisions appeared to have been made for nurses, thus creating an informational gap between

government and nurses at production level yet both the Freedom Charter and the Constitution of the Republic of South Africa (South Africa 1997c:10) makes provision for the right of all citizens to speak out, organise and have meetings not only with unions but professional associations as well. Ngwenya (2009:481) argued that nurses have the freedom to form a unified front that will represent them at the bargaining table and at government level and those policy makers to negotiate their nursing and health care needs.

When the OSD was agreed upon, and nurse's salaries which were long regarded as abysmally low, were reviewed and substantially increased, DENOSA (2007:1) proudly announced that the year was a year of celebration for nurses in South Africa. DENOSA is a voluntary organization for South African nurses and midwifery professionals. DENOSA champions the rights of professionals and helps to ensure that members have an acceptable working life and a balance between their career demands and social requirements ensuring an effective health service system. DENOSA participates in policy-making bodies affecting health of district, provincial, national and international levels (Gwagwa 2008:3). Professionalism, expertise in nursing management and representation to government are necessary to provide proper perspectives on issues surrounding nursing fraternity and that excellence in delivery of care is attained.

DENOSA was part of the signing of the signing of a collective agreement on OSD of nurses with other four (4) unions in the PHSDSBC. The editor-in-chief raised concern that there seems to be great unhappiness among nurses regarding the manner in which OSD was implemented. What is of great concern is the fact that the resolution on OSD was interpreted differently and, as such, was implemented differently from province to province. An agreement was signed with one employer, not with nine employers, thus the employer could not negate the importance of negotiations centrally. The bargaining forum was to look at the disparities and pave way forward (Gwagwa 2008:2). "Nurses are still waiting for solutions even today." The researcher argued that may be DENOSA was unable to intervene because the discussions with labour organisations centered on the mechanisms of improving conditions for health professionals so that they could be retained in public health facilities, thus OSD concentrated to qualifications (DoH 2010:5).

### 3.4.3 Theme 3: Development of specialty and general nursing streams

The OSD framework adopted in 2007 aimed to introduce an integrated career framework encompassing several aspects including remuneration, career progression models, career paths and performance management for its professional workforce. An analysis was undertaken to determine the pay of health professionals and it was found that the 'one-size-fits all' approach to salary determination was hurting the health sector. The motivation was that it was inappropriate to remunerate health professionals in the same way and level that general staff were remunerated (DoH 2010:5).

The National DoH at its National Human Resource Council (NHRC) meeting resolved that provincial department should establish task teams for the implementation and monitoring of OSD. Workshops were convened by the National DoH including province of KZN. Occupational class for professional nurses included four streams namely: General nursing stream, specialty nursing stream, primary health care nursing stream and nursing education stream. Enrolled nurses and enrolled nurse auxillary were not classified into streams, but only to grades 1, 2 and 3 meaning that according to OSD they were not registered with SANC as registered nurses, did not meet the appointment requirements that is, possessing the relevant qualification for the relevant post or specialty and not performing functions of the relevant post. The themes and categories came as result that general nurses were not happy about the classification of streams.

#### *3.4.3.1 Category 3.1: Nursing care not quantifiable*

Many participants, especially general stream professional nurses and enrolled nurses felt that nursing is not quantifiable. Nursing of patients is the same and aims at rendering quality nursing care as revealed by the narratives below:

> "Bathing of a patient in a medical ward and in an intensive care unit follow the same basic nursing principles''.

> "This is very unfair, how do you say what is specialty and general nursing care? You can't divide the line; we all do the same job".

The researcher argued that nursing is not homogenous; specialty nurses undergo intensive and special education and training to acquire a certificate, knowledge and skills. One cannot relax to study but be rewarded with same benefits as a highly skilled individual although experience cannot be overlooked.

Masondo (in Rispel 2008:21) pointed out that in the past enrolled nurses used to be 'hands-on' with patient care, but are now too distant. She suggested key strategies that include new models of power and authority; independence of nurses and re-focus on critical thinking skills to meet the new challenges.

#### *3.4.3.2 Category 3.2: Dissatisfaction of nurses classified as general stream*

One of the conditions for the OSD implementation was that human resource must consult with nursing managers in the identification of professional nurses in respect of the streams into which they were to be placed based on the working sphere of their utilisation as at 30 June 2007 (DPSA 2007:2) The narratives below indicate that nurses were not happy with the classification:

> "I feel much undermined by being called a General Stream nurse. It sounds like I have inferior knowledge and have no value to the institution and department of Health".

> "I am the 'so-called' General Nurse who did not benefit from the OSD working in the Outpatient Medical Admission ward. I am the first contact identifying specialty problems and patients, stabilize and transfer them to specialty units, ICU, Theatre etc. thus I regard myself as specialty nurse because I can nurse patients with pacemakers, I can perform a 12 lead electrocardiogram same as an ICU trained nurse, and I don't get any money".

> "All nurses are doing a better job, which is quality patient care; there was no need to divide us, we all work very hard".

> "I want to know what specialty post-basic course I need to do as I'm working in a medical ward. I will be pushed up and down to cover shortage because I am a general nurse, unlike specialty stream where it is indicated that if they want to be

transferred to general stream must accept in writing the lower scale attached to the post in the general stream".

"Why doctors and other allied health care workers were not classified as General or Specialty streams? This proves that our government is still not recognising nurses as important as it says".

According to DoH (2010:9), one of the objectives of the policy on remuneration was to reward skills and professional competencies as there has been no salary differentiation for professionals who obtain a higher level of education through postgraduate programmes. In the health sciences field higher education levels are tied to improve skills and practically advanced knowledge through certification, thus the policy intended to reward knowledge and skills improvement that translated to enhance clinical performance.

#### *3.4.3.3 Category 3.3: Short courses not considered for OSD*

The SANC introduced short courses as an attempt to replace the skills shortages within the Public Health Sector. These were later curtailed when they failed to achieve their intended purpose. Further misunderstandings seem to emanate from the following short courses for professional nurses that were approved by SANC and promulgated in Government Notice R238 of 13 February 1981, Government Notice R237 of February 1981 the government Notice R670 of 31 March 1983: renal nursing, stoma care nursing, occupational health nursing and spinal injury.

Due to community changing needs, the calibre and volumes of patients that are received in the public institutions, nurses are using expertise they gained from the short courses to render services to communities as revealed by the narratives below:

"I am allocated in the radiology department. I prepare and set trays for embolisation and assist doctors to give radiation to oncology patients. I am exposed to a lot of radioactive rays, I must be OSD compensated. I feel this is a specialty function that is why I wrote to the SANC motivating for the course but unfortunately I did not get any feedback or advice".

> "I have worked in the crisis centre since 2002. I did forensic clinical course which was not registered with the SANC, but there was a promise that it was going to be recognised by the South African Qualifications Authority (SAQA) and finally by SANC. I do a lot legal work which include, age and mental assessment, manage sexually assaulted cases, give post exposure prophylaxis, manage blood for deoxyribonucleic acid (DNA), conduct pre and post confession interviews, manage blood from drunken drivers and manage ex-military pensioners. This is a national programme, monitored by the Honourable Minister of Justice. Most nurses are reluctant to deal with the sensitive issue of sexually assaulted clients, but those who are committed to the job are not recognised by OSD".

Recently a document (DoH 2012:1) came out stating that the National DoH is drawing up a database of all nurses that have undergone training in Clinical Forensic Nursing and or Sexual Offences, nationally. These nurses are requested to submit the following information: Full names, ID number, type of training undergone, contact numbers (office and cell numbers) present appointment including institution and department. It is said that this information is required for planning and also to facilitate the recognition of the qualification by SANC for OSD purposes. This further confirms that nursing OSD system is continuously being reviewed to close the gaps identified during the implementation.

The SANC Regulations, R237 and R238 were later repealed under Government Notices R1746, R1747 AND R1748 in August of 1994 when SANC resolved that " it would no longer regulate short courses that were less than one academic year" (SANC 1984). According to Ngwenya (2009:504) many frustrations and dissatisfaction among professional nurses were due to the fact that short courses they have were not accredited by the SANC and did not qualify them to benefit from OSD.

**Table 3.2 A comparative analysis of professional nurses (PNs) with 'specialty' and without 'specialty' qualifications**

| | PNs with specialty on 30.06.2007 | PNs with NO specialty on 30.06.2007 |
|---|---|---|
| 1 | OSD specialty paid | OSD specialty not paid |
| 2 | Long service (experience) recognised and remunerated according to OSD | Long service (experience) working in a particular specialty area not recognised by the OSD |
| 3 | Rural allowance paid (if in rural area) | Rural allowance paid (if in rural area) |
| 4 | Dual career path: Progress to higher levels with salaries equal to/or higher than that of mangers in general nursing without moving into post | Translate as a once-off provision to the lowest salary scale attached to production post (entry level) in that specialty |
| 5 | Career path by means of grade progression for PNs who choose to remain at production levels, than move into supervisory posts | No grade progression to higher salary scale attached to the post in that clinical specialty without first obtaining the required qualification |
| 6 | (3%) pay progression every two years without to supervisory post in that specialty | (3%) pay progression every two years in the 'General 'nursing stream |
| 7 | An employee with specialty qualifications (according to R48 and R212) working in a non-specialised unit forfeits specialty benefit | In the absence of post-basic qualifications but working in specialty units due to staff shortages, a salary structure applicable to General Nursing stream will be paid for replacement of that specialty |
| 8 | Request for transfer by specialty nurse to General Nursing: A lower scale attached to the post with reduction in the relevant notch applies | Request for transfer by professional nurse without speciality to General Nursing: A General Nursing stream salary structure is applicable |
| 9 | Employer initiated transfer to General Nursing: A lower scale attached to the post with retention of salary notch will be paid | Employer initiated transfer to General Nursing: A General Nursing stream salary structure is applicable |
| 10 | PNs on study leave (training ranks): Non-OSD employment and remuneration framework apply | PNs on study leave (training ranks): Non-OSD employment and remuneration framework apply |
| 11 | Facility managers (Assistant Directors) in large Community Health Centres (CHCs) and sub-district managers shall translate to Assistant Manager Nursing (PHC) | Managing without PHC specialty shall translate as a once-off provision to the appropriate salary scale at management level in that specialty |
| 12 | Facility managers in small clinics shall translate to operational managers nursing (PHC) | Managing without PHC specialty shall translate as a once-off provision to the appropriate salary scale attached to the related management level |
| 13 | All employees from outside public hospitals shall comply with requirements for OSD (returnees and internal nursing employees) | All employees from outside without the required specialty, qualify for entry level scale only (returnees and internal nursing employees) |
| 14 | Newly qualified (4 year course) with relevant specialty qualifies for OSD specialty benefits | PNs with 20 years-service experience without the required specialty in that specialty area do not qualify for specialty benefits |
| 15 | Diploma in clinical assessment, diagnosis, Treatment and Care translate to PHC | OSD for specialty not applicable without first obtaining required qualification (PHC) |

(Adopted from DPSA 2007:8-11)

### 3.4.4 Theme 4: OSD as a solution

Arising from the probing questions during in-depth interviews and focus group discussions this theme and the categories emerged. The probing question was asked to all the participants as: what were your lived experiences with the implementation of OSD at the Umgungundlovu district in KZN?

#### *3.4.4.1 Category 4.1: OSD a solution to migration*

South Africa had experienced a critical shortage of human resources for health particularly within the nursing profession at a time when the population and the burden of ill health due to HIV/AIDS and TB are on the increase. This shortage was severe within the nursing profession, which has witnessed significant emigration due to poor remuneration. The introduction of OSD in 2007 sought to improve the public services 'ability to attract and retain employees (George & Rhodes 2012:1). In the focus group discussions with nurse managers most of them agreed that OSD has reduced migration to overseas and from public sector to private sector as revealed by narratives below:

> "OSD has stopped migration of nurses; they are now returning back from overseas and private sector as they are attracted by the salary package".

