THE COPING SKILLS OF REGISTERED NURSES

IN THE CITY HEALTH CLINICS IN CAPE TOWN

By

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submitted in partial fulfillment

of the requirements

for the degree of

MAGISTER ARTIUM IN NURSING SCIENCE

at the

UNIVERSITY OF SOUTH AFRICA

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JANUARY 2003

DECLARATION

I declare that ***The coping skills of registered nurses in the City Health clinics in Cape Town*** is my own work and that all the sources that I have quoted have been indicated and acknowledged by means of complete references.

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SUMMARY

ABSTRACT

The aim of this study is to explore and describe the coping skills of registered nurses in a changed working environment. The research is conducted in the City Health clinics.

The objectives of the study are:

- to identify strategies which nurses use to cope with the changes in the health care services;
- to explore appropriate support systems that will enhance the coping skills of registered nurses in clinics in the City Health Department; and
- to deduce guidelines on how to support staff from the literature study and the results of the research.

The research problem is the following: nurses in primary health care facilities do not adequately cope with major changes in health care delivery.

A qualitative approach for the research was chosen. Personal interviews and focus group discussions were used to identify the coping skills of registered nurses.

Data analysis was done manually. Transcriptions of recordings of the individual interviews and group discussions were done. Themes were organized and categorized into meaningful links and relationships.

The findings indicate that the following factors improve the coping skills of registered nurses:

- team-work and support;
- to voice your opinion when necessary and good communication between staff;
- regular breaks during working hours;
- inherent factors for example strong spiritual and emotional strength that assist registered nurses to cope;
- family support;
- the provision of quality care is rewarding;
- the assistance and support from the church (congregation);
- the effective re-organisation of health services;
- continuous support programs for staff; and
- continuous education to develop skills of registered nurses.

KEY TERMS:

- Culture
- Health care culture
- Stress
- Coping skills
- Change.

DEDICATION

This project is dedicated to the nurses working in primary health care services. These nurses' daily work is rendered with love and care to provide a quality health care service to the underserved communities. They continue to provide health care in spite of the ever-present threat to their personal safety and security. This work is for you.

Soraya Elloker

January 2003

ACKNOWLEDGEMENTS

I wish to express my sincere appreciation to all those persons who contributed to the research and those who assisted me in completing this study.

In particular I would like to thank the following:

- Almighty Allah for giving me strength and health to complete this research project.
- Ganief, my husband, for his support and encouragement when I needed it most.
- My daughters, Gadija, Aisha, Toughieda and Rukeya for their interest.
- Mrs. Rhoda Khan and Mr. Hassan Khan for assisting with the editing.
- Dr Human, my supervisor, for her advice and contribution throughout this research project.
- Dr Alberts, my joint supervisor, for her advice and support.
- Dr Van De Linde for the editing.
- All the respondents for their valuable contribution and time. Without them this research would not have been possible.
- The Cape Town Administration for financial assistance.
- The Cape Town Administration for allowing me access to the clinics.

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CHAPTER ONE

1 ORIENTATION TO THE STUDY

1.1 INTRODUCTION

During the apartheid era South Africa had little commitment to provide equal access to good health care for all its citizens. Health services were fragmentally divided along racial lines with the “white“ population receiving First World health care while “black” people received poor health services (Torkington 2000: 5-9).

After South Africa’s first democratic elections in 1994 the new government of South Africa has identified the redressing of inequalities amongst the population groups created by years of apartheid as one of its main challenges. New public finance policies, recent appointments in the health system, the Human Immunedeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) crisis and decentralization of health services to the district level have placed new burdens on health staff struggling to manage scarce resources while addressing issues of equity (Equity Project 2001: 18). A rapid changing health regulatory environment drives the reform. The aim of the reform is to provide efficient and effective health services closest to where communities live (Department of Health 1996: 7-11; Department of Health 1997: 11-16). The financial constraints resulted in the primary health care services being provided primarily by registered nurses. The responsibility to provide services needed by the communities they serve require of registered nurses to continually extend their functions to provide in the needs of the communities served.

The communities, in which people live and work, influence their collective health and well-being. Although health and illness are personal issues, evidence indicates that it is also community issues. The spread of the human immunodeficiency virus (HIV) pandemic, as well as health and health related issues such as sexually transmitted diseases, tuberculosis, teenage pregnancy, violence and substance abuse concern communities. Communities can influence the spread of disease, organise ways to combat outbreak of infectious diseases and promote practices which contribute towards individual and collective health. Multidisciplinary teams render services in the community health field.

The professional nurse forms an integral part of this team and liase with physicians, social workers, government officials, community health committees and non-governmental organisations. One of the challenges community health practice faces is remaining responsive to the community's complex needs (Allender & Spradley 2001: 2-3).

As the health care system is continually evolving, the community health nursing practice evolves to remain effective with the clients it serves. Over time the roles of the community health nurse have broaden to include the following roles:

- Clinician roles
- Educator
- Advocate
- Leader

- Collaborator
- Manager
- Researcher (Allender & Spradley 2001: 41).

The research contributes toward an understanding of the coping skills which registered nurses implement in the delivery of health services to communities.

1.2 BACKGROUND OF THE PROBLEM

1.2.1 Legislative changes which impact on the health care system

The first democratic elections were held in South Africa in 1994, with the African National Congress (ANC) becoming the ruling party in South Africa. The vision of the ANC for the health system of South Africa is reflected in the ANC's health policy. The aim of the policy is to transform the health services into a comprehensive primary health care service. The policy's changes resulted in changes throughout the health care system. These legislative and policy changes impact on the human resources of the country, resulting in an increased demand on the coping skills of registered nurses. The coping skills of registered nurses, their thoughts, ideas, perceptions and feelings about how and why they are able to cope is of interest. Changes are being implemented in a phased approach based on the policy changes of the country. The health needs of the communities also contribute towards policy changes for instance the current legal court battle, where AIDS activists succeeded in taking the government to court and forcing the government to provide Nevirapine to all pregnant mothers who are HIV positive.

The following are examples of legislation, which drive the changes in the South African health care system.

1.2.1.1 A National Health Plan for South Africa

This plan addresses the complete transformation of the national health care delivery system and all relevant institutions (African National Congress 1994: 7). It addresses the priorities of the national health services of South Africa. The challenges facing the health services are to adequately allocate budgets in line with the country's priorities for instance greater allocations to primary health care.

Registered nurses as frontline providers of primary health care are expected to manage the provision of primary health care services. Capacity building and clinical skills training are required for certain categories of health workers to effectively implement the district health system (Department of Health1996: 41).

1.2.1.2 Reconstruction and Development Program

The Reconstruction and Development Program emphasises the role of the National Health Service in delivering Primary Health Care services. The approach to Primary Health Care advocates that communities should participate actively in the planning, managing, delivery, monitoring and evaluation of the health service in their areas. Health service providers will have to be accountable to the local communities they serve (African National Congress 1994: 42-46). This implies changing the way in which registered nurses are used to performing their role and function in order to include consultation with the communities they serve.

1.2.1.3 Restructuring the National Health system for universal Primary Health Care

This official policy document, issued by the Department of Health, discusses the Primary Health Care (PHC) delivery system in terms of the basic principles, the PHC package and the PHC delivery model. Some of the main features of the PHC delivery model are to fast track certain elements of the restructuring program. These elements impact on health workers and in particular on registered nurses in clinics who have to provide the primary health care services. The financial constraints have prevented the implementation of most of the elements. The existing personnel have to fill the gaps and continue to provide the extended services which government promised the people. Providing additional health services with the same personnel over an extended period can affect the coping skills of health workers. Other elements of the restructuring program are:

- Improvement of access to the PHC system.
- Development of the district based health care system.
- Increased autonomy and efficiency of public PHC providers.
- The introduction of accredited private providers.
- Increasing the supply of Primary Health Care Nurses (PHCN) in public PHC facilities.
- Increasing the supply of medical personnel working in public PHC facilities.
- The creation of adequate numbers of effective district and facility managers.

- The implementation of additional measures to improve staff distribution and efficiency.
- Addressing the gap in provision of PHC facilities.
- The provision of an Essential Drug List (EDL) (Department of Health 1996: 37-41).