> "OSD implementation helped to stop migration of nurses, they are now retained in their areas of specialisation especially ICU and theatre".

It emerged from in-depth interviews with professional nurses that although the level of migration to overseas had drastically reduced but the general stream nurses are now migrating from public sector to private sector believed to be induced by being not OSD recognised and inhuman work environment as revealed by narratives below:

> "I can tell you now; I am leaving, going to private sector, serving my one month notice, particularly because I need to develop professionally. I have already signed with them that after six months post employment they will send me to do Trauma course unlike public sector where you have to wait for one full year accumulating experience before you can be considered for post-basic training".

> "I need to support my family, everything is too expensive. Private sector offered me a better salary scale than what I'm earning now, although it is with much sadness as I have been here for seventeen (17) years".

> "Yes it is a solution to those who benefited a lot from it, like the specialty nurses".

According to Hadebe (2009:10) with OSD intervention there is huge improvement with more nurses coming back into the system meanwhile other provinces are still unable to prevent nurses from seeking better employment elsewhere.

#### *3.4.4.2 Category 4.2: OSD a solution to moonlighting*

Mabuda (in Rispel 2008:17) highlighted some challenges faced by health facilities with regard to moonlighting and nursing Agencies. He reported that there is general shortage of professional nurses especially with experience in specialty nursing and post-basic nursing qualifications including critical care, operating theatre technique, orthopaedics, advanced psychiatric nursing science and advanced midwifery nursing science. Many health institutions do not maintain a Remunerative Work outside Public Sector (RWOPS) register (which is an application by the employee to do RWORPS and proper screening by the employer before approval) and or have written approval on file of the nursing staff members who participate in remunerative work through nursing agency. RWOPS stipulates that nurses and doctors must seek permission to do work privately if they are employed by the state.

The perceptions that emerged for moonlighting during data collection were two-fold; nurse managers based their views to the fact that RWOPS has been stopped as revealed by narratives below:

> "No nurse is allowed to do moonlighting, if doing so they are transgressing the instruction from the Head of department".

> "RWOPS have negative implications on service delivery, including high absenteeism, abuse of sick leave privileges, high stress levels especially to those left to pick up the slack due to work overload".

> "Some nurses are continuing to moonlight without approval, they are risking their jobs, if found, will be disciplined as they were made to read, sign and implement the circular on stopping RWOPS".

General stream professional nurses based their views on fact that they did not benefit from OSD, their salaries are not enough as revealed by narratives below:

> "I have a lot of debts trying to support my family as a breadwinner. Unfortunately moonlighting has been stopped by the Provincial Department of health. I am now selling Tupperware to top up my salary".

Provincial Human Resource circular came out stating that remunerative work outside public service has been withdrawn with effect from 01 January 2010 whilst the DoH reviews control and processes Circular 161 (DoH 2007e:2)

#### *3.4.4.3 Category 4.3: OSD a solution to professional development (career path)*

The implementation of OSD put in place a proper career-path model for occupational categories. Such a model was not an automatic salary increase but a forward-planning framework to systematically increase salaries after pre-determined periods based on specific criteria such as performance, qualification, scope of work and experience (Fouche 2007:1).

According to DPSA (2007:5), all professional nurses who received once off payment because they were working in the specialty units without post-basic qualifications of relevant specialities must be given first preference to do post-basic courses. Most nurses are eager to develop as revealed by narratives below:

> "I consider myself lucky to work in a specialty unit, I benefitted to a once off payment, now OSD implementation has encouraged and indirectly forced me to do post-basic course".

> "I have recently done the post-basic qualification, I am happy because I have acquired more knowledge and skills that I apply to render quality patient care".

According to the DoH (2010:18), career progression was to be closely linked to performance so that progression does not become an automatic occurrence. Each health professional category would in terms of this policy have a career path within the public sector. Most professions would have continuing professional development (CPD) systems that are linked to management of performance.

### 3.4.5 Theme 5: Disparities in allocation of OSD

The differences and inequalities in the OSD salaries would have not been an issue should HR in the provinces read and followed the agreement and remunerative policy for professionals employed in the public sector. It was recommended that when fixing remuneration of health professionals, regard has to be given to the nature of the work the employee was doing, rather than to fixed salary scales across the board (DoH 2010:6).

#### *3.4.5.1 Category 5.1: Gross inequality on salaries*

According to DPSA (2007:1), the OSD came into being following an identified need to adjust the remuneration policy, processes and systems in organisations to continuous changing circumstances including South African public Service. Consequently it was found that the existing remuneration framework in the RSA was failing to attract and retain sufficient skills crucial to improve public service delivery. Professional nurses among others continued to exit the public health sector. Given this challenge, government policies regarding remuneration of public servants were subject to change, after an agreement with organised labour was reached. A new salary structure OSD was subsequently introduced to attract and retain employees with effect from 01 July 2007, in agreement with PSCBC Resolution 1) (PHSDSBC 2007:1).

> "I am very excited to announce to our nurses that as a result of the agreement we have signed today, 14 September 2007, the entry level salaries for staff nurses will increase by 20%, the entry level salaries for Nursing Assistants and professional nurses in general nursing will be both increased by 24%. Nurses are going to get increment of between 20 and 80 percent".

The nurses were disappointed as they did not benefit from OSD; only those with specialties did, as revealed by narratives below:

> "The rest of us registered nurses are bitterly disappointed and angry with the manner in which OSD had been implemented in KZN. Other provinces have had no problems."

> "My morale is very low, I thought OSD was going to have a positive impact in my life but it has worsened things because of huge salary scale difference. Some of my colleagues can pay half of my salary yet we qualified same month and year".

> "My salary is still too inadequate for me to make a living; I am still living from hand to mouth".

> "Nurses salaries are very low, at the level of the secretary/ or junior clerk and yet they are regarded as an essential service and the bedrock of the Public Health Service, but when it comes to their pay, it is shocking".

The narratives above are supported by Tota (2008:37) who questions whether this is being done to nurses because the majority of them are women and therefore not capable of fighting for their rights. Or whether this is done to nurses because nursing is not viewed as career but as a calling? What has happened to the slogan, "Wathint 'abafazi wathint'imbokodo"? {You strike a woman, you strike a rock}.

The introduction and implementation of the OSD has made significant progress in reducing the wage gap or disparity between human resource for health in our country and the rest of the world (George & Rhodes 2012:10). This was also confirmed by the quiet response from nurses when Dr Mahlathi asked if there was any nurse general or specialty who would consider the old pre-OSD salary package during his visit in one of the Umgungundlovu district hospitals.

Tshabalala-Msimang (2007) pointed out that through engagement with other state institutions; an additional amount of R1.4 billion was allocated for the improvement of salaries for nurses through the OSD signed with the health sector unions. This seemed to suggest a general increase for all nurses. However, the DPSA (2007:3) stated that the implementation of OSD did not entail a general salary increase for employees in

these occupations or that all nursing employees will gain the same financial benefit with implementation of the respective OSD. The reason for this was that the new salary structure would use posts and grade progression.

#### *3.4.5.2 Category 5.2: Different salary packages*

The data analysis indicated that participants were disturbed that there were disparities in the implementation of OSD in general as revealed by narratives below:

> "Primary Health Care Assistant nursing manager and operational managers are earning more than us at the hospital levels. It is really disturbing because they refer patients to us, some of them having not properly investigated and managed well, yet once the patient complicates we must do damage control".

> "In the units we are working in, we are earning different salaries. I think we should have been placed on the same salary scale, because after all we are working as a team, there isn't any place where nurses are just seated doing nothing. So it should be reversed".

> "There is a huge gap of salary package between myself as an Operational Manager General stream and my colleague operational manager specialty stream. We are doing the same management functions and apply the same generic processes of management. Implementers should have consulted us, people at the ground level. They can still correct it if they really consider nurses as important as they are saying".

> "I regret applying and getting the Assistant Manager Nursing post from being an operational manager. There is little or no difference in my salary, instead I have added myself more work and responsibility. I am now supervising eight wards instead of one".

As far back as 2001, government had introduced a job evaluation system, some provinces proceeded to upgrade the salary levels of certain health professionals categories resulting in salary disparities across the public health sector (DoH 2010:6).

According to Minnaar and Selebi (2009:33), salaries of nurses are poor; nurses left their employment because they experienced discrepancies in salary structures of other professionals. The dissonance between pay and responsibilities which nurses are experiencing now, lead to staff turnover and need attention from management in health services.

#### *3.4.5.3 Category 5.3: Exclusion from OSD*

The data analysis revealed that nurses have a lot of unresolved issues. They have unanswered questions that need explanations but human resource were and still unable to give explanations as stated by some of the participants.

> "I went to human resource to find out why I did not benefit from OSD as I was on study leave on the 30th June 2007, being seconded by the institution's human resource development and nurse manager. The answer from HR practitioner was: Hamba uyobuza kumatron wakho asazilutho thina (Go and ask your matron we know nothing)".

> "I really don't understand, I was officially on vacation leave on the month of June 2007. My colleagues benefitted from OSD and I did not. This does not make sense because is a must, not a privileged, it is catered in the Basic Conditions of Employment Act. My leave was also scheduled with my supervisor". Thus physical absence from duty/ ward on 30 June 2007 meant exclusion from OSD.

> "Our colleagues without post-basic qualification benefitted a lot because they were lucky to work in the so-called OSD specialty units. They were given the once-off translation, which did not do justice to us general stream nurses. We are professional nurses irrespective of where we work and allocated".

DPSA (2007:5) stated that professional nurses who occupied a designated post in a nursing speciality and who are **not** in possession of the prescribed post-basic clinical nursing qualification recognised (accredited) with the SANC and listed in Government notices R48 or R212, but who are permanently appointed in a post in such a speciality unit and has been performing these duties satisfactorily on 30 June 2007, translate as a **once-off provision** to the lowest grade (salary scale) attached to the production post. This professional mentioned above shall not progress by means of grade progression to

the higher grade (salary scale) attached to the post in the clinical specialty without first obtaining the required post-basic clinical nursing qualification in the specialty.

According to Dolamo (2009:33), the previous Minister of Health, Barbara Hogan raised the issue which brought hope in the health fraternity that the government has become aware that people in civil services are generally not well paid compared to the private sector, hence the introduction of OSD which had some problems. Some of the participants especially those who did not benefit from OSD, disagreed that OSD salary structure was a solution.

### 3.4.6 Theme 6: Benefits of OSD

Although there is a big cry about implementation of OSD, there are positive things that were brought by OSD. Nurse Managers and some nurses were satisfied about the implementation of OSD, especially those who benefitted (specialty stream) as revealed by narratives below:

#### *3.4.6.1 Category 6.1: OSD stopped migration of nurses*

> "OSD has not stopped migration but reduced it. Remember not all nurses leave to overseas for monetary value, some just want to experience something different but the number of nurses migrating to overseas countries has been reduced drastically".

#### *3.4.6.2 Category 6.2: OSD has recognised other post-basic qualifications*

> "I am happy my post-basic qualification as a Paediatric nurse has been recognised by OSD, unlike scarce skills allowance which recognised critical care and operating theatre courses only".

#### *3.4.6.3 Category 6.3: Future employment targeted skilled qualified individuals*

> "It is very easy for me to get a job anywhere as I possess a post-basic qualification certificate. It looks like OSD has targeted skilled, competent and knowledgeable individuals".

#### *3.4.6.4 Category 6.4: OSD does not allow rotation of staff*

> "OSD salary structure does not allow for rotation of employees from one stream to another, thus we are happy as specialty nursing stream because we are now practising in our specialty departments not moved up and down)".

#### *3.4.6.5 Category 6.5: Increased salaries of all nurses*

> "Let us agree and thank our government, salary structure for all nurses were increased".

> "OSD improved nurse's salaries as they were very low at the level of secretary and yet they are regarded as the backbone of the Department of Health. Some nurses benefited a lot in terms of remuneration".