1.2.1.4 The White Paper for the Transformation of the Health Care System in South Africa

The White Paper for the Transformation of the Health System in South Africa, offers various strategies designed to meet the basic needs of all of people in South Africa, given the limited resources available (Department of Health 1997).

The above legislative changes in South Africa are impacting on the provision of health services. These changes in the health care system assert pressure on registered nurses to change their roles, functions and the health care system to suit the needs of the country. There is pressure on the health system to change in terms of service provision (Bowman 1995: 10). These changes require from registered nurses to perform their roles and functions in a transformative manner. Registered nurses are expected to consult with communities, actively engage with health committees around community needs and provide comprehensive health services notwithstanding the financial constraints. The focus of the provision of health services is the patient and not the services.

These changes spearheaded a dramatic shift in professional roles as a result of the restructuring of the health care system. Nurses and other health professionals take on new duties set new priorities and view clinical practice from a new perspective. (The new perspective includes the needs of the patient and the family as the central point. New duties and priorities include the management of opportunistic infections in HIV positive patients, increasing the condom distribution to prevent transmission of HIV/AIDS and the management of Prevention of Mother to Child Transmission programme). Major changes in organisational roles, structures and relationships have resulted in uncertainty and fear in registered nurses of who they are and how they fit into the new health care culture. The development of a strategy to manage and support change within the nursing profession is necessary (Lowery 1997: 5).

However, these changes could cause conflict within the individual and contribute towards the development of stress. These changes could even aggravate the stress that is caused by the current problems in nursing. (The problems in nursing include shortage of staff, high patient working, violence in communities where nurses are required to deliver services and managing very ill patients with dual infections for instance HIV/AIDS and tuberculosis). These changes affect nurses as health care providers negatively. The coping skills of registered nurses are reflected in their philosophy of self-care and how they deal with everyday stresses (Smythe 1994: 5-8). It is therefore imperative that coping skills should be developed to empower registered nurses to cope with the changed work environment. Various authors

discuss coping skills and the need to develop these (Smythe 1994; Myburgh & Poggenpoel 1999; De Wet 1998; Frydenberg 1999).

1.2.2 Impact of legislative changes on the role and function of registered Nurses

The need for legislative changes arose from an unequal situation in health service delivery, illustrated by a high concentration of resources within the hospital sector, under-resourcing of primary health care services and the historic geographic maldistribution of human and other resources (Van Rensburg, Fourie & Pretorius 1992: 246-148). The National Health System serves to address these inequalities and is based on a comprehensive primary health care approach.

Within the core primary health care team, primary health care nurses will in general, act as the front-line providers of clinical primary health care services (Department of Health 1996: 2-18).

The dominance of the medical profession in the health care delivery system, resulted in specific priorities and emphasis in care, contributed to a situation in care delivery structures to suit own (medical profession) vocational and professional interests. This gave rise to consequent inability to address the health needs of the majority of citizens (Van Rensburg et al 1992: 363). Moving towards a primary health care approach will impact on the role and functions of nurses whom form the backbone of health services in the country. Registered nurses will be responsible for the PHC

core package of services. The financial constraints limit the employment of full time employed medical doctors. The role of registered nurses implies more and more the provision of curative services and the nursing care role of patient support and health promotion whilst disease prevention becomes secondary.

1.2.3 The stressful environment of nursing

Nursing takes place in a stressful environment for the following reasons:

1.2.3.1 The health care system

The current problems involve escalating cost and affordability of health care, inequality in health care, HIV status in South Africa, fragmentation and the inefficient co-ordination of the health care supply. These problems reflect the unequal provision of services and result in a shortage of health personnel (Van Rensburg et al 1992: 353-355). The shortages of health personnel are further exacerbated by the increased need for health care through the primary health care mode that encourage patients to attend local primary health services first before being referred to a secondary health care facility.

The funding requirements for Primary Health Care are projected to increase from R4, 768 billion in 1995/6 to R7, 050 billion in 2000/01. It is envisaged that the total government fiscal allocation for Primary Health Care would grow on average by 7.7% per year (Department of Health 1996: 41). Although primary health care facilities will

be expanded, no provision has been made to increase the staff allocation to these services.

In most clinics in the City Health department a decrease in personnel has been experienced (statistics about filling of posts are available). When a registered nurse retires or resigns the post is evaluated to determine whether it is an essential post or not. If it is an essential post the recruitment process starts which can take up to six months to fill a vacant post. If the post is not perceived as essential the vacant post is removed from the staff establishment. The director for City Health decides about the above.

1.2.3.2 The role of women in society

A contributing factor to the stressful working environment of registered nurses is the gender role socialization. Another factor is the conflict of traditional and changing roles that limit women, to certain socially acceptable behavior, roles and careers (Nixon 1995: 19-24). Furthermore, nurses as wives are expected to fulfill their domestic obligations and parental obligations as well as to cope with occupational responsibilities. This could be stressful and result in absenteeism and consequently a shortage of staff at the functional level.

Nursing as a female dominated profession reflects the status of women in society as followers and not as leaders (Nixon 1995: 19-24). It creates dependent roles and results in nurses not taking the lead and the initiative.

1.2.3.3 The nursing educational system

The nursing education system strives to equip nurses with competency and skills to deliver quality of care. Nurses are not always encouraged to think critically and act independently, although they are expected to act as independent and efficient team members. The nursing education programs' are taught with emphasis on the dependent function of nurses and the independent function of nurses are neglected. The nursing education system allows students to work under supervision throughout their student years and very little independent practice occurs in recently qualified registered nurses. The inability of nurses to earn credibility through critical independent inputs, leads to conflict, frustration and stress (Smythe 1994: 19-24).

Many nurse education curricula do reflect the counseling and the management of opportunistic infections and the syndromic management of sexually transmitted infections. Within the context of the Acquired Immune Deficiency Syndrome (AIDS) pandemic in the country it has not been adequately reflected or voiced by the sector as a whole in South Africa.

1.2.3.4 The increased need for health services

The current legislative changes in the country focuses on service delivery that should be provided within a district health system. The elimination of user fees for all primary health care services was introduced through policy in 1996 (Health Systems Trust 1996: 197). This resulted in increased attendance at PHC level. The increased utilisation of health services did not coincide with the increase of personnel at PHC

facilities. It became difficult for staff to manage large numbers of clients without compromising the quality of care.

1.2.3.5 The morbidity and mortality profile of the Metropole Area

The morbidity and mortality patterns of a country impact largely on the demands on registered nurses in the health services. The morbidity and mortality trends in the Cape Metropole illustrate some of the demands on the nursing personnel in primary health care facilities. Statistics indicate an increase in morbidity and mortality over the period from 1986 to 2000 in the Cape Metropole area.

The overall IMR (Infant Mortality Rate) in the country has shown an increase that can be associated with the HIV/AIDS epidemic (Department of Health 1998: 8). The IMR in the Central Health District includes Langa, Factreton, Maitland, Claremont, Salt River, Woodstock and Central Cape Town areas) of the City Health Department (City of Cape Town 2000).

Table 1 Central Health District Infant mortality

Infant Mortality Rate	**Per 1000 live births**
1998/1999	13.7
1999/2000	15.4

- The Cape Metropole region has the highest proportion of curative attendance (the number of patients attending the health clinic for curative services) compared to other regions nationally (Department of Health 1998/1999: 24). Curative services include the management of diarrhea, respiratory tract Infections and minor ailments (City Health Directorate, definitions for Health Information. Source unpublished and undated).
- The number of teenage pregnancies as a proportion of total deliveries is 6,9% for the Cape Metropole. The target is to reduce it to 5% (Department of Health 1998/1999: 29).
- The phenomenon of Low Birth Weight (LBW) babies is an important indicator of the nutritional status of a child at birth. It also reflects the poor nutritional status of the mother, substance abuse, poor access to health services and under utilisation of health services (Department of Health 1998/1999: 24-25), 11.3% LBW babies were born in the Central Health District for the period July 1999-June 2000 (City Health Directorate. Source unpublished and undated.). LBW babies require special care, support and they should be followed–up frequently at the clinics.