According to the DoH (2010:8) there has been no salary differentiation for professionals who obtain a higher level of education through the available postgraduate programmes. It is therefore the policy intention to reward knowledge and skills improvement that translates to enhanced clinical performance.

### 3.4.7 Theme 7: OSD challenges

The migration of skilled public sector employees led to the development and implementation of OSD in 2007 by the South African Government. The OSD aimed at improving the conditions of service and remuneration for public service workers, including public sector health professionals.

The objectives of the OSD were to improve the public services' ability to attract and retain employees, to provide differentiated remuneration dispensations for the vast number of occupations in the public service, to cater for the unique needs of the different occupations, to provide a unique salary structure per occupation, to prescribe grading structures and job profiles to eliminate inter-provincial variations and to provide adequate and clear salary progression and career path opportunities based on competencies, experience and performance.

### *3.4.7.1 Category 7.1: Challenges related to differences of interpretation*

The data analysis revealed that a number of challenges mainly related to differences of implementation of OSD were encountered during the implementation process. There were differences in approach to translation between provinces and institutions as revealed by narratives below:

> "My colleague (assistant nursing manager) is supervising surgical/orthopaedic department with critical care post-basic qualification, benefited from OSD in her institution whereas I am also supervising surgical/orthopaedic department having operating theatre post-basic qualification but did not benefit'.

> "We have friends and families from other provinces who informed us that Accident and Emergency Unit have been classified as a specialty unit. We fought up to the end and we classified as specialty and benefited from OSD, we could see that we were being robbed".

This was in contrast with the Provincial Human Resource Circular (DoH 2008:1) which stated that Trauma and Emergency unit was not a clear cut specialty area, investigation in all institutions was conducted to determine the actual number of specialty posts required if any, the posts identified were to be advertised. At the end posts were not advertised, HR from the institutions were instructed to do costing because nurses were doing this specialty function without being paid thus they benefited.

> "It is clear that nurses at the production were not there during OSD negotiations. How on earth could you leave maternity when MDGs 2 and 3 talks to maternity. We are happy because we fought until we got what was due to us. Maternity midwives with one year midwifery certificates were finally recognised, unlike when it was initially implemented and only considered those with Advance midwifery and neonatal post-basic course".

The National DoH also communicated a circular stating that it had come to their attention that there were differences in approach to translation between provinces, reporting that employees appointed in provincial head offices wanted to be translated because they claimed that their colleagues in other head offices were translated. The department also identified a gap that some programme managers have been incorrectly

translated to R235 659 instead of R180 000 The Department acknowledged that there was also lack of uniformity among provinces in recognising specialties due to lack of synergy between R212 and DPSA implementation directive (Manana 2008:3).

#### *3.4.7.2 Category 7.2: Critical units left out by OSD*

The participants indicated that some critical units were left out by OSD, as they felt that medical wards should have been considered due to the increase of HIV/AIDS as revealed by narratives below.

> "This makes me wonder why medical wards were left out, HIV/AIDS and TB are regarded as National priorities and also taken care by the Millennium Development Goals (MDGs), but when it came to money we were left out. I have colleagues who have contracted TB in the medical wards, others are diagnosed as MDR but guess what? No compensation is given".

> "Kubuhlungu, siphele amandla nomdlandla. Okusalayo siyazithanda iziguli zethu". {This is painful and discouraging, but we still love our patients}.

> "It is disheartening to experience and witness what is happening in the medical wards. We are infected by TB/MDR every day, some of our colleagues are admitted in the TB institutions, protective clothing, working environment and infrastructure is not up to the standard. We are getting no compensation, and sadly not recognised by OSD".

> "My experience of working in the medical ward is very bad. Many mental health care patients are now admitted in the medical wards for 72 hours observation according to the new Mental Health Care Act, before transferred to psychiatric institutions (South Africa (Republic) 2002:45). We are allocated in these wards without midwifery or psychiatry courses. A patient went missing while my colleague without psychiatry post-basic qualification was on duty. Patient was searched for and was later found dead. The investigation was conducted and finally the professional nurse was found guilty, suspended for 3 months without pay. The sadness of the enquiry was that the investigator asked why she nursed psychiatric patients when she was not trained as a psychiatric nurse. Nobody could protect her as she did not allocate herself in that ward. No danger allowance is given to us

because we are not psychiatry institutions, yet we nurse these patients whilst they are acutely ill and very aggressive.

Abaphathi abasibhekelele basivikele ngoba bayazazi izimo esisebenza ngaphansi kwazo. Abangenzi sengathi kuhamba kahle konke ezikhulwini" {Management should relook and protect us because they are fully aware of our working conditions. They must not pretend as if everything is running smooth in front of the provincial authorities}.

Section 34(1) of the Mental Health constitutes a 72-hour assessment and findings of medical practitioner or mental health care practitioner after head of health establishment has granted application for involuntary care, treatment and rehabilitation. This assessment is also done to assess the general physical health and exclude signs of communicable diseases from mental conditions (South Africa (Republic) 2002:45). The person placed in a 72-hour hold must be advised of his or her rights. During this involuntary hold, the hospital is required to do an evaluation of the patient, taking into account his/her medical, psychological, educational, social, financial and legal situation. By the end of 72-hour hold, the patient may be released, sign in as voluntary patient or put on a 14day involuntary hold (a "certification for intensive treatment").

"I want to know what specialty course do. I need to do as I am working in a medical ward. I will never do any post-basic qualification course whilst I am working in this institution. I will be pushed up and down to cover the shortage because I am a general nurse".

"It is heartbreaking not to be considered by OSD in the renal unit. Renal is incorporated in the ICU course, just as cardiology. We are exposed to a lot of body fluids, Nurses working in the coronary care unit benefited whilst we did not and yet we do haemodialysis which is a highly specialised procedure, our colleagues from other institutions have benefitted".

Data analysis also revealed that there was non-recognition of specialty units in the district hospitals as revealed by the narrative below:

I have Intensive Nursing Science post-basic qualification, and I am working in a high care unit (High Dependency Unit) nursing ICU patients that are ventilated whilst looking for the bed at the Regional/Tertiary institution. Some get better and

discharged to the wards having not being transferred to tertiary/Regional hospitals because there is a high demand of ICU beds. I am very much discouraged, because my nurse manager is aware of the tasks that I do, but cannot force Human Resource to consider my specialty as they said I do not qualify. At the end HR knew nothing about nurses' specialties and activities and they act as if the money is coming from their pockets".

#### *3.4.7.3 Category 7.3: Changing of titles of nurse managers*

Participants felt that there were conflicting ideas and interests from National DoH Professional Associations, nursing representatives and unions as revealed by nurse managers below:

"OSD changed my title from nurse manager to deputy nurse manager yet I am occupying an executive level under CEO with Medical, Finance, Human Resource and Systems managers. It was not clear whom to deputise, and how to deputise somebody you are not working with".

"The job description aligned to OSD KZN Intranet stipulates that Deputy Manager Nursing for Level 1 and 2 hospitals will report to the Manager Nursing Central /Tertiary institution, how feasible is that? How is this going to help effective and efficient service delivery when the Manager Nursing in the Central/Tertiary institution is inundated with her own institutional needs and problems? What is the role of the hospital manager (CEO)? Should he/she be ignored and problems reported to Manager Nursing (Central/Tertiary) while he/she is on site. Nobody from the Department of Health has ever checked and followed its applicability".

"I was called to a meeting and informed very categorically that I must now assume the post of Assistant Manager Nursing (AMN Area) monitoring and evaluation (level 10) from Deputy Nursing Manager (level 11). This came with shock, anger and dismay, turned very sour and ironic as it had serious implications in my salary package in terms of OSD. I was going to be downgraded. I applied for Deputy Nursing Manager's post, underwent interview processes and was appointed. I want to know who demoted me and why am I demoted"?

"The nursing college principals and their deputies retained their titles. Is this because nurses at production level were represented by nurse educators who do

not have any interests at heart of what is happening in the clinical area, and thus decided the fate of clinical nurses".

The International Council of Nurses (ICN) (2005) advocates for nurses to be protected from false information, the withholding of relevant information, misleading claims and exploitation pertaining to job descriptions, benefits or allocation of specific offers. Accordingly access to truthful employment – related information should be guaranteed, as well as the concept of informed consent to all parties involved in employment issues and negotiations. In the (Task Team Meeting 2007:2) it was explained that there was a need to standardise former job titles across all the provinces to create synergy and consistency in management structures.

#### *3.4.7.4 Category 7.4: Ethics and professionalism deteriorated within the nursing profession*

Data analysis from focus group discussion with nurse managers indicated that it has become a critical issue and difficult to maintain ethical standards and norms within the nursing profession as revealed by the narratives below:

> "We are experiencing a big problem which compromise patient care, nurses are uncooperative with negative attitude and angry. They do not want to do more, are very reluctant to be requested and asked to go and relieve in the areas where there is staff shortage because of this disfunctioning OSD. Nurses from general stream wards are saying that they are not paid for specialty duties; they feel specialty nurses must work because they are paid".

> "It looks like no general nurse want to take responsibility. Emotions are very high, division is increasing amongst nurses, there is gross absenteeism and team work is negatively affected".

The ethics theory of teleology (consequentialism) focuses on the ends or consequences of actions. The choice of action in this theory maximises good over the bad (Brunner & Suddarth 2008:27).

According to Pera and van Tonder (2005:10), nursing is an inherently moral enterprise and the nursing profession is only as strong as its commitment to its ethical obligations

and values. Nursing codes of ethics have established high ideals and make many demands on nurses.

#### *3.4.7.5 Category 7.5: OSD not supportive of DoH Recruitment and Retention Strategy*

According to DPSA (2007:1) the remuneration policy, processes and systems of any organisation must be dynamic to adapt to continuously changing circumstances. Recent studies have shown that the then current remuneration framework impacted negatively on the state's ability in attracting and retaining sufficient numbers of employees with the required competencies in certain occupations, and to motivate such employees with the view to improve service delivery.

During data analysis the participants appeared to be confused and worried to discover that OSD worked to the advantage of returning professional nurses to the public health sector, evidenced by their disapproval of OSD being used as a recruiting and retention strategy as revealed by the narratives below:

> "It is surprising to see that nurses who resigned and enjoyed all their benefits, then decided to come back to the department, enjoy the most. Their experience is taken into consideration by OSD whilst those who honestly remained, loyal to the government and served the communities despite poor salaries, their experience was not considered".

> "You can only be recognised as a faithful and loyal employee when you are a fixed term employee that has resigned or retired as they were remunerated for their experience, but we, the ones who remained to continue service delivery were not recognised. The government is only interested in attracting and recruiting the nurses who left the department for greener pastures, and has no interest to the loyal, honest nurses".

> "I am a professional (PN Grade 1) speciality, my post-basic qualification certificate is only three years, which means that it is going to take me another seven years to apply for PN Grade 2 post thus I will leave to private sector if they offer me an attractive salary package".

According to the Retention Strategy (DoH 2009:5), one of the challenges faced by the DoH in KZN is perpetual staff shortages as a result of attrition, which includes resignations, deaths, medical boarding, dismissal and others. The provincial human resource provided guidelines for advertisement and filing of OSD posts as follows:

**Table 3.3 Advertising of OSD posts**

| Post | Salary | Experience |
|---|---|---|
| PN GR1 General Stream | R106 086 | No experience required |
| PN GR2 General Stream | R130 473 | A minimum of 10 years appropriate/recognisable experience in nursing after registration as professional nurse with SANC in general nursing |
| PN GR3 General Stream | R160 470 | A minimum of 20 years appropriate/recognisable experience in nursing after registration as professional nurse with SANC in general nursing |
| PN GR1 Specialty | R160 470 | A minimum of 4 years appropriate/recognisable experience after registration as a professional nurse with SANC in general nursing of which 1 year must be appropriate/recognisable experience after obtaining one year post-basic qualification |
| PN GR2 Specialty | R197 358 | A minimum of 14 years appropriate/recognisable experience after registration as a professional nurse with SANC in general nursing of which 10 years must be appropriate/recognisable experience after obtaining one year post-basic qualification |

(Adopted from DoH 2007d:3-4)

From the above information table, it is clear that general stream nurses were not recognised by OSD. Professional nurse, grade 3 general streams with 20 years experience getting the same salary with PN grade 1 specialty with 5 years experience (4 years experience after registration as PN with SANC and 1 year experience after obtaining one year post basic qualification). In their exasperation, the only way out appeared to be resignation from their posts, which actually seemed to defeat the purpose of OSD to attract and retain employees especially nurses.

## 3.5 SUMMARY OF DATA ANALYSIS

From the above data analysis, most respondents did not benefit from the new salary structure, probably due to government's intention to use it as a recruiting and retention

strategy for specialty qualifications. It seemed no prior information was provided on the distribution of OSD in terms of who would benefit and what was required to qualify for OSD. There is still a lot of unhappiness with regard to the OSD implementation and it is primarily about the big gap of salaries and how implementers can get feedback and review OSD implementation. As an emphasis of the above summary there is one narrative attached that excited the researcher (annexure I).

## 3.6 CONCLUSION

This chapter presented the data themes and categories that emerged from data analysis. Relevant literature was also referred to as a control for research findings.

In the next chapter the conceptual frame work is analysed and the summary of the framework is presented.

# CHAPTER 4

# CONCEPTUAL FRAMEWORK

## 4.1 INTRODUCTION

Chapter 3 dealt with data analysis and literature control. The data analysis in the previous chapter indicated that an overwhelming majority of nurses were emphatically dissatisfied with the new salary structure. In trying to explain the experiences of nurses on the implementation of OSD there was a need to identify and select the theory most appropriate to form the basis or framework of this study. This chapter analyses Adams Equity theory on job motivation and the pay in relation to the study's findings and summarises participant's experiences and narrative statements extracted from focus group discussions and in-depth interviews.

## 4.2 ADAMS' EQUITY THEORY

Equity theory is a theory that attempts to explain relational satisfaction in terms of perceptions of fair/unfair distributions of resources within interpersonal relationships (Adams 1965:1). It is considered one of justice theories that asserted that employees seek to maintain equity between inputs that they bring to a job and the outcomes that they receive from it against the perceived inputs and outcomes of other (Spector 2008:8).The major postulates of this theory are that: the perceived inequity creates tension in the individual, the amount of tension is proportional to the magnitude of the perceived inequity, the tension created in the individual will motivate him to reduce it, the strengths of the motivation to reduce inequity is proportional to the perceived inequity and the concept of equity is most often interpreted as a positive association between an employee's effort on the job and the pay he or she receives (Spector 2008:14).

The belief is that people value fair treatment which causes them to be motivated to keep the fairness maintained within the relationships of their co-workers and the organisation. Adams equity theory can serve as a guide to pinpoint issues and challenges in the new

salary structure which are identified as equity, inequity, comparison, inputs and outcomes, in the context of OSD implementation.

### 4.2.1 Comparison/referent

Adams Equity theory model extend beyond the individual self, and incorporates influence and comparison of other people's situations, such as colleagues and friends in forming a comparative view and awareness of equity which commonly manifest as a sense of what is fair (Spector 2008:14). Adams equity theory further explained why pay and conditions alone don't determine motivation. Participants in their narratives were often comparing the work and pay in their situations, saying that all nurses are contributing towards quality patient care but only one category that PNs specialty benefited from OSD. This confirmed and emphasised that what nurses put into their work included many factors besides working hours and that what nurses received from their work included many things apart from money.

Adams used the term **'referent'** others to describe the reference points or people with whom we compare our own situation. In this study nurses working in general stream wards compared themselves with nurses working in the specialty wards that nurses are all working under similar situations including inhuman work environment, increased health burden due to HIV/AIDS, TB, trauma and accidents and others, but only one category or classification benefited from OSD. This was termed as unfairness or inequity.

### 4.2.2 Inequity/unfairness

This theory helped to provide the basis for studying the motivational implications of perceived unfairness and injustice in the workplace. It laid the foundation for more recent theories on distributive (how much is allocated to each person) and procedural equity (how rewards and job requirements are determined) (Cropanzano & Folger 1996:4). In a meta-analysis of many of these theories, Cohen-Charash and Spector (2001:321) found that both distributive and procedural equity were related to job performance, job satisfaction and the intention to quit which is applicable to this study of OSD implementation.

The way people base their experience with satisfaction for their job is to make comparisons with themselves to people they work with. If an employee notices that another person is getting more recognition and rewards for their contributions, even when both have done the same amount and quality of work, it would persuade the employee to be dissatisfied (Hackman & Lawler 1991:260). In any position, employees want to feel that their contributions and work performance are being rewarded with pay. According to Adams (1965:3), anger is induced by underpayment inequity and guilt is induced with overpayment equity.

In this study, implementation of OSD was in direct contrast with the idea of equity theory, in the sense that participants that did not benefit from OSD verbalised being underpaid resulting in them feeling hostile towards the DoH, the government and their colleagues. They feel underappreciated, worthless and demotivated. These perceptions of inequity have caused some nurses especially general stream, to take actions to restore equity such as quitting the public health sector by resigning or applying for a transfer to other institutions with different positions. Some are reacting by producing less thus reducing their efforts, some attempting to exert a restrictive influence on the performance of others and being uncooperative.

### 4.2.3 Equity/fairness

Employees seek to maintain equity between the inputs that they bring to a job and the outcomes that they receive from it against the perceived inputs and outputs of others (Spector 2008:8). According to the Equity theory when people feel advantageously or fairly treated they are more likely to be motivated, a highly motivated employee is the one who perceives his rewards are equal to his contributions, thus ‘all else being equal’. In this study, it would be acceptable to the participants for the senior nurses to receive higher compensation, since the value of their experience (input) is higher. This would mean that the rewards (OSD payment, outcomes) are directly related to with the quality and quantity of the senior, experienced nurses’ contributions (inputs). Another option recommended by participants was that all nurses should have been rewarded with a flat rate across-the-board wage increase which may have delighted all nurses. The nurses would have realised that the government is fair, observant and appreciative.

### 4.2.4 Inputs

Inputs are defined as each participant's contributions to the relational exchange and viewed as entitling to rewards, and they are logically what we give or put into our work (Hackman & Lawler 1991:260). The Adam's equity theory of work motivation describes inputs in terms of effort, loyalty, hard work, skill, commitment, colleague support, personal sacrifice, ability, tolerance, and trust in superiors, determination, heart/soul, enthusiasm and determination. The basic idea behind the Equity Theory is that employees, in an attempt to balance what they put in to their jobs and what they get from them, will unconsciously assign values to each of their various contributions.

In this study participants revealed that in addition to their time they contributed their experience, qualifications, skills, loyalty, competency, capability, acumen and ambition. They feel that most of their inputs were not appreciated by the government in the sense that their experience and academic qualifications were not recognised by OSD.

Furthermore those who were loyal to the government, did not go overseas for greener pastures were not favoured by OSD but instead those who resigned and now coming back are highly considered by OSD. The Equity Theory thus confirms that participants are demotivated in relation to their job and employer because their inputs are greater than outputs.

### 4.2.5 Outputs

Outputs are defined as the positive and negative consequences that an individual perceives a participant has incurred as a consequence of the relationship with another. The Adam's Equity Theory describes outputs as typically all financial rewards including salary, expenses, perks, benefits, pension arrangements, bonus, commission, recognition, reputation, praise, interest, responsibility, stimulus, travel, training, and development, sense of achievement, advancement career path and promotion. The theory further shows that employees strive to achieve equity between themselves and their co-workers. This equity can be achieved when ratio of employee outputs over inputs is equal to other employee outputs over inputs. The outputs include financial rewards, like pay increase, benefits and job security.

The participants, general stream nurses were not happy about OSD implementation saying that it has segregated nurses choosing specialty stream over general stream. All nurses are working hard, looking at the disease profile; the very generalist nurse is overworked, contracting diseases, but not OSD recognised. The Nursing Management is now concentrating on training the professional nurses working in the specialty units without post-basic qualification that benefited from OSD (once off payment).

#### *4.2.5.1 Propositions of equity theory*

According to Walster, Walster and Bershcheid (1978:3), the equity theory propose that when individuals find themselves participating in inequitable relationships, they become distressed, the more inequitable the relationship, the more distress individuals feel. According to equity theory, both the person who gets “too much” and the person who gets “too little” feel distressed. The person who gets too much may feel guilt or shame. The person who gets too little may feel humiliated.

## 4.3 APPLICATION OF EQUITY THEORY IN THE ORGANISATIONS

Equity Theory has been widely applied to business/organisational settings by industrial psychologists to describe the relationship between the employee’s motivation and his or her perception of equitable or inequitable treatment (Adams 1965:4). Employees compare themselves with other employees who do not put in the inputs that are equal to the outputs they receive. In the ward situation there are individuals who may be present physically but when one ask for tasks done they are none. They tend to compare themselves with other employees to find out if they are being treated fairly (Spector 2008:10). They seek a balance between their inputs and outputs and it is not always possible to provide them with correct balance. According to Clay (1997:1), nursing as a profession has not been taking notice or reacting to changes that have been taking place around its practice.

OSD implementation caused poor human relationships amongst nurses. Both specialty and general stream nurses are distressed in the sense that those who benefitted from OSD feel guilty as if they are the ones who said others must not benefit, and the ones that did not benefit are angry and feel humiliated. Individuals who perceive that they are in an inequitable relationship attempt to eliminate their distress by restoring equity. The

greater the inequity, the more distress people feel and the more they try to restore equity. Most nurses who are general stream are requesting to be allocated in the specialty wards, resigning, to go and undertake training so as to upgrade themselves and migrating to private sector.

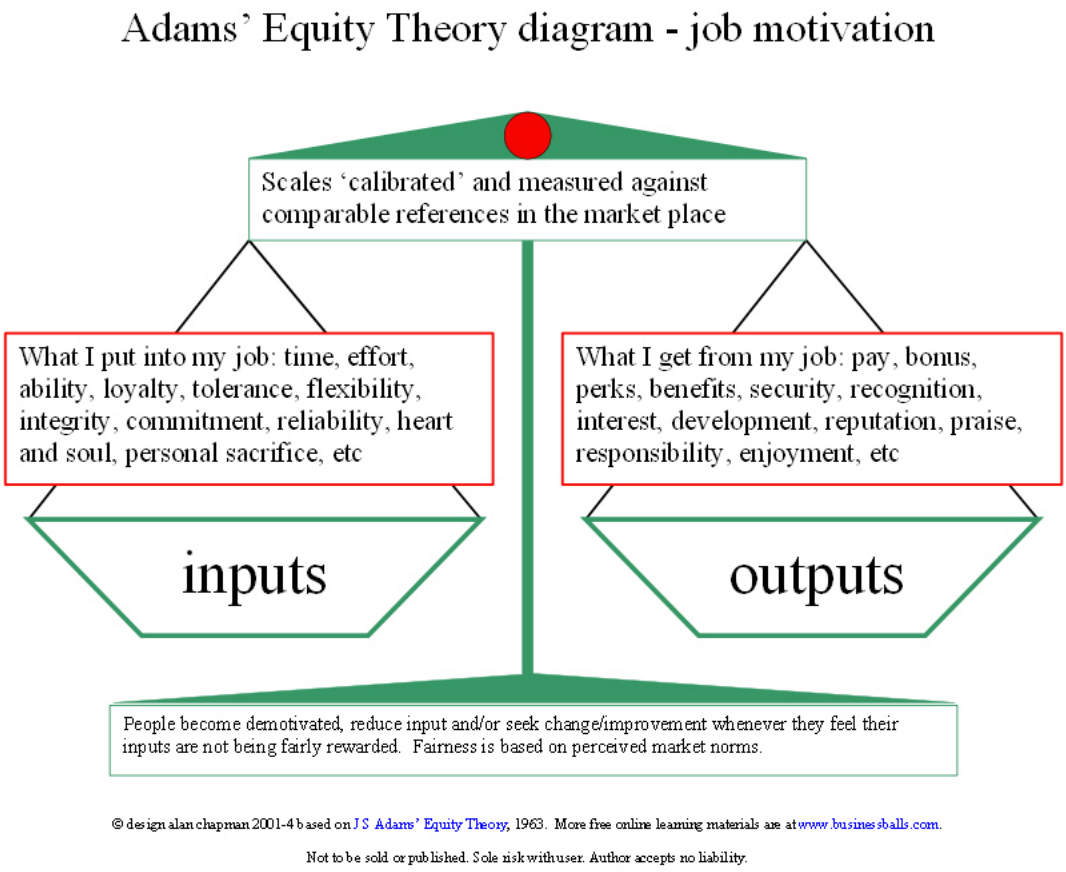


**Figure 4.1 Diagram reflecting the inputs/output patterns, of Adams' Equity Theory of job evaluation**

(Adopted from Chapman 2002:5)

### 4.3.1 Actions to restore equity

Dissatisfied employees can undertake different ways to restore equity till the ratios are equitable. These can be seen when one:

Reduces the inputs and deciding to put less effort into the job. Or by taking more time to finish the tasks; reducing the reliability and quality of the tasks; and refrain to take

additional roles and responsibilities. In this study nurses were reported to be uncooperative and reluctant to assist in busy areas because they were not OSD recognised.