- Termination of pregnancies in the Metropole amounted to 1 847 for the period July 1997-June 1998 and 2 042 for the period July 1998- June 1999 (Department of Health 1998/1999: 32). The Termination of Pregnancy Act expects of all health professionals to advise clients on the Termination of Pregnancy (TOP) Act, initiate TOP counseling and refer the client to the nearest appropriate facility. This resulted in an additional demand on the registered nurses. Workload and patient-nurse ratios, greatly impact on the time for nurses to effectively adhere to the legal framework.
- HIV/AIDS is the fastest growing epidemic in the world. The Western Cape has the lowest prevalence of HIV/AIDS infection in South Africa and is reported as 5.2% (Department of Health 1998/1999: 35). The number of new HIV cases reported at the City Health Department clinics for the period 1999/00 is 483 (City Health Directorate: 2000. Source unpublished). The preferred care for people with AIDS is symptomatic management of the disease is best done at a primary health care level. If an effective primary health care system is not in place, Aids patients overload hospital systems through increased admissions due to HIV/AIDS related symptoms and complications (Health System Trust 1996: 168). The majority of HIV positive clients should be managed at primary health care clinics with prophylactic management to prevent TB and opportunistic infections. This has resulted in an increased workload for registered nurses.
- Males who attended primary health care clinics with penile urethral discharge in 1998/1999 amounted to 325/100 000 (Department of Health 1998/1999: 44).

The syndromic treatment of Sexually Transmitted Diseases (STD) management has become the responsibility of the registered nurse in the PHC setting.

- The TB (Tuberculosis) incidence /100 000 population in the Cape Metropole is 509 for the period 1999/00 (City Health Directorate: 2000. Unpublished).
- The five top causes of death in the Cape Metropole for the period July 1999-June 2000 are (City Health Directorate. Unpublished and undated):
    1. Cancer
    2. Homicide
    3. Heart Failure
    4. Stroke
    5. Heart Attacks
- The Top five causes of death for infants during the same period in the City Health Directorate are:
    1. Prematurely
    2. Unknown causes
    3. AIDS
    4. Gastro-enteritis
    5. Congenital malformations (City Health Directorate: 2000).

The mortality data indicates the disease profile of the City Health department. AIDS and gastro-enteritis are diseases that require continues intervention strategies at all levels of government, civil society and Non Governmental Organisation's (NGO).

1.2.3.6 Shortage of human resources

- The report on “Restructuring the National Health System for Universal PHC” released in 1996 by the Department of Health, suggests that an additional 7 187 professional nurses and 10 766 clinical nurse practitioners will be required in 1996/7 (Health Systems Trust 1996: 93). With legislative and other changes impacting on health and health care delivery, the need for additional nurses is clear. The staff shortage was further highlighted in an article placed in the Southern Mail (25 October 2000: 3) in an attempt to address the large numbers of clients attending the emergency services of the Retreat Day Hospital (Cape Town) after hours. The sister in charge comments in the article that the majority of clients did not present with emergency needs. They however insisted on being managed, often to the detriment of acute emergency cases

1.2.4 Transcultural nursing

- A major aim of transcultural nursing is to understand and assist diverse cultural groups with their nursing and health care needs (Andrews & Boyle 1995: 4). An important demand on nurses in primary health care clinics is to become more service-orientated, introduce the “Batho Pele” principles and to focus on the community as a client. Nurses should therefore have accurate knowledge of the causes, distribution of health problems, effective interventions, values, goals and acceptable cultural practices of the diverse community who attends primary health care facilities (Andrews & Boyle 1995: 324).

1.2.5 Role and function of registered nurses

In 1996 the duties and responsibilities of registered nurses included the following:

- Preventative and promotive health services.
- Management of minor ailments for children under six years of age.
- Management of chronic infectious diseases inter alia treatment of tuberculosis
- Women's health services inter alia family planning.
- Treatment of Sexually Transmitted Diseases (job description of registered nurses in 1994 in the City of Cape Town).

Due to the changing health care environment, responsibilities of registered nurses also had to change to include the following major duties: -

- The curative management of conditions in children under thirteen years of age.
- The syndromic management of sexually transmitted diseases.
- Pre- and post-test counseling for HIV detection and follow-up of HIV / AIDS, including their nursing management.
- Termination of pregnancy counseling for clients who request termination of pregnancy after being counseled regarding referral options.
- Dispensing of chronic medication to patients, whose conditions are stable and whom doctors at the Day Hospitals have referred to the clinics. Patient ready prescriptions are prepared at the Day Hospital and delivered to the clinics (City Health Directorate Job description for the year 2000).

Comparing the job descriptions of nurses of 1996 and 2000, it becomes apparent that additional functions and responsibilities have been included such as:

- The pre- and post-test counseling for HIV.
- The nursing management of HIV/AIDS clients.
- Provision of curative services to children under thirteen years of age.
- The counseling and referral of clients for termination of pregnancy and
- Dispensing of stable adult clients' chronic medication.

1.2.6 Coping skills

Work stress in the nursing profession has been studied extensively and researchers use the term "stress" differently. According to Boey (1998), work stress exists when people perceive difficulties in coping with the demands relating to work and when their sense of well-being is being threatened (Boey 1998: 353).

Lazarus (1991) described coping strategies as purposeful attempts or efforts at solving a problem without the requirements of reaching an immediate agreement. Nursing takes place in a stressful environment. There is little direct control over many of the stressors that affect job satisfaction and a sense of well-being. There is however control over how people allow events to affect them. Skills to take control of their lives and care for "themselves" are acquired. Acknowledgement of current problems in nursing, while at the same time accepting personal responsibility for managing individual stress levels, will promote coping in stressful environments,

including professional problems and problems in the health care system (Smythe 1994: 31).

1.2.6.1 Factors that impact on the coping skills of registered nurses

1.2.6.1.1 Financial constraints

- Changes in the financial policy introduced between 1994 and 1999 attempt to address equity and sustainability of health programmes. The lack of financial capability and capacity in the province to adequately provide the financial means to cope with increasing health demands at primary health care level, place nurses in the forefront to cope with unsatisfied clients. Nurses have to explain to clients why they have to wait for a long period of time, before being attended to, why limitations on medications exist and why they have to be referred to other facilities for more specialised services. The health sector resource allocation formula, supported the geographic reallocations of public sector health budgets in favour of the formerly under-resourced provinces, which was introduced. This resulted in existing services having to be scaled down with consequent adaptation of nurses who also had to cope with unsatisfied clients.

1.2.6.1.2 Free health care for children under five years of age

- Policies that ensured primary health care, free of charge to specific vulnerable groups, were not effectively planned for and resulted in an substantial increase in clients at primary health care level, without additional personnel, supplies and

equipment or facilities. The above-mentioned factors resulted in uncertainties with regards to planning, poor morale of service providers and declining quality of care and increasing public dissatisfaction with the public health system (Gilson 1999: 7).

1.2.6.1.3 Increased demands on registered nurses

- The additional responsibilities of nurses in primary health care clinics, resulted in changing professional demands of registered nurses. The registered nurses have to manage and cope with the caring of very ill patients, for instance HIV/AIDS patients. Clinical support of doctors in clinics is not readily available and registered nurses practice independently most of the time.
- Fewer registered nurses have to provide increased services too more demanding communities while budget cuts affect the appointment of registered nurses in vacant posts. Clients wait longer to be attended to as was illustrated by an initial waiting time survey that was conducted in 1999, with a follow-up survey in 2001. Nursing has historically been identified as a high stress profession, because of the caring nature and high level of responsibility of the profession (Myburgh & Poggenpoel 1999: 36). Ethical issues and critical decisions place additional stress on nurses. In situations of staff shortages and the demands of critically ill patients or large numbers of patients at clinics, nurses cannot cope with the demands of quality service provision (researcher's observations).

1.3 CONCEPT CLARIFICATION

Coping skills: Ashford (1988: 21) defines coping skills as those aspects of the self that provides general resources for handling adverse environmental events (Cilliers 1998: 33).

Positive coping skills: Positive is having qualities worthy of approval or constructive attitude (Schwartz, Davidson, Seaton & Tebbit 1988: 1139). Thus positive coping skills relate to using resources constructively for handling adverse environmental events.

Coping strategy: Coping strategies are basic attempts to regulate both the internal and external environment (Aldwin 1994:217).

Coping mechanisms: Mechanisms is actions that assist with coping (Smith 1993:135)

Support systems: Support systems modify the potentially negative effects of stress, by reducing the stress or facilitating the individual's efforts to cope (Monat & Lazarus 1985:50).