Pursuing higher outputs like confronting the management/government for high pay. Some nurses with their unions in some institution have taken the employer to court, because they want to benefit from OSD.

Influencing others to alter their inputs/outputs the employee might get indulged in office politics, deliberately misguide others, be very critical of their performance, refuse to cooperate with others, create unnecessary dependencies to decrease their productivity. Quit and change the job – the employee might perceive the current work environment and its culture to be hopeless and chose to quit the current job in pursuit of finding a better, more equitable work environment. Nurses are looking for jobs that will offer a better salary. All the above is being undertaken by some nurses especially those who did not benefit from OSD, many are moving from public to private sector.

### 4.3.2 Balance and imbalance employee inputs and outputs

Adams Equity Theory also called for a fair balance between an employee's inputs such as, effort, loyalty, hard work, commitment, skill level and flexibility and employees outputs, salary, benefits, recognition and job security. This balance serves to ensure a strong productive relationship with the employee and result being contended, motivated employee (Adams 1965:1).

The theory stated that positive outcomes and high levels of motivation can be expected only when employees perceive their treatment to be fair. The idea behind this theory is to strike a healthy balance with outputs on one side of the scale, inputs on the other, both weighing in a way that seems reasonably equal. If the balance lies too far in favour of the employer, some workers may work to bring balance between inputs and outputs on their own (Adams 1965:1). In this study nurses who did not benefit from OSD are seeking balance by moving to private sector.

### 4.3.3 Adams' Equity Theory applied in this study

Nurses expected a fair return for what they contributed to the job. Participants maintained that care and goal of a patient care is the same whether in a general or specialty ward. Nurses in this study were reported withdrawing both emotionally and physically, engaged in absenteeism, tardiness and some quitting the public sector.

Understanding Equity Theory and especially its pivotal comparative aspect helps managers and policy-makers to appreciate that while improving one person's terms and conditions can resolve that individual's demands. People see themselves and crucially the way they are treated in terms of their surrounding environment, team and system, not in isolation.

## 4.4 SUMMARY OF THE THEMES AND CATEGORIES

### 4.4.1 OSD "unfair" labour practice

Most nurses felt that OSD came with unfair labour practise to them. In most instances all categories of nurses were bitterly disappointed and angry with the manner in which OSD was implemented. It excluded other categories of nurses, excluded some of the nursing specialties and qualifications and worse did not recognise experience of most senior nurses with long service.

### 4.4.2 Lack of involvement of nurse managers and other nurse categories in OSD decisions

Nurse managers and other categories of nurses felt that there was no initiative taken by the DoH, unions or institutional management to elicit the reaction of the nurses to the proposed remuneration method (OSD), explain reasons for the selection of the two streams and why the South African Government decided to settle for this strategy.

The nurse managers were only invited at a provincial meeting once to attend a workshop of the OSD implementation. They were informed to go back and identify certain categories of nurses and enter them in the relevant annexure to benefit or not benefit from OSD. This created a lot of problems because they did not understand the

concept and the procedure for OSD as they were not part and parcel of the OSD negotiations at Bargaining Chamber. Institutional Human Resource departments were unable to unpack the OSD .circulars. Nurse Managers cannot attend to nurse's grievances, thus they feel they are not giving enough support and nurses feel that nurse managers are not doing enough to speak on their behalf so that they could also benefit from OSD.

### 4.4.3 Development of specialty nursing and general nursing streams

The nurses did not experience dissatisfaction only but, also friction, division, segregation, hatred and dissension because of the 'specialty offer' that was made available for certain qualifications only. Many areas/units such as High cares, cardio thoracic units, renal units, forensic/crisis centre and maternity wards as they include labour and delivery and being National programmes should have been included under specialty wards. Nurses felt that confusion and misunderstanding would not have existed had there been a policy document to settle disputes from the SANC that clearly delineates specialty courses, particularly because Government Notices R48 and R212 were followed by the DoH and DPSA in the distribution of the OSD, and were found to be devoid of most of the of the specialty qualifications designated by the SANC.

### 4.4.4 OSD as a solution

Nurse managers were experiencing gross shortage of nurses at the time when population and the burden of ill-health due to HIV/AIDS and TB are on the increase (Dolamo 2009:31). The shortage is also currently caused by the fact that nurses are reporting debts, thus use resignation as a means of withdrawing their pension funds to pay their debts. There is also a link between ill health among nurses and the prevalence of HIV and AIDS among nurses in South Africa. This shortage of staff increased sick leave of nurses remaining in the institutions (Minnaar & Selebi 2009:29). Nurses in general agreed that OSD came as a solution in the sense that it stopped/reduced migration of nurses from public sector to overseas and private sector, helped to reduce moonlighting especially with the highly specialised skilled nurses and put in place a proper career pathing model based on performance, qualification scope of work and experience.

### 4.4.5 Disparities in the allocation of OSD

The nurses cited disparities in the implementation of the OSD in general. Newly qualified professional nurses from the 4-year course earned the same salary with PNs who had twenty years experience in nursing. OSD also worked to the advantage of returning professional nurses to the public sector. Other nurses who were on study and annual leave did not benefit from OSD.

Nurses expressed that the OSD had not solved the problem of earning low salaries especially as the cost of living was too high for the low salaries they earned. They are still desperate for salaries commensurate with their qualifications and years of experience. The reason being that OSD excluded professional nurses with high academic qualifications and long years of experience on the basis of not having specialty qualifications.

### 4.4.6 Benefits of OSD

Nurses, especially (specialty stream) and nurse managers experienced some positive things that were brought by the implementation of OSD. These included stopping of migration, recognition of other post-basic qualifications, focus on career pathing, prevention of staff rotation and lastly the general increase of salaries of all nurses.

### 4.4.7 OSD challenges

A number of challenges were encountered and experienced by the nurses during the implementation of OSD. There were differences in approach to translation between Provinces and within Districts and institutions of the same Province. It appeared as if implementers did not follow the PHSDSBC, Resolution 3 of 2007 DPSA implementation guide.

Other challenges included leaving out of critical units, such as medical wards as they are faced with the burden of HIV/AIDS and TB, changing of titles of nurse managers and their deputies, the major cry being that the nursing education structure was not affected by this, negative deterioration of ethics and professionalism within the nursing profession as general stream nurses are angry and uncooperative.

## 4.5 CONCLUSION

Based on Adams Equity Theory, compensation is typically among the first things potential employees consider when looking for employment. After all, for employees, compensation is the equivalent not to how they are paid but, ultimately, to how they are valued. These forces, which have a direct impact on the profession, are social, political and economic in nature. Nurses are not seen to participate in any arguments on policies that affect their future. They are seen to be reluctant in confronting issues that pertain to their practice, probably due to fear of affecting patients under their care negatively. Their general experience on the implementation of OSD is that it has divided the nursing profession causing a lot of dissatisfaction and friction.

In the next chapter, the summary of the findings, the conclusions drawn by the researcher, the limitations of the study and recommendations are presented.

# CHAPTER 5

# SUMMARY OF FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

## 5.1 INTRODUCTION

Chapter 4 discussed the conceptual framework and analysed Adams Equity theory on job motivation and the pay in relation to the study's findings. This chapter summarises the study, discusses the findings, outlines the limitations and makes recommendations according to the research findings. The purpose of the study was to unpack the experiences of nurses on the implementation of OSD and to recommend to stakeholders the manner of implementing this in future.

## 5.2 SAMPLE REALISATION

Participants in this study were all the categories of nurses as they were all affected by the OSD at Umgungundlovu district. The research consulted with authorities to interview individual nurses who met the criteria as stipulated. Arrangements were made to meet in-depth interview participants at their own convenient times. The researcher recruited more than the required number of nurse managers to participate in each FGD in order to solve non-show. This was followed by phone calls made the day before the actual interview to remind and confirm attendance by the participants.

## 5.3 SUMMARY OT THE STUDY

The study was an exploratory, hermeneutic, (human becoming) phenomenological and contextual qualitative one. The interviews and focus group discussions were conducted in English, but participants were allowed to respond in their own language if they felt comfortable. The interviews were captured by digital voice recorder, transcribed and analysed. Themes and categories that emerged from the data were used to describe the phenomenon being investigated. The objectives of the study were as follows:

- To explore experiences of nurses on the implementation of OSD in the public hospitals in the Umgungundlovu district.
- To recommend guidelines that can be used to improve the implementation of OSD.

## 5.4 SUMMARY OF FINDINGS

The data generated from all three selected public hospitals within the Umgungundlovu district are discussed collectively because of the similarities in emerging themes and categories (Patton 1990:376). The discussion focused mainly on participants' narrative statements extracted from in-depth interviews and focus group discussions. Seven themes emerged from the data with categories emerging under themes. The summary of findings as interpreted by the researcher is done according to the objectives of this study:

### 5.4.1 Experiences of nurses on the implementation of OSD

The researcher interpreted and summarised the findings as discussed by nurses as following:

- OSD was not fairly done since some nurses did not receive what they expected. The findings of the study revealed that the nurses viewed OSD as unfair labour practise because it divided nurses; there are those who grossly benefitted and those who benefitted less. The other ill-feeling was that some nurses qualified the same month and year but just because one individual happen to be in the specialty unit without a post-basic qualification she/he benefitted a lot from OSD.
- Although, it also emerged from the study that nurses in general agreed that OSD came as a solution in the sense that it stopped/reduced migration of nurses of nurses from public sector to overseas and private sector, helped to reduce moonlighting especially with the highly specialised skilled nurses and put in place a proper career pathing model based on performance, qualification scope of work and experience.
- The data suggested that no prior consultation with professional nurses and no feedback sessions specifically regarding the criteria used to classify 'specialty' qualifications and why long service for some nurses was not considered by the

OSD. The data reveal serious problems with representation of nurses on the provincial government, the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) and the Public Service Co-ordinating Bargaining Council (PSCBC).

In the FGD with nurse managers the researcher summarises the findings as:

- The data suggested that no prior consultation with nurse managers and no feedback sessions specifically regarding the criteria used to classify 'specialty' qualifications and for how long the service for some nurses was not considered by the OSD.
- There was also a level of dissatisfaction by nurse managers as some nurses were not willing to be moved to other wards if there was a need for them to be moved.

The researcher concluded that since salaries are foremost in this study, nurses' salaries should therefore superlatively reflect that value in all remuneration packages not only professional nurses, specialty, rural or scarce skills without external pressure from unions, strike actions and nurse migration.