Culture: Culture refers to the learnt, shared and transmitted values, beliefs and norms and life ways of a particular group that guides their thinking, decisions and actions in patterned ways (Leininger 1991: 47).

Health care culture: Every health care system has a cultural component which involves the knowledge, skills, ideologies, values, symbols, norms, technologies and material means, through which the health care system functions (van Rensburg et al 1992: 4).

Stress: Stress is a complex composition of physiological and psychological phenomena that includes the actual stressful event or stresses, the individual's perception of the stress, the external and internal mediating factors and the manifestations of the response (Sawatzky 1996: 410).

Change: Morrison (1993: 256) defines change as a process of making or becoming different. Change is continually occurring, it is dynamic and possesses several special characteristics. Change is a dynamic process and is influenced by many variables and the effects thereof are widespread (Naude 1996, 20(4): 40-41).

Clinical Nurse Practitioner: This refers to registered nurses who completed a post-basic diploma or certificate course in clinical nursing science, health assessment, treatment and care (South African Nursing Council regulation number 48 1982).

1.4 PROBLEM STATEMENT:

The aim of the study is to explore and discuss the coping skills of registered nurses working in a changed environment.

1.5 RESEARCH QUESTIONS

1.5.1 What is the impact change has on the care and responsibilities of nurses?

1.5.2 What coping mechanisms do nurses apply in their daily activities?

1.5.3 What assistance and support systems are necessary to ensure that registered nurses as frontline providers of the District Health System can cope with the health service demands?

1.6 AIM OF THE STUDY

The aim of this study is to explore and describe coping skills of registered nurses in primary health care clinics in the Cape Metropole area. The identified coping skills can assist management in initiating support structures and programs to assist registered nurses to support change initiatives and implement policy in a positive manner. The implementation of the research findings could contribute towards registered nurses that can provide in the health needs of the communities.

1.7 RESEARCH OBJECTIVES

- To identify strategies, which nurses, utilise to cope with the changes in the health services.
- To explore appropriate support systems that will strengthen the coping skills of registered nurses in clinics in the City Health Department.
- To deduce guidelines on how to support staff from the literature study and the results of the research.

1.8 SIGNIFICANCE OF THE STUDY

The development of stable, well-supported registered nurses that are able to manage the pressures currently experienced in PHC is essential to enable quality health care. The City Health Department is under obligation to use the research results to manage and reduce the stressful work environment on registered nurses. Exploring the coping capacity and trends of nurses in primary health care clinics and

identifying strategies to create a supportive working environment have the following significance for individuals, the profession, the health system and the community.

1.8.1 The significance for the nurse

- The results of the study can assist registered nurses to promote and optimally utilise coping skills in the dynamic and changing health system.
- The results of the study could further be used to identify, implement and utilise support systems that will contribute towards a more conducive and less stressful working environment.

1.8.2 Significance for the profession

- The ability of registered nurses to effectively cope with stressors in their daily professional activities will improve quality nursing that will contribute to an improved credibility of the profession.
- The development of scientific knowledge in the primary health care field could improve nursing practice.

1.8.3 Significance for the health system

- The implementation of a District Health System requires registered nurses as frontline health service providers to develop coping skills that will assist them in effectively addressing the changing demands placed on them.
- The study will assist managers in the health system to ensure efficiency, effectiveness, quality and acceptability of the health system.

1.8.4 Significance for the community

Communities will benefit by an appropriate service of high quality, which is only possible when the health care providers know how to effectively cope with the challenges and dynamics of health care delivery.

1.9 RESEARCH METHODOLOGY

1.9.1 Research method

A qualitative approach to the research will be followed which will include individual interviews and focus group discussions.

1.9.2 Sampling

Purposive sampling is used to select registered nurses for the personal interviews and group discussions. Registered nurses are selected from six clinics within the City Health Directorate.

1.9.3 Data gathering

Six individual interviews and three focus group discussions have been conducted to ensure saturation of data.

1.9.4 Data analysis

The interviews and focus group discussions were recorded and then transcribed. The data was then assessed and manually coded into central themes, which emerged (open coding process).

1.9.5 Ethical measures

The research study complied with ethical principles, which includes informed consent and voluntary participation.

1.9.6 Trustworthiness of data

The trustworthiness of the data was assessed through credibility, transferability, dependability and confirmability of the data (Polit & Hungler 1995: 359-363).

1.10 CONCLUSION

This research aimed to explore the coping skills of registered nurses in the changing health care environment. The national health care system has undergone major legislative and policy changes. It seems inevitable that the existing health care system will undergo further fundamental changes. These changes will bring about profound re-organisation in existing structures and drastic reorientation in the prevailing emphasis in health care. The nature and direction of change will depend on the political and economic processes in the country.

Coping skills for registered nurses are fundamental in ensuring that registered nurses cope efficiently with the transformation in this country. The coping skills used by registered nurses to cope with these legislative changes are the focus of this research. Data has been collected through individual interviews and focus group discussions.

CHAPTER TWO

2 LITERATURE SEARCH

2.1 INTRODUCTION

The research material was obtained from the libraries of the University of South Africa, the University of Cape Town, public libraries, City Health Directorate and the government printers. The literature search identified a limitation of the available literature relating to coping skills of primary health care nurses/community health nurses. Coping skills of registered nurses in ward settings and community psychiatric nurses are available thus it was used in this chapter. Most of the literature used is from the United States of America and the United Kingdom.

The impact of legislative changes are far-reaching and forces registered nurses and managers to provide health services that address the changing needs of the community. The coping skills of nurses during times of change have a major impact on the quality of health services delivery. Coping skills documented in existing literature will be studied and applied to the study.

2.2 CHANGES IN SOUTH AFRICA

The changes were driven by the concept of government, of health for all and many changes were envisaged in the way care was organised and delivered (Gray 2000: 1). The emphasis of the ANC Health Plan, published in 1994, was to develop a health care delivery system based on health districts. It was considered the most appropriate way to reverse half a century of neglect and misallocation (Gray 2000: 2).

To ensure the implementation of change and the policy development to enable change, the next generation of nurses must be educated in community settings that:

- allow nursing students to provide continuity of care for clients in outpatients settings;
- practice health promotion and disease prevention strategies;
- develop client communication and negotiation skills with diverse populations and
- deal with social, financial and ethical aspects of care.

These community-based experiences will emerge only through meaningful curriculum revision and the development of new partnerships and alliances between nursing schools and community partnerships. Strategies for shifting expectations and demands on nursing professionals as well as the schools that have trained them are needed. Strategies for supporting these institutions in adapting to change with in the curriculum and community are also essential (Matteson 2000: 34; 44; 60; 124; 160).

2.2.1 The change process

After the first democratic elections in 1994 change was inevitable. Uncertainty was felt at all levels in the health care system. The communities felt more empowered and expected the health services to immediately provide in all its needs. However, change and transformation occurred at its own pace. The pace of change and transformation occurred at a variant pace in the health sector. The legislative

changes were introduced. A process of planning, implementation and monitoring was developed through the legislative processes.

During the implementation of changes in South Africa there was consultation with stakeholders on a national and provincial level. The National Minister of Health initiated the consultation process with stakeholders. Consultation occurred through discussion documents and consultative forums on new legislation and the strategic priorities of government. Twice a year the National Department of Health hosts a consultative workshop with government officials, organised labour, role-players in the health sector, non-governmental organisations, the private health sector and other relevant interest groups.

This consultation process ensures a credible transformation process. Through the consultation process stakeholders form part of the process and are more likely to accept the transformation of the health system. The challenges facing transformation are:

- resistance to change; and
- the inability to cope with the rate, scope and intensity of change (Muller 1997: 27-31).

The above indicate the process and changes that occurred within the health services and provides the background to understand the external pressure.

Currently South Africa is surrounded by numerous demands for change. Change can be planned or unplanned. Unplanned change is accidental change, resulting from an imbalance in the system and it results in hostility and resistance because individuals

feel surprised, uninformed and threatened. Planned change is goal-oriented and moves the system slowly and carefully in the planned direction. If change is planned and implemented effectively, it meets with minimum hostility and resistance. The legislative changes can be compared with unplanned change. The changes were sudden and unexpected. Registered nurses in primary health care services were responsible to implement some of these changes.

2.2.2 Legislative changes

The driving forces of change in South Africa are the legislative changes, community needs and the promotion of equity (A National Health Plan for South Africa (1994); White Paper for the Transformation of the Health Care System in South Africa (1997)). The development of a District Health System (DHS) in South Africa is the foundation on which future health services are being built. The principles of a DHS include access to services, local accountability, community participation, decentralisation, sustainability, developmental, equity and an intersectoral approach. In a DHS the country is divided into geographic coherent and functional health districts (Department of Health 1995: 8). A district management team will manage each health district and is responsible for the planning and management of all local health services in a defined population. Over time, one single authority will employ all staff at district level. Three governance options are recommended:

i. The provincial option, where the province is responsible for the delivery of the DHS.

ii. The statutory district health authority option, a model where a district health authority for each district is created through legislation by the province.

iii. The local authority option entails the rendering of all district health services by the local authorities, if they have the capacity to deliver such services (Department of Health 1997: 29).

Some of the above changes have been introduced in the clinics and the changes are continuing.

The concerns of registered nurses result from lack of information and uncertainties about conditions of service and job insecurity cause additional stress. After the local government elections on 5 December 2000, it is envisaged that all the staff will be transferred to the Unicity (Cape Town Metropole). Unicity negotiations with the trade unions have resulted in a possible strike action regarding the new conditions of service and the restructuring processes of the Unicity. Resulting from the restructuring and the placement of staff all posts that become vacant due to staff retiring or resigning are frozen. However, critical vacant posts are temporary filled with a one year contract posts (Unicity Newsletter 2001). These changes create instability in the working environment, which cause additional stressor that affect, the coping skills of registered nurses.

The City Health Directorate staff is currently working with minimum staffing levels. The open door policy in terms of accessibility, shortage of staff, restructuring of services and the transfer of staff to the Unicity could affect the coping skills of registered nurses (researcher's views).

2.2.3 Impact of legislative changes on nurses

The implementation of the following legislative changes has impacted on the working load of health workers and professional nurses in particular:

2.2.3.1 Free health care policy for children under five years of age

The presidential lead program introducing free health care for children under six years of age (Health Systems Trust 1996: 183). This policy increased the patient load at clinics without an increase of staff (City Health Directorate, Health Information Statistics).

2.2.3.2 Termination of Pregnancy Act, 1996

In 1996, Act no 92 of 1996 was promulgated in South Africa regarding freedom of choice in respect of termination of pregnancy. Poggenpoel, Myburgh and Gmeiner in 1998 researched nurses' experience of abortion and the prescribed guidelines to support nurses. It was found that nurses felt inadequately prepared to deal with these patients in terms of counseling skills. The researchers recommended that special clinics should be established to accommodate these clients. It was further recommended that nurses should volunteer to work at these clinics and not be compelled to work at those special clinics (Poggenpoel, Myburgh & Gmeiner 1998: 2-7).

This legislation impacted on all levels of the health care system. It “forced” registered nurses to clarify their own values and emphasised the importance of being non-judgmental. Due to insufficient time to train and prepare nurses for this “new” demand, nurses are not able to cope effectively with their responsibilities regarding termination of pregnancies. This is an example of an additional service registered nurses perform. The registered nurses identify, counsel and refer eligible clients for termination of pregnancy to appropriate hospitals.

2.2.3.3 Integration of psychiatry care and community health nursing

Currently, clinics are under pressure to integrate psychiatric care into the primary health care system and in some clinics the integration has occurred. This places pressure on the already faltering system and on registered nurses who are the primary providers after minimum in-service training (Uys 1997: 28).

2.2.3.4 Employment Equity Act

The Employment Equity Act applies pressure on employers to introduce affirmative action policies in the work place. Employers had to submit employment equity plans to the Department of Labour, outlining their targets in the employment of designated groups (Government Gazette 1998: 18). The implementation of affirmative action caused tension in the workplace for various reasons. Cultural diversity and the need to provide quality and appropriate service by culturally competent providers to consumers with diverse beliefs systems are required. Promotion opportunities for

certain designated groups are minimal and registered nurses in these groups feel threatened. The tensions impact on the performance of registered nurses.

2.2.4 Changing role of registered nurses

For centuries the primary role of nurses has been to care for patients. It included assisting the physician and contributing towards the assessment and treatment of patients. Registered nurses are currently struggling to shed their historical stereotyped role of being subservient and underpaid females. The unionisation of nurses occurred in the early seventies and attempts have been introduced to change the historic roles of nurses within the health care delivery system. New roles have emerged for all categories of health workers, including registered nurses. Nurses now perform duties as clinical nurse specialist, nurse clinician, nurse practitioner, nurse anesthetist, project managers and district managers. These positions involve working in diverse settings such as ambulatory care clinics, nursing homes, home care programs and primary health care centers. The question that comes to mind is how nurse's roles will evolve even further in the changing health care environment (Lancaster 1999: 20-21). Nurses execute these roles, but experience this as challenging to cope with in addition to their normal function.

2.2.5 Managing change

According to Bowman (1995) nurses are confronted with changes in their profession and organization daily. Nurses are not well prepared for these changes. It is the responsibility of management to ensure that sufficient processes are in place, which

would allow nurses to cope and achieve success for themselves, their patients and their organisations (Bowman 1995: 12).

Lowery's (1997) view is similar to Bowman (1995) that processes must be in place to manage change effectively. According to Lowery (1997), change affects personnel, organisations and professions. An effective strategy to manage the process of change is critical to the success of the change initiatives. It includes:

- Leadership that move people into and through continuous change, with a clear and common understanding of where it is going.
- Structural changes with flat management structures and teams that support the new focus and business strategies of an organisation.
- The identification of new competencies, training, development programmes, and performance assessment processes, which can accurately measure the progress of individuals and teams. According to Manion (1990: 33-63) innovative skills, assertiveness, self-esteem, negotiation skills, time management, leadership skills and creativity are essential for nurses to enable them to fulfill their role.
- Individual and group incentives must be linked to performance ensuring the support of these changes.
- Effective communication is a determining factor whether a change initiative will succeed or fail (Lowery 1997: 15-28).
- Strategies to prevent or limit resistance to change are important and challenging.

The following strategies should be used by managers to limit resistance to change:

- Involvement and participation through open communication.
- Facilitation and support in the acquisition of new skills required to implement change.
- Negotiation and support (Naude 1996: 40-42).

Action research conducted to introduce and evaluate change in nursing care in an accident and emergency unit in Durban revealed that approximately eighty percent of the time was spent with the nursing staff on the unit to support and maintain the relationship with the researcher. Only twenty percent of the time was spent discussing change processes (Kerr 1996: 15). Lowery (1997) and Bowman (1995) emphasize the importance of addressing the processes of change. Kerr's findings indicate only 20% of time were spend on discussing the change processes which appears inadequate to effect change. The understanding of the change process provided an insight into coping skills of registered nurses.

2.2.5.1 Manifestations of not coping with change

In the workplace the effects of not coping with change often causes absenteeism. The effects of not coping are manifested as depression, suicide, heart attacks and other stress related illnesses. Change occurs everyday, at work and in society at all levels. Human resource development managers have a crucial role to play in addressing the stressful environment of employees in a meaningful manner (Viviers

1998: 42-43). Coping skills of registered nurses must receive attention given the extended functions. Registered nurses and nurse supervisors must be exposed to the evidence on registered nurses that do not cope with changes.

2.3 CAUSES OF STRESS

2.3.1 Stress and ill health

A growing body of research indicates that mild and even positive, affective states can markedly influence everyday thought processes, enhancing creativity and flexibility in problem-solving and assist with efficiency and thoroughness in decision-making and improved thinking. Furthermore, recent findings in the coping literature indicate that when people must cope with adverse events, positive effects assist with effective coping and reducing defensiveness (Lewis & Haviland – Jones 2000: 417-418).

Emotions can have an impact on illness via direct and indirect pathways. The direct patterns are linked to cardiovascular disease. The indirect link, whereby emotional processes, lead to behavioural changes that induce disease. Depression, for example, can initiate excessive alcohol consumption in men and cigarette smoking in women. This high-risk behaviour can produce physiological changes leading to serious chronic illness, such as hepatic necrosis and pulmonary DNA alterations, which could cause liver cirrhosis and lung cancer. The disease risk will vary from individual to individual and are based on genetic susceptibility. These indirect

pathways are the most potent contributors that cause the development of illness (Lewis & Haviland – Jones 2000: 523-524).