### 5.4.2 Suggested guidelines for the implementation of OSD

#### *5.4.2.1 Remuneration structure*

The participants were not aware of this section of the OSD. This included the definition of scope or description of each occupation and the concomitant salary structure with 3% increments between notches to facilitate progression of PNs at production level, without them necessarily moving into supervisory posts in General Nursing and Specialty Nursing (DPSA 2007:3)

#### *5.3.2.2 Unequal distribution of the OSD*

The participants indicated that nurses were expecting a general increase for all. It should be noted that this expectation was not unreasonable as it was founded on the information provided by unions to nurses.

In addition, Tshabalala-Msimang (2007) pointed out that through engagement with other state institutions, an additional amount of R1.4 billion was allocated for the improvement of salaries for nurses through the OSD signed with the health sector unions. This suggested a general increase for all nurses. However, the DPSA (2007:3) stated that the implementation of OSD does not entail a general salary increase for employees in these occupations or that all nursing employees will gain the same financial benefit with implementation of the OSD. The reason for this was that the new salary structure would use post and grade promotions; hence the discrepancy against non specialty nurses.

#### *5.4.2.3 Specialty offer*

The DPSA (2007:5) clearly stated that the allocation of the OSD for PNs was based on possession of the prescribed post-basic clinical nursing qualifications accredited by the SANC and listed in Government Notices R48 and R212. These PNs were also required to permanently appointed in a post in such a specialty unit or primary health care clinic and should have been performing these duties satisfactorily in specialty units on 30 June 2007. This suggests that if PNs with specialty qualifications were allocated in areas other than specialty units, they would not qualify for the specialty offer. However this study identified the following problems:

- If Regulation R425, the education and training leading to registration as a nurse (general, psychiatry and community) and midwife are considered basic course qualifications, this suggests that they will have to repeat one or all courses comprising the four-year course in order to convert them to one-year post-basic qualifications, in order to qualify for the OSD, and the purpose of the R424, (4 year course) would be defeated; nursing could find itself regressing instead of progressing.

- If the one-year post-basic midwifery is considered specialty as indicated in Regulation R.212, then the purpose of OSD could be defeated because almost all PNs have the one-year Midwifery as a post-basic qualification. Thus in the hospitals that finally considered maternity department as a specialty, PNs with the one-year Midwifery course, should have been working in the maternity section on 30 June 2007 and are still working there.

According to the participants, Medical Admission Wards, High care in Surgical and Medical wards, Burns Unit, ENT, Urology, Cardio thoracic units and other units which were traditionally considered ‘Specialty ‘ units, were excluded from OSD. These were found not listed in Regulations R.48 and R.212. And the participants wished to know which regulation covers these areas. Non-remuneration of experience and skills in the general stream, long service (experience) working in a particular specialty area was not recognised by the OSD.

These factors seem to have contributed immensely on dissatisfaction of the implementation of OSD among PNs in the public health service (PHS). It is clear that the participants did not fully comprehend that the allocation of OSD was not based on units in which they were working, and on specialty qualifications possessed by PNs, recognised by SANC, and PNs actively practising those specialty skills in related specialty units. That is why PNs working in specialty units, without the required specialty qualification, were not considered for the OSD. The DPSA (2007:19) states that the inclusion of other specialties for this purpose is subject to the relevant one-year post-basic qualification being registered with the SANC in the relevant specialty. Consequently, if it is not a post basic qualification according to the SANC’s classification of post basic courses, it should not be considered a specialty (Regulation R212) (South Africa (Republic) 1993:5-26)

#### *5.4.2.4 Pay progression system*

The participants did not mention this aspect in their responses, The pay progression allows for 3% increment every two years according to qualifying criteria (DPSA 2007:3). The commencement of the first biannual (two-yearly) pay progression cycle for translated incumbents was on 1 July 2007 to 31 March 2009, which put the next pay progression on 1 July 2009, thus nullifying the previous annual pay progression (yearly basis) (DPSA 2007:15).

#### *5.4.2.5 Long service*

Most of the participants indicated that their years of experience were not considered in OSD. In their perception, the impression portrayed by OSD is that the ‘General Nurses’

do not appear valuable to Health Care Service (HCS), as focus has drastically shifted to 'Specialty' qualifications.

With regard to these concerns, the DPSA (2007:5) stated that PNs already occupying permanent production posts in specialty units without required post-basic qualifications on 30 June 2007 (long service) shall be translated as a 'once-off provision' to the lowest grade or salary scale attached to those posts. These PNs "shall not progress by means of grade progression to the higher grade (salary scale) attached to the post in the clinical specialty without first obtaining the required post-basic nursing qualification in the specialty" (DPSA 2007:5; 16). However, these PNs will still be eligible for the DPSA Incentive Policy Framework pay progression in the lower production grade (DPSA 2007:16). This, then, made the salaries for PNs with specialty qualifications equal to/or higher than those PNs with long service.

#### *5.4.2.6 Appointees from outside the public health service*

The participants were concerned about new appointees who were remunerated higher than those who had been loyal to the DoH and the organisations. According to DPSA (2007:3), all appointees from outside the PHS or the promotion of internal nursing employees to PNs posts in specialty nursing, Primary Health Care (PHC) and unit managers in specialty areas will have to comply with the required qualifications. This will enable appointment of employees from outside the public service to be given a salary recognition that allows them higher notches at unit level, based on their specialty, as an attempt to attract and retain PNs with specialties (DPSA 2007:3). This clause addresses the following participant's comment:

"Those who left the public sector and came back, their scale is higher than those who have been honest with the public sector".

From the data, the OSD strategy had good intentions and unpleasant elements; hence some PNs embraced it while some were dissatisfied.

#### *5.4.2.7 Consolidation of scarce skills allowance*

Participants did not understand or consent to the classification of ‘Scarce Skills’ when it was introduced in 2004 because there were questions on what criteria were used for this classification. The Scarce Skill allowance, which was already being paid to other health professionals and PNs working in the specialties Intensive Care Unit (ICU), Operating theatre and Oncology, in terms of PHWSBC Resolution 1 of 2004, was consolidated in the new OSD salary structure (DPSA 2007:3). The incongruence of information between decision-makers and nurses suggests that vital information did not filter through to nurses at the production levels as intended.

#### *5.4.2.8 Rural allowance*

Although Resolution 2 of 2004 was passed at the PHWSBC, many of the participants still appear to be uninformed about its origin, purpose and who qualify for it, as evidenced in their responses. According to OSD policy, the Rural allowances will continue to be paid together with the new OSD structure to PNs working in those identified areas until the allowance is re-negotiated in the PHCDSBC (DPSA 2007:17).

#### *5.4.2.9 Request transfer to general nursing stream post*

PNs with specialty nursing qualifications, who request a transfer to a general nursing post, will have to accept a reduction in their notch and a lower scale attached to that post. If the employer initiates such a transfer, a lower grade attached to that post will be awarded, while they retain their salary notch. According to participants, this did not consider patient acuity levels in general wards, which in most instances were equally or more hectic than specialty units, particularly if the transfer were arranged by the employer to cover staff shortages.

#### *5.4.2.10 Vacant posts*

The participants expressed resentment and frustration that others in the same units with equal years of experience were earning significantly higher than they were. To clarify that disparity, the DPSA (2007:16) requires that when vacant posts in specialty areas cannot be filled, such posts be advertised on the salary structure applicable to the

general nursing stream. These PNs then should not be compensated with a specialty salary by virtue of working in specialty areas to cover staff shortages. The participants held that the new pay system worked against the generalist nurses because per definition, they were performing similar duties with specialising nurses in the same units without corresponding remuneration. This was a potential source of resistance, dissension, poor production, division, tension and shifting of responsibilities among PNs in those units.

#### *5.4.2.11 Honours, Master's and Doctoral qualifications*

Some participants with academic qualifications were dissatisfied over a lack of consideration for these qualifications since the OSD document did not appear to elucidate specific positions about these degrees at the production levels. The main focus appeared to be on the "one-year" post-basic qualification accredited by SANC in Regulations R48 and R212. However, provision has been made for the post and salary structure for clinical nurse specialists career stream in PHSDSBC, Resolution 3 of 2007 to be implemented immediately upon promulgation of the required Regulations (DPSA 2007:20). This should hopefully benefit PNs with advanced academic qualifications.

Finally the foregoing inconsistencies clearly point to a serious information gap between the OSD policy and the employees' level of knowledge, as the participants' remarks stand in stark contrast to the policy. The National DoH promised to assist departments with implementation of OSD through regular provincial visits and on a continuous basis monitor the implementation of the OSD but the participants do not appear to be clear about OSD.

## 5.5 LIMITATIONS OF THE STUDY

The salary scale for nurses in private hospitals could not be obtained for reasons beyond the researcher's control. This would have been helpful in comparing private and public health sector salaries to further determine if salaries take pre-eminence over conditions of service. However, it is worth noting that a small sample was a convenient way of conducting the study, considering the type of research and the costs entailed for a larger sample.

Furthermore, over-reporting or under-reporting might have occurred as a result of the sensitive nature of implementation of Occupational Specific Dispensation (OSD) involving nurses salaries.

## 5.6 RECOMMENDATIONS

Conclusions drawn from the study will be discussed following objectives of the study. Based on the findings of the study and with regard to the themes, guidelines that could be used to improve implementation of OSD will be suggested:

### 5.6.1 Recommendations to National DoH

- The National DoH must review OSD to close gaps identified during implementation.
- The National DOH must develop a clear performance management appraisal mechanism relevant to clinical fields as the remunerative policy states that career progression must be closely linked to performance, at the moment it is not in place.
- The salary redress in future should be preceded by research and sufficient consultation and communication with nurses at production level to solicit their ideas, so that the re-implementation and distribution is based on understanding and consensus.
- Open communication between the DoH and nurses and involvement in decision making, and ensuring that all employees are taken care of, are valuable strategies that should be employed by the government. This could also assist with recruitment and retention of skilled staff because it is not about special salaries for certain skills.
- The government should encourage nurses and allow them to venture into the political arena and not to rely on mechanisms (unions) that do not fully represent their interests due to lack of deeper insight into and experience with nursing and health care issues.
- There should be a monitoring system designed to monitor closely the health professionals who do remunerated work outside public service (RWORPS) as this cripples the services of the public sector.

- Basically, the government should understand what is to be done and the actions taken that will help motivating the employees. According to Equity Theory the following can be applied to motivate employees, tie rewards to employee performance, rewards to match the amount of performance put forward by the employee. Develop tools to pay nurses in proportion to their contributions. Let the employees know who their pay referents are in the pay system, identify pay competitors and internal pay comparators. Monitor internal pay structure and position in the labour market for consistency (Adams 1965:6).

### 5.6.2 Recommendations to the profession

- The SANC should consult with other nursing pioneers who have presented papers or conducted research on nurse's challenges/salaries and other issues involving nurses or even consult with nurses to obtain more input before embarking or agreeing on critical issues like salaries to avoid confusion and dissatisfaction.
- Nurses need to be unified under one nursing organisation that accommodates all nurses in the RSA, where they can be briefed on proposed changes, ask questions, examine policies that affect them, and agree or disagree based on proper understanding of the policy before it takes effect.

**Further research**

This study's main participants were professional nurses, although all categories of permanent nursing staff were targeted in the sample. It is highly recommended that independent study investigating enrolled nurses and or enrolled nursing auxiliaries be conducted as their valuable contribution in the workplace cannot be overlooked.

Research on impact of OSD on quality of health care services since its implementation in 2007 should be conducted.

A relatively larger sample size including all hospitals in the KZN and or other provinces should be used to get the real experiences of nurses on the implementation of OSD.

The nurses who migrated to private health sector after OSD implementation can provide valuable information regarding the “pull factors’ in private hospitals, in order of importance.