The outcome perspective examined and researched the factors that mediate the emotional adjustment to illness. It assessed how coping procedures was influenced by the impact of disease on functioning and the consequences of these processes for the emotional status and quality of life. The findings indicate that physical illness leads to functional decline and disruption of activities of daily living, which increase depressed moods. The diseases covered range from cancer to symptoms and distress caused by common illnesses. Studies examining the links between disease and the affects thereof demonstrate these bi-directional links (Lewis & Haviland– Jones 2000: 524-525). There is an awareness that registered nurses could be affected by illnesses and diseases, thus the above could impact on their coping skills.

Studies examining the relationship between life stress and the development of infectious diseases provide strong evidence that links emotions to diseases. Studies by Kiecolt-Glaser and colleagues investigating the impact of examination stress in medical students, marital strain in spousal pairs and depression in caregivers of persons with Alzheimer's dementia, demonstrated effects on a variety of infectious illness outcomes. There is evidence that stress decreases resistance to the common cold. The data shows that respiratory infections and its clinical manifestations correlate positively with the degree of psychological stress reported. In the study of

stress/ emotion and cardiovascular diseases, the stronger impacts of stress are seen on compromised systems (Lewis & Haviland-Jones 2000: 531).

Women undergoing a biopsy for a suspicious lesion, which's self-regulatory style was characterised by "engagement" (actively confronting the possibility of illness). They were more likely to report positively affective responses as measured by a scale of general psychological well-being, compared to women whose coping responses were characterised as "avoidance" (actively avoiding information and discussion about the illness). In the context of breast cancer family risk assessment, confrontive coping strategies (for instance pursuing early detection behaviour) were associated with lower levels of anxiety and fear, contrasted to evasive or fatalistic strategies which were associated with higher levels of distress (Lewis & Haviland-Jones 2000: 545). The experiences of how women cope in situations could be informing the researcher.

2.3.2 Ways in which nurses cope

A work survey was conducted amongst 673 municipal employees from various occupational categories, 68 nursing respondents reported significantly more stress on the job yet consumed no more alcohol than the other workers in the study. The purpose was to examine ways that nurses respond to workplace stress other than consuming alcohol excessively (Moore 2001: 31-32).

The ethnographic inquiry was used to determine the kind of stressors faced by nurses and the ways they relieved their stress. The ethnographic interviews identified that nurses experienced the following stressful factors:

- to defer to doctors who do not respect them;
- unsupportive supervisors;
- the bureaucracy in general;
- verbal abuse and harassment from hostile patients;
- being harmed by physically abusive patients in the emergency and psychiatric wards;
- having to interact with relatives when patients are in need of care;
- caring for injured and abused children;
- caring for dying patients;
- fear for HIV infection from needle sticks;
- odd hours;
- long hours and associated sleeping problems;
- understaffing;
- budget cuts; and
- the move to managed care (Moore 2001: 33-35).

Protective factors, which reduce stress, were considered as elements of job satisfaction. Nurses identified several positive factors for instance:

- valuing talented and caring co-workers;

- working independently and a good civil service position which includes job security, pay and benefits;
- traditional motives for becoming a nurse including helping the helpless and patients;
- the engaging and challenging character of their work;
- interesting patients;
- professional growth opportunities;
- interdepartmental transfer; and
- for some the odd hours fit their family/school obligations (Moore 2001: 35).

Nurses relieved stress in different ways. The most frequent being to seek social support of family members, friends, supervisors and especially co-workers, to take “mental health days” off, to exercise, take classes and become engrossed in hobbies or writing during non-working hours, commuting between work and home assist nurses to adjust from the situation which they are from, fighting the system and trying to reform unfair policies, taking a brief break by stepping outside when the incident occurs or smoking a cigarette and addressing the problem as it occurs. About a third of the interviewed nurses smoked cigarettes because it offers a chance to step out of the door. The nurses had developed many alternatives to using drugs and alcohol to cope with in the workplace stress and do not consider drugs and alcohol as options (Moore 2001: 36-38).

There is evidence of differential rates of substance abuse in different nursing specialties. The role of the working environment is important in the prevention of substance abuse (Moore 2001: 38). This study was conducted in a hospital in America. The researcher selected respondents across the various wards in the hospital. The findings could be useful to understand whether nurses in South Africa use the same coping skills given the different work situations.

2.3.3 The relationships between nursing work-related stressors, coping strategies and its impact upon nurses' levels of job satisfaction

A study was conducted in Australia to examine the relationships between nursing work-related stressors, coping strategies and its impact upon nurses' levels of job satisfaction and mood disturbances. The results indicated that working load was the highest perceived stressor in the nurses' working environment. Working load included issues arising from the physical environment, such as actual workload, inadequate staffing levels and insufficient time to complete nursing tasks. In addition, creative problem-solving was the most frequently reported coping strategy used by the nurses in this study. The findings of the study suggest that nurses use adaptive coping strategies in dealing with their work stress through the use of creative problem-solving. The findings provide some support for the transactional model of stress of Lazarus and Folkman (1984), with situational factors influencing the nurses' coping strategies. Escape avoidance, the least used coping strategy, and workload, were the significant predictors of mood disturbance. However, work stress explained more variance in mood disturbances than the coping strategies. Organisational

interventions at reducing the impact of environmental stressors such as workload and staffing levels therefore become more appropriate and are more beneficial to some staff than interventions such as stress management and concentrating on individual coping strategies. Improving the working conditions of nurses could decrease their stress levels and encourage them to continue nursing. Sixty-seven percent of nurses in this study thought about changing their occupation (Healy 2000: 686-687). The fear of loosing more registered nurses could strengthen the recommendations of this study.

2.3.4 Burnout and coping strategies: A comparative study of ward nurses in Canada

A study in Canada focused on the relationship between burnout and various coping strategies on medical and surgical ward nurses. The results indicated significant relationships between burnout and coping levels. It also indicated that coping style could contribute to reducing burnout in nurses (Ogus 1992: 121). Medical nurses experience significant more burnout than surgical nurses do. It thus suggests that the type of nursing unit may impact on the coping style and level of burnout. The following recommendations were made:

- The development of work-based programmes to improve the use of coping skills more effectively.
- Changing the work environment enables nurses to deal with daily stressors.
- Improvement of flexibility and control through greater involvement in policy decision- making.

- Encouragement of nurses to lead healthy lifestyles (Ogus 1992: 122-123).

The study conducted in Australia by Healy (2000) indicate similar findings than Ogus's study (1992), that is to improving the work conditions of nurses could decrease their stress levels.

2.3.5 Role of registered nurses in assessing proposals for change

A study was conducted in the United Kingdom to provide a baseline against which to explore the role of registered nurses in assessing proposals for change. The study was conducted in two district health authorities. Registered nurses perceive the following as major factors that impacted on their abilities to meet their responsibilities:

- unrealistic staffing levels;
- increased working load; and
- Reliance on inexperienced registered nurses and excessive paperwork (Bowman 1995: 56 – 57).

Registered nurses have difficulty in ensuring the standard and quality of care, which they are accountable for. All these factors also give rise to conflict within the nurse resulting in the development of stress (Bowman 1995: 101). This study was conducted in the United Kingdom but the experiences of registered nurses were similar from the Australia study (Healy 2000) and the Canada study (Ogus 2000), which indicate that the staffing levels and increased workload impact on registered nurses.

2.3.6 Stress in mental health nurses: comparison of ward and community staff

This study compared the relative stressfulness of community versus ward-based mental health nursing. The following main stresses confront ward and community nurses:

- the lack of facilities in the community to which clients can be referred;
- knowing that there are likely to be long waiting lists before clients can get access to services;
- not having enough time for study or personal improvement;
- trying to deliver good quality care;
- having too many interruptions when trying to work in the office;
- visiting unsafe areas;
- the perception of insufficient hospital back-up;
- working with clients with a known history of violence;
- coping with changes at the work base (Carson, Leary, De Villiers, Fagin & Radmall 1995: 579-580).

These factors pressurise nurses and result in registered nurses not coping. However, the following coping skills can assist registered nurses to cope:

- caring for yourself in order to care for others;
- the development of a balanced healthy style of living;
- focusing on what is possible, a problem-solving approach;

- the more nurses become aware of the unrealistic expectation they have about themselves as care-givers, their profession and their clients, the easier they will be able to alter their perceptions of the stresses in nursing;
- the process of self- reflection;
- thinking one's way through distress;
- making interpersonal relationships work for and not against oneself (Smythe 1994: 48-191).

The stressors and coping skills of mental health nurses is different from the studies, which focused on ward nurses. The different coping skills used educate the researcher on diversity.

The survival of the health care system depends upon the ability of those within the system to adapt and embrace the changes. Nurses have a unique contribution to make to the ongoing changes that are experienced (Manion 1990: 34-38). Indicating the importance of registered nurses to adapt and cope with change.

Coping is what one does to deal with the everyday service demands. Frydenberg (1999) proposed that a formula for understanding coping must include both the characteristics of the person in a specific situation as well as the individual's perception of the situation.

2.4 COPING WITH CHANGE

According to Cilliers, Viviers, & Marais (1998: 330-337) some individuals cope with change and others not. There are inherent factors to organisational change that could impact on the coping ability of the individual. The nature of change, the forces propelling change and the duration of change could impact on individuals' coping abilities. There can be no doubt that organisational change impacts directly on the coping ability of the individual because the organisations assistance of individuals is minimal to cope with change. Employees use coping resources to manage change. The coping resources used are self-efficacy, locust of control, self-esteem, freedom from self-denigration, tolerance of ambiguity, hardiness, mastery, potency, learned resourcefulness and integration.

The manner in which registered nurses respond to changes or stressors could have a positive affect on patient care and job satisfaction (Petermann & Springer 1995: 53). Although changes could at first be perceived as negative, strategies to effectively cope with these changes could therefore have positive effects.

Effective coping skills together with efficient support systems can assist registered nurses to manage change. Various researchers link non-coping to stress and burnout (Viviers 1998; Petermann & Springer 1995; Sawatzky 1996).

It is therefore important to determine the type of support that should be provided for registered nurses to ensure that they continue to contribute significantly as health care providers (Bowman 1995: 112-113).

2.4.1 Theoretical framework of coping

Coping involves two dimensions. The one is passive coping that involves the strategy of avoidance. The other dimension is active coping or non-avoidance. Health and well-being are measured through the effectiveness of coping.

Many authors link non-coping with stress and burnout. Working load, poor collegial support, role conflict and role ambiguity affect stress and burnout. Individual differences impact on the manner in which registered nurses cope in the work environment (Levert, Lucas & Ortleppe 2000: 36-38; Solomon 1998: 40).

Levert's et al (2000: 38-40) findings indicate that burnout levels for a similar sample of psychiatric nurses in South Africa were higher than those of similar groups found in studies in the United States of America. Lack of resources and social support or broader socio-economic factors, specific to South Africa, could be the reasons why. A cognitive-transactional model of stress indicates that the interaction between stressors in the environment, and their consequences or strains are moderated by intervening psychological processes. The aim of the study was to determine the role that sense of coherence plays in the relationship between nurses' work environment and burnout. In South Africa nurses make a significant contribution to the well-being

of patients but it goes largely unacknowledged and unrecognised. Despite the essential services nurses provide, the long hours and strenuous work and the inferior remuneration, nurses are seen as playing an inferior role to doctors and other clinical staff. This study did not find the sense of coherence to be a significant moderator (Levert et al. 2000: 38-40).

According to Shaw (1999: 1250-1255) the locus of control, social support and self-efficacy impact on coping strategies. Research conducted by Petermann and Springer (1995) on the analysis of job demands and coping techniques, divided registered nurses into two groups, based on their responses namely the “I” and “they” groups. The “I” and “they” groups demonstrated realistic expectations of them and prioritized their workloads. The “I” group demonstrated positive self-care practices in contrast to the “they” group who did not demonstrate self-care practices and blamed others for causing stress (Petermann & Springer 1995: 52-53). The findings are similar to Levert’s et al. (2000) that individual differences impact on the coping skills of registered nurses.

A few research articles focused on coping strategies for community psychiatric nurses. One of these research articles (Coyle, Edwards, Hannigan, Burnard & Fothergill 2000: 63-65) explains the coping strategies used by community psychiatric nurses in Wales. Six hundred and fourteen community psychiatric nurses were surveyed to determine the coping strategies used to reduce occupational-related stress. The strategies used most by the respondents in the study were:

- having a stable home life;
- looking forward to going home at the end of the day; and
- having outside interests and hobbies.

The study found that nurses prefer informal approaches to coping with occupational stressors with only a small number of nurses favouring supervision (Coyle et al. 2000: 63-65). These findings do not respond to the Manion (1990: 33-63) study, which recommends innovative skills, assertiveness, self-esteem, negotiation skills, time management, leadership skills and creativity.

The second study was the Claybury study (Fagin**,** Brown & Barlett 1995: 356 – 357) on community psychiatric nurses that was conducted with the aim of determining whether it is more stressful to work in hospital or in the community. Within both groups a large proportion of nurses experienced high levels of emotional exhaustion due to demands of work. In general community psychiatric nurses experience less stress than ward-based psychiatric nursing. The major contributing factors were identified as job insecurity and an inadequate working environment.

Coping strategies to manage stress include a higher degree of involvement, social support and personal achievement. There was a small but significant difference between the degree of unsupportive and very unsupportive managers as perceived by both groups. Staff support groups, stress management training and adequate supervision by line management must therefore be developed (Fagin et al. 1995: 356-357). The coping strategies is different from the study by Coyle et al. (2000)

which found that the coping strategies used included: having a stable home life; looking forward to going home at the end of the day and having outside interests and hobbies. The community setting is similar to the clinic setting and the coping skills provide insight and understanding.

In the present stressful political, social and economic realities facing South Africa, the industrial psychologist has a vital role to play in facilitating the mental health of employees. The Hawthorne studies (Viviers 1998: 38 – 39) indicated that interest shown in individuals, as employees would positively affect the employees approach to work, cope with stress and serve as a stimulus for optimal functioning. Insufficient attention is given to coping and personal development of employees in general. The focus is on production in terms of work-output. A salutogenic orientation enables the person to function in a holistic sense as a balanced and adjusted employee. The industrial psychologist should care for people as unique and complex individuals who spend approximately one-third of their lives in the working environment. He/she should assist employees to deal with stress to prevent physical and psychological illnesses.

The identification, development and stimulation of a salutogenic orientation will benefit employees and the organisation. The shift should be from an employee's job skills to that of a broader orientation in life skills. A salutogenic orientation should be integrated into the selection and testing of employees, especially when selecting managers. This approach could result in a mentally healthy workforce with a positive

life orientation and more productive workers. Thus, employees with a personality profile characterised by a salutogenic orientation will approach their work more positively due to a pro-active approach (Viviers 1998: 38-39). The need for training of new health service managers, including in-service training for the existing managers, have become more and more important to support the changes (Health Systems Trust 1996: 58). The use of an industrial psychologist to assist employees could be similar to other studies recommending in general support for registered nurses.

2.4.2 Coping skills

When learning to cope, it is the culture and the context within which this occurs that are important. Coping skills can be taught through specifically designed programs (Frydenberg 1999: 23-26). Calitz & Weyers (1998: 37) indicates that anxiety management training can improve coping skills and correct faulty perceptions and thought patterns.

Many studies have found that happiness is correlated with the level of satisfaction with relationships for instance the married is happier than the unmarried. Many studies have shown that social relationships can “buffer” stress (Frydenberg 1999: 81). According to Frydenberg (1999: 348-349) coping is synonymous with co-operation, assertion, self-control, responsibility and empathy. If decision-making occurs in a stressful environment, it increases anxiety and hyper vigilance.

According to Smythe (1994: 60), nurses must adopt a philosophy of self-care. It is not coping with stress, it is a process of promoting an optimal sense of well-being that is on going (Smythe 1994: 60). For Smythe, coping skills are a balance between relaxation, good nutrition, physical fitness and spiritual awareness. It reflects a balance between oneself and the rest of the world (Smythe 1994: 169-179). According to Smythe (1994) the following coping strategies can assist nurses in their stressful environment:

- Goal setting and time management. Setting goals should include the development of an action plan to achieve goals. It further includes continuous evaluation on what went wrong and reinforcing successes (Smythe 1994: 84).
- An understanding of stress and stress management. The more one becomes aware of unrealistic expectations, the more one will have the understanding and insight to alter one's perception of the stress in nursing. The process of self-reflection and the management of stress will assist nurses to cope (Smythe 1994: 128-138).
- Developing and maintaining social support. It has been demonstrated that when cohesiveness within a working group is high, work-related anxiety decrease (Smythe 1994: 211-212).