Perhaps a study on financial spending in OSD is important to reveal shortcomings as there was a cry that huge weaknesses in provincial health departments and are behind R7.5 billion debt accumulated mainly by KZN, Gauteng and Eastern Cape (Thorn & Cullinan 2011:1)

## 5.7 CONCLUSION

This study set out to explore the experiences of nurses on the implementation of OSD in the three selected public hospitals in the Umgungundlovu district. The study has helped to identify gaps which occurred during OSD implementation. The researcher was able to meet the objectives of the study and formulate guidelines that could be used to implement OSD if reviewed.

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**ANNEXURE A: APPROVAL FROM THE UNIVERSITY**

UNISA university of south africa

**UNIVERSITY OF SOUTH AFRICA**
**Health Studies Higher Degrees Committee**
**College of Human Sciences**
**ETHICAL CLEARANCE CERTIFICATE**

**HSHDC 58/2011**

Date of meeting: 6 December 2011 Student No: 0637-169-8

Project Title: Experiences of nurses on the implementation of Occupational Specific Dispensation (OSD) in selected public hospitals in the Umgungundlovu District in KwaZulu Natal.

Researcher: Nompumelelo Annatoria Kunene

Degree: MA Health Studies Code: MPCHS94

Supervisor: Prof BL Dolamo
Qualification: D Litt et Phil
Joint Supervisor:

**DECISION OF COMMITTEE**

**Approved** [√] **Conditionally Approved** [ ]

**Prof E Potgieter**
**CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MC Bezuidenhout**
**ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

**ANNEXURE B: APPROVAL FROM THE HEALTH RESEARCH & KNOWLEDGE MANAGEMENT. DEPARTMENT OF HEALTH, PROVINCE OF KWAZULU-NATAL**

health
Department:
Health
**PROVINCE OF KWAZULU-NATAL**

**Health Research & Knowledge Management**
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg, 3200
Tel.: 033 – 395 2895
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

**Reference : HRKM 006/12**
**Enquiries : Mr X. Xaba**
**Telephone : 033 – 395 2805**

Dear Mrs NA Kunene

**Subject: Approval of a Research Proposal**

1. The research proposal titled **'Experiences of nurses on the implementation of Occupational Specific Dispensation (OSD) in selected public hospitals in the UMgungundlovu District in KZN'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby approved for research to be undertaken at Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba.

Yours Sincerely

**Dr E. Lutge**
Chairperson: Provincial Health Research Committee
KZN Department of Health
Date: 20/01/2012

**ANNEXURE C: APPROVAL FROM THE UMGUNGUNDLOVU HEALTH DISTRICT**

health

Department:
Health
**PROVINCE OF KWAZULU-NATAL**

UMGUNGUNDLOVU HEALTH DISTRICT OFFICE

OFFICE OF THE DISTRICT MANAGER

Private Bag X9124, Pietermaritzburg, 3200
Brasfort House, 262 Langalibalele Street, Pietermaritzburg, 3201
Tel.: 033-8971002,
Fax: 033-897 1078
Email.: thule.kunene@kznhealth.gov.za
www.kznhealth.gov.za

Reference : 19/P
Enquiries :Mrs.N.M.Zuma- Mkhonza
Date: 19 January 2012

**TO:** Mrs. N.A. Kunene
Edendale Hospital
KwaZulu-Natal Department of Health

RE: PERMISSION TO CONDUCT RESEARCH PROJECT.

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research in "Experiences of nurses on the implementation of Occupational Specific Dispensation (OSD) in the selected Public hospitals in the UMgungundlovu District in Kwa-Zulu Natal"
PLEASE NOTE THE FOLLOWING

Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.

This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department.

Please ensure that this office is informed before you commence your research.

The District Office will not provide any resources for this research.

You will be expected to provide feedback on your findings to the District Office.

Thank you

Original Signed available on request
MRS N.M. ZUMA - MKHONZA
DISTRICT MANAGER
UMGUNGUNDLOVU HEALTH DISTRICT

## ANNEXURE D: PERMISSION LETTER TO CONDUCT STUDY AT GREYS GOVERNMENT TERTIARY HOSPITAL

HEALTH
KwaZulu-Natal

**GREY'S HOSPITAL**
**OFFICE OF THE CHIEF EXECUTIVE OFFICER**
Private Bag X 9001, PIETERMARITZBURG, 3200
Townbush Road, Chase Valley, PIETERMARITZBURG, 3201
Tel.: 033 – 897 3321, Fax: 033 – 342 2324
email.:sandy.sivrathan@kznhealth.gov.za

Reference : Research
Enquiries : Dr K B Bilenge

16 November 2010

Ms N A Kunene
Edendale Hospital

Dear Ms Kunene,

**RE: PERMISSION TO CONDUCT RESEARCH AT GREY'S HOSPITAL**

I have pleasure in informing you that permission has been granted to you by the Hospital CEO to conduct research on "Experience of nurses on the implementation of Occupational Specific Dispensation (OSD) in the selected Public Hospitals in the Umgungundlovu District in KZN.

Please note the following:

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

Yours faithfully,

**DR K. B. BILENGE**
**ACTING CEO / MEDICAL MANAGER**
**GREY'S HOSPITAL**

**ANNEXURE E: PERMISSION LETTER TO CONDUCT STUDY AT NORTHDALE GOVERNMENT DISTRICT HOSPITAL**

health
Department:
Health
**PROVINCE OF KWAZULU-NATAL**

**NORTHDALE HOSPITAL**
1389 Chota Motala Road, Pietermaritzburg 3201
P/B X9006, Pietermaritzburg 3200
Tel.: (033) 387914, Fax.: (033) 3879014
E-mail:mag.molla@kznhealth.gov.za
www.kznhealth.gov.za

**Enquiries: Dr MAG Molla**
**Date: 21 December 2011**

**To: Nompumelelo A. Kunene**
**Edendale Hospital**
**Department Of Health**
**Kwa-Zulu Natal**

Dear Kunene

**RE: PERMISSION TO CONDUCT RESEARCH PROJECT**

Please be advised that permission has been granted to conduct research on topic "Experience of nurses on the implementation of occupation specific dispensation in selected public Hospitals in the Umgungundlovu District in Kwazulu-natal.

Finding s of research must be given to the Hospital Management.

We wish you success.

Yours faithfully

.....
**Dr MAG Molla**
**Medical Manager**
**Northdale Hospital**

21/12/2011
**Date**

**ANNEXURE F: PERMISSION LETTER TO CONDUCT STUDY AT EDENDALE GOVERNMENT DISTRICT/ REGIONAL HOSPITAL**

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Edendale Hospital
Private Bag X 509, Plessislaer, 3216
Tel: 033 395 4040, Fax: 033 395 4087
email: thandiwe.ndlovu@kznhealth.gov.za
www.kznhealth.gov.za

OFFICE OF THE CHIEF EXECUTIVE OFFICER

Reference: HSHDC 58/2011
Enquiries: Mrs. TJ Ndlovu
Telephone: 033 3954040
Date: 03 January 2012

Mrs. Kunene
ANM-ICU
Edendale Hospital

Dear Mrs. Kunene

**REQUEST FOR APPROVALTO CONDUCT RESEARCH STUDY ON EXPERIENCES OF NURSES ON THE IMPLEMENTATION OF OCCUPATIONAL SPECIFIC DISPENSATION IN THE SELECTED PUBLIC HOSPITALS IN THE UMGUNGUNDLOVU DISTRICT IN KWAZULU-NATAL.**

Your letter dated 13 December 2011 refers,

Your request to conduct the above-mentioned surveillance is supported by Edendale Hospital Management, subject to approval by Department of Health Research Committee.

Yours Sincerely,

MRS BC MAPHANGA
ACTING CHIEF EXECUTIVE OFFICER
EDENDALE HOSPITAL

**ANNEXURE G: INFORMED CONSENT**

Interview Question Route (English Version)

**Experiences of nurses on the implementation of Occupational Specific Dispensation (OSD) in selected hospitals in the Umgungundlovu District in KwaZulu-Natal.**

Interview: Informed Consent Agreement

Good morning / afternoon. I want to thank you for taking time to meet with me today. My name is Nompumelelo Kunene from the University of South Africa. I am conducting interviews on the **experiences of nurses on the implementation of Occupational Specific Dispensation (OSD)**. The findings from this research will contribute meaningfully by assisting authorities both provincially and nationally to be aware of the challenges as experienced by the implementation of OSD and outstanding issues related to nurses OSD implementation as they were the pilot.

I would like to have your permission to talk with you today about your ideas and experiences related to the implementation of OSD. It is up to you if you wish to answer any or all of my questions. You may end our discussion at any time. Everything you say will be kept private and confidential. To ensure I have a complete record of everything you say, I would like to tape record our conversation. Don't worry only the researcher will listen to the tape and no one will be able to identify you. Similarly your name will not be used in any research findings.

If you agree to participate in this interview, please sign this page. If you do not wish to participate thank you for your time.

Signature: Rank:

Date:

**ANNEXURE H: INTERVIEW GUIDE**

**Main question:**

**What was your experience with the implementation of OSD at Umgungundlovu district KZN as a manager?**

Probe: 1do you have any complaints/grievances that you can raise about OSD?

Probe: 2 did OSD stop migration of nurses?

Probe: 3 do nurses moonlight because of OSD?

**What good things that were brought about by OSD?**

Probe: 1 were nurses satisfied with the OSD?

Probe: 2 which category of nurses benefited from OSD?

**How did you expect OSD to be implemented?**

## ANNEXURE J: PERMISSION TO COLLECT DATA

health
Department:
Health
**PROVINCE OF KWAZULU-NATAL**

**GREY'S HOSPITAL**
**OFFICE OF THE NURSING MANAGER**
Private Bag X 9001, Pietermaritzburg, 3200
Townbush Road, Chase Valley, Pietermaritzburg, 3201
Tel.: 033 – 8973322, Fax.:033 – 8973328
Email.:Cynthia.Sosibo@kznhealth.gov.za
www.kznhealth.gov.za

**Enquiries :** Mrs CN Sosibo
**Telephone :** (033) 8973331

04 January 2012

**To: Mrs. N. A. Kunene**
**c/o Gilbert Road**
**Bisley Heights**
**Pietermaritzburg**

Dear Madam,

**RE : PERMISSION TO COLLECT DATA FOR RESEARCH PROJECT**

Thank you for your letter dated 13 December 2011.

Permission has been granted for you to come and meet with different categories of nursing staff to collect data for research.

**DATE : 05 – 09 March 2012**

Kindly report to Nursing Manager's office at 07H00 on the 05th March 2012.

Looking forward to see you.

Thank you.

**MRS. CN SOSIBO**
**NURSING MANAGER**

HEALTH
KwaZulu-Natal

**NORTHDALE HOSPITAL**

Chota Motala Road, P M Burg

Private Bag X 9006, PM Burg, 3200

Tel.: 033 3879012, Fax: 033 3971914

Email: champa.hutheram@kznhealth.gov.za

| | | |
|---|---|---|
| Enquiries: | Date: | Reference: |
| Imibuzo: MS J WEBSTER | Usuku 2012/03/15 | Nkomba: |
| Navrae: | Datum: | |

**ATTENTION MRS N.A KUNENE**

**RE: PERMISSION TO COLLECT DATA**

The above matter bears reference.

Permission has been granted to collect data at Northdale Hospital from 12 March 2012 up to and including the 16 March 2012.

***THANK YOU***

***Mrs J Webster***

***Nurse Manager***

***2012/03/15***

**ANNEXURE I: EXCITING NARRATIVE FROM ONE THE PARTICIPANTS**

Thank you for allowing me to participate as one of your candidates and assist you with this research programme.

Just to take you right back to when the OSD initially commenced. My first feeling was that the department did not have adequate people in terms of training with expert knowledge with the very OSD. What had happened at the insert we were just issued with various circulars from the Department of Health. Worst of all was that the circulars that came kept contradicting each other. And that was our major concern.

Those were the initial hurdles that we were encountered with and just to give you an example of this very institution, people had to read circulars to understand it initially in terms of who should be streamed and why they should be streamed. At the initial stage we did not have like a committee put in place with various stakeholders representing different departments or domains so to speak for example; nursing medical, paramedical and stuff like that. So that was a huge hurdle. So those were the initial problems that we had in terms of OSD.

Right, then the next unfortunate situation was when we were called to meetings. Obviously that was the right thing to do to call us to meetings to induct us to the new programmes and tell us what we don't have to do. But the worst one, for me, I'll just use my experience first. When I applied for this job at this Hospital, I was Deputy Nurse Manager, deputising for the Nurse Manager. And those were the categories in terms of the nursing hierarchy and unbeknown to us, meetings were held by I'm not sure, by people in the nursing fraternity that we were told, were from the Education sector and not in the nursing management sector, in terms of deciding our fate as nurse managers and deputy nurse managers. And that we didn't take very kindly too. Resulting from that

we were called to a meeting by the department of health. Finally all the deputy nurse managers were identified and called to a separate meeting by a labour representative from head office and told us what our fate would be in terms of OSD.

Having gone through that meeting with labour, all of us had different opinions in terms of whether we were going to be advantaged or disadvantaged. Most of us listened and I'm not sure whether I can say we complied with what was said to us because at that stage we did not realise the repercussions that were going to have on our salary levels in terms of OSD. When we got back looking at the structure, what I actually found out was that the nurse manager had been dropped to the level of deputy nurse manager and **me,** the deputy nurse manager and my colleagues from other hospitals were dropped to the level of the Assistant manager nursing. Fine, that is just a name of the category that was just being used. When I consulted the remuneration package in terms of where I am going to be in OSD, I got a shock and then addressed my personal issue with one of the educators who represented the nurses in OSD negotiations. She took me through the process and told me that in terms of the OSD we were not going to benefit much. We as Deputy nursing managers then engaged in a lots of meetings, we travelled up and down; we even had a meeting with the KZN OSD Nurse Managers Forum coordinator trying to get answers. What I want to say at this stage is that I think all what we did turned into deaf ears because nobody acknowledged what we grieving about and it was left there.

At a subsequent meeting that was held, I alluded to the fact that nurse educators decided our fate instead of us or senior nurse managers deciding our own fate. We were told very categorically that we must now assume the post of Assistant Manager Nursing Monitoring and Evaluation. That meeting went a bit sour because I was the one that told the chairperson that it's very ironic to go through an interview for the deputy nurse manager's post and somebody unilaterally sees it fit to ask us to assume the position of monitoring and evaluation. I thought that was very unfair in terms of treatment as senior nursing management personnel.

So for me in this hospital I am not and I said it to my boss that I am not going to assume the post of monitoring and evaluation, come what may, they can do whatever they please and I am not interested. I will do the job as I was interviewed according to Key Result Areas (KRAs) and found me competent for this job. Nobody interviewed me for monitoring and evaluation and how then do they see it fit that I 'm the right person to do the job. It's totally against my wishes so therefore at this hospital I have made it very clear that I am not monitoring and evaluation, if they down grade me into Assistant nursing manager I'll continue to do the job as a deputy nurse manager.

Now coming to the workload, the workload is astronomical, when my nurse manager attends executive management meetings, I am the person that takes the workload of the entire nursing component and evidently as you can see, I even deal with affidavits and have to get it right for South African Police or hearings and staff. I've got to do the allocation of the whole entire nursing component, do skills development, take care of staff going on leave including maternity leave, I got to do everything towards human resource and human resource development, oversee Occupational Health and Safety and get daily report from the clinic and finally I oversee all of the OSD issues in terms of the nursing component.

I attend to all grievances that emanates with regards to the OSD. There is still a lot of unhappiness, and at that point I must state that the Department of Health will put a circular today and guide you to a certain angle and a few months down the line there's another very contradicting circular where it puts you in a situation where you don't know what to do.

At the moment we have got few grievances that emanates with regards to placement of nursing personnel and specialty. My suggestion to the institution was to put an OSD committee in place with representatives in different domains so that we talk the same language and be very transparent in terms of translating people. To mention a few experiences, the main circular (circular 92 of 2007) would say professional nurses at operational level, then you get an operational manager that wants to be streamed using

the same circular for professional nurses at operational level and when you try to breakdown what an operational manager is in terms of the professional nurse at operational level, its two different components and yet when you try and explain they don't seem to understand that an operational manager has had a salary adjustment in terms of being an operational manager. You thus find yourself spending a lot of hours which is totally wasteful expenditure sitting with bilateral trying to sort out an issue or things that is very clear cut.

Then one of the flip sides of the coin is the person who request to go and work in the clinic because of ill-health reasons or request night shift although there is no night duty in any circular that I have seen thus far. You then place them in a 07H00- 16H00 situation because of ill-health reasons, to me that is **employee initiated** thus I inform those who are in the specialty units to write and indicate that they are no longer in the specialty unit so that they are paid accordingly as indicated by the provincial circular, and behold they continue to get paid stream specialty by my HR colleagues which I have a huge problem with because its double standards and its fraud. My question therefore is how can you be doing light duties and be streamed "specialty". So the OSD by enlarge has got too many gaps in terms of circulars, in terms of how we practice and in terms of how we stream people.

I know in this situation you do things according to policy because that is what we are mandated to do as managers, but people at the ground feel that we are treating them unfairly in terms of the streaming. So now I believe in the EPMDS (Employee Performance Management Development System) that's the driving force in terms of your job output and productivity. But other people out there would say but she is working in this domain and rightfully she should be streamed and should not be moved. Then I write and say this is an employee initiated placement, I cannot use her for night shift, I cannot move her from 7-4 job although I'm short staffed, and this is fraud in other words.

You see besides that, the other thing I would really like somebody to listen to is that it's the OSD fine, we had lots of names, we called it the nightmare, monster, and we called

it so many names but with the OSD what has happened also is that staff are jumping on the band wagon to do post basic courses aligned to OSD, not for the job, not to be productive but for monetary gain. Unfortunately for us in management the EPMDS is not a fair estimation of the job output. So those are like all the gaps that we have to be putting up with. We don't mind sending people to upgrade in the very specialty but what we do mind is that a person with specialty would be in a ward working with a person without specialty. You would find the person without specialty but for mere fact that she's got all these many, many years of experience makes a better nurse in that specialty because of the experience as compared to the one with a piece of paper. Therefore OSD is now a hindrance in terms of outputting or seeing to the needs of the specialty nurse and the nurse with experience because at the end of the day the nurse with experience is also teaching the one with specialty certificate (laughs) and you know it becomes so ironic.

In the workplace there is a lot of disharmony because people put back and say "you earning the money, why should I teach you" .Its created this type of disharmony amongst working colleagues which is no fault of theirs, it's there because of this nightmare OSD that is being put in place without people giving it forethought. They should have given it forethought and said fine nurses need to be reimbursed. All nurses work very hard, all nurses have to do night duty, so therefore take this budget and spread it across the board so that every nurse benefit. You know that was one that was just glaring because staff nurses work so hard. The Nursing Assistants work extremely hard, they run off the field but they haven't benefited also. So that concern is still there because the very nurse with the specialty sits back in the duty room and does all the paper work, and who runs off their feet? It's the staff nurse, the poor staff nurse. Yes OSD, OSD, OSD its came, it's here to stay, we are working with it, we are doing the best we can but it has come with a lot of issues, too many issues.

My feeling is that, (breathes) you know something if I'm going to tell you what I feel it's going to be very unfair because people have been participating reimbursed right up to

half a million. OSD has supported and concentrated to certain percentage of personnel and that it is that piece of paper which is called specialty certificate that has caused the

damage. Once you can prove that whether you can deliver the goods or don't deliver the goods you get streamed according to the piece of paper. When they start backdating and start calculating, people are walking away with up to R500, 000.00 which is a lot of money. Most of us got nothing, did not even get R20, 000.00.

The way forward is to relook at the OSD If there is an adequate budget there should be even distribution and up people's salaries especially the people that are earning very little, bring their salaries to par. The staff nurses and ENAs need to be upgraded in terms of the salary. And for me personally, sometimes doing the job of the nurse manager, I can run the nursing service, we've been sidelined for our experience, skills and without being an experienced person you can't go anywhere. I would still the ex-deputy nurse managers have been disadvantaged. They need to look at that because we've got to sit at executive management meetings, cash flow meetings, extended management meetings, we are all over the show when the nurse manager is not around, attending meetings or on leave, but we got nothing in terms of OSD. It's time that we should be remunerated for our expertise, our skills, our experience over the years, we've got tons and tons of experience. When a new CEO comes you find yourself guiding the CEO because you have the longest stay in the institution.

As nursing management we have a lot of responsibilities assigned to us, after hours and weekends we work as plumbers, electricians, cleaners, manage the institution in the absence of various managers in fact we look after everything. They told us that they were only looking at the operational people, right! Now if take away management and leave operational, let them run at their own which won't happen, management is still needed, so reimburse them.

I think we'll stop there I don't want to put too much negative into it. Its been a good exercise. I must say but the manner in which it was sort of managed you know I just personally feel they should have given a lot more thought to it, come down at ground level and involve all of us to say listen guys this is what we are deciding to do, what do you think? because we were the ones affected. We feel let down by the educators

deciding for us. We still feel very disadvantaged in terms of not being recognised for our experience, They took another facility to decide our fate, this is not right.

Remember they also had all these HODs for every subject. A tutor was now an HOD, so they benefited. They put their house in order and gave us the boot, so that is why we still feel very disadvantaged by that. That must be taken up whether this piece of paper can do something I don't know but it needs to be known out there.

I f you look at our upward mobility I mean we want to be perhaps nurse manager but sometimes you are in the wrong place at the wrong time, you know what i am saying, and most of us will retire here at this ANM's post. We are going to be leaving this service with our vast amount of knowledge and instead of leaving and going away with additional and remuneration that is what we were asking for. We needed to be honoured for our expertise as well. But it's also sad to know that the many meeting we had, we were actually shut down because there was a circular that came from head office that said no more forums. You remember? that circular came out because we were up and going with our meetings. Then the circular come out to say "' no more forums" We had to stop in our tracks and I mean fair enough you're working for government we want to be proud of the government but equally we feel that the government must be proud of us as well and also reimburse us equally. But all said and done the bad taste is still there for us especially the ex-deputy nurse managers and the OSD is still going on. The people are studying, people are still getting their certificates, we are streaming team speciality, we upgrading them, seeing to their needs, It didn't stop us from doing the worth. We are still working very hard and we are ensuring that everyone so far is still benefiting from OSD You Know?

And just off the cuff there were some letters on my table to say "' matron I worked in this department and now will I be paid pro-rata because the circular says working 2007 and still working there'" you know, and there were people that missed it by one day. You know the maternity OSD there were people because it's the 30th of June, people started on the 1st of July. They missed it by one day and you know how painful that was. It was very painful for some of the girls and I had to call them in and say You know guys I am

following the circular you can bring it up, 24 hours decided their fate which was very sad.

You know? The maternity ones, and also I want to add this one about the maternity, template came up for that OSD. I wrote a big letter to the department but I didn't get a reply till now. To say that template they used did not cover for that person in the gynae ward and the neonatal nursery I could only give them two ticks because the template spoke about middle 3, real middle 3, pregnant woman, delivery, etc but they are going to use same template to measure job output in the neonatal nursery where they have got nothing to do with the pregnant woman and then they took same template and say gynae ward, where they just looking at gynae patients only, They have to access now whether the pregnant woman, what they doing and all of that stuff. It doesn't align! And whoever is running with the OSD higher than us also needs to think whether they doing things correctly. They are not doing things correctly. When you look at the template it has loads of stories to fill in. I had major problem with that one and then they put out a circular today, they want it in a few hours time, they want it on their tables, you are rushing doing stuff. I did it, I wrote a covering letter I said "'HR here's it. That my feelings" that's what feel I don't want the nurses to feel that I'm jeopardising their situation. I'm answering the template.

Ja, so that was the OSD. Every time I talk about OSD I get depressed. So it's nice to just stay away from OSD.

Thank you