De Wet (1998) researched burnout in the nursing profession. The research was conducted amongst registered nurses who were employed by Health Canada, Medical Services Branch, working in the North Zone, in Manitoba (De Wet 1998: 147). The study emphasised that management especially should become aware of

the interdependent factors that could result in burnout and stress. Suggested coping strategies in this study included:

- to place things in perspective, work enjoyment and recognising the benefits of added monetary reward;
- coping with added responsibilities in an expanded role brings satisfaction;
- being in control;
- commitment;
- freedom of choice;
- being in charge;
- challenge;
- problem-solving strategies that include staying active, the use of imagination when troubled, relying on other people, having outside interests, using common sense, pampering oneself, healthy eating habits, close friendships, frequent breaks, spontaneous debriefing, learning about different cultural groups; and
- enhancement of skills that practitioners develop over time (De Wet 1998: 325-327).

The coping strategies recommended by Smythe (1994: 211-212) are different from those described by De Wet study. Smythe recommend the following coping skills: goal setting and time management, an understanding of stress management and developing and maintaining social support. It could indicate that individual's coping strategies are different.

A study conducted in Hong Kong (Callaghan, Tak-Ying & Wyatt 2000: 1518-1527) identified that paediatric nurses reported the highest stress levels. Nurses on lower grades reported higher stress levels than nurses at the higher grades. Single nurses had marginal higher stress scores than married nurses and females had slightly higher stress scores than males. The respondents' major sources of stress were related to nursing issues, which include:

- high working load;
- higher job-induced tension including fatigue and uneasiness;
- interpersonal relationships;
- promotion and career development issues;
- doctor related issues;
- working night duty and overtime; and
- dealing with the hospital administration.

Fifty four percent of respondents felt supported by their managers. The respondents coped through the support from family and colleagues, using different cognitive strategies, for instance not thinking about work when off duty and through leisure activities. The findings indicated a significant link between the respondent's stress and sickness levels (Callaghan et al. 2000: 1518-1527). The major limitation of the study is the 33.6% response rate, however the findings are supported by similar findings (De Wet 1998; Frydenberg 1999;).

A study conducted in Singapore (Boey 1998: 353-361) examined the role of coping strategies and family relationships in mitigating the negative effect of work stress on nurses. The results indicated low levels of job satisfaction with two-thirds of nurses thinking of quitting. Nurses were satisfied with the support from the family. Behavioural and cognitive coping were most frequently used. Nurses relieve stress through support from family members according to the Moore (2001) study, which is similar to Boey's (1998) study. Some research findings were used to structure research.

Research conducted to determine the extent to which school and nursing service managers succeed in coping successfully show that the most effective coping strategies are used when registered nurses actively solve their problems. Both groups perceive themselves as inadequate to deal with interpersonal demands. In-service training programs, workshops and stress management interventions can be used to develop interpersonal and time management skills should reduce stress (Myburgh; Poggenpoel 1999: 43-44). This finding is similar to the finding from Health Systems Trust (1996), indicating the need for in-service training for managers. Management support and coping skills of registered nurses are related and relevant to the study.

Bowman in 1995 (107) found that the following events predispose nurses to stress:

- the nature of the nurses role;
- its complexity and demands; and

- workload and job insecurity.

Workload was identified as a significant factor affecting nurses (Healy 2000, Levert et al. 2000 & Fagin et al).

Various coping strategies were identified to embrace change which include problem solving, active distraction, self-nurturing, emotional expression, forward planning, goal orientation, delegation and a healthy lifestyle (Govender 1999: 16-18; Smythe 1994).

Nurses working in Aids-care experience many stressors thus are susceptible to eventually occupational burnout. Qualitative research methods were used to identify sources of occupational stress (Kalichman, Gaeritault-Chalvin & Demi 2000: 31). Fifty percent of the Ways of Coping Inventory were used to indicate which coping strategies the nurses made use of. A four-point Likert scale was used to indicate the degree to which nurses responded to coping strategies (Kalichman et al. 2000: 32). Results indicate that nurses who identified workplace-related stressors differ significantly from nurses who identified patient care stressors in terms of the coping strategies used.

Nurses who identified workplace-stressors as their most stressful experience reported using significantly more wishful thinking, creative problem-solving, rational problem-solving and avoidance coping, compared with nurses who identified stressors that are related to care of patient. Nurses reporting these stressors used

significantly more acceptance for coping with a trend towards using more positive appraisal (Kalichman et al. 2000: 34-35). Further analysis indicates that institutional sources of stress are most likely confronted using creative problem-solving.

- Personnel stressors were managed through avoidance, wishful thinking and rational problem solving;
- Stressors from biohazards, such as needle-stick injuries, were managed through wishful thinking and avoidance coping;
- The death stressor were confronted through positive appraisal and acceptance;
- Stress of informing patients was managed through spirituality;
- Treatment dilemmas, ethical issues and concerns about quality of care were mostly confronted through creative and rational problem-solving strategies (Kalichman et al. 2000: 35).

Nurses working in AIDS care identified 32 different categories of occupational stress experience. More than one third of stressful events involved institutional settings and personnel aspects of work environments. These coping patterns suggest a pragmatic approach to dealing with institutional stressors, could be because these problems appear amenable to change. Patient care stressors were accepted and no clear pattern on coping with death and resistant patients emerged. Caring for chronically ill patients and dealing with life and death issues are major sources of emotional exhaustion for nurses in Aids-care (Kalichman et al. 2000: 36). The Georgia State University conducted the study on the members of the Association.

The focus is on nurses in AIDS care and are appropriate for the South African situation where registered nurses care for AIDS patients in al health care services.

Jones & Johnson (2000) critically reviewed the relationship between perceptions of the work environment, coping and mental health in trained nurses and patient outcomes. Nurses use problem-focused coping methods where there are high levels of stress. Differences in coping strategies have been revealed in distinct specialist settings. Socio-demographic factors such as age may also influence coping. Older nurses seek help in difficult situations and may use less avoidance than less experience nurses (Jones & Johnson 2000: 78-79). Emotion-focused coping strategies, for instance optimistic humour, are associated with reductions in emotional stress for Intensive Care Unit nurses.

Developmental models of burnout indicate that a lack of critical resources in the form of social support and low control beliefs lead to emotional exhaustion which gives rise to depersonalisation. This indicates a reciprocal relationship between coping and work-related distress. The indirect impact of work-environment on quality of care provision via the emotional and physical well-being of the nurse practitioner. Depression in trained nurses as a result of a highly stressed work environment is associated with poor quality of patient care (Jones & Johnson 2000: 81). The level of perceived work stressors and the control opportunities may modify coping. The use of “avoidance”-coping where there are excessive workload are linked to negative mental health outcome, however coping by accepting the job as is in situations with

low control opportunities can result in low levels of tension and fatigue. The use of problem-focused coping by practitioners may not be appropriate in all situations, co-workers and managerial sources are required to alter difficult working conditions and reduce work-related distress in individual practitioners (Jones & Johnson 2000: 81-82). It was described by Healy that in an Australia study, problem solving methods was used (Healy 2000).

2.5 CONCLUSION

Coping skills of registered nurses within the changing health care environment is a complex phenomenon. Change has become an integral part of the daily activities of registered nurses. Change also results in increasing demands on staff. Change of a major nature has marked effects on the behaviour of nurses, when they are not prepared for the change and its effects. Sufficient preparation of nurses and the planning of change must be a high priority by management and it should be ensured as far as possible that nurses are able to cope with change and achieve success for themselves, their patients and the organisation (Bowman 1995: 12).

Various coping skills have been identified from the literature, which can assist registered nurses in managing change. The role of organisations, management and registered nurses in managing the stressful environment of nursing has surfaced as an important element in the process of managing change.

CHAPTER THREE

3 RESEARCH METHODOLOGY

3.1 INTRODUCTION

The fundamental aim of the study was to explore and discuss the coping skills of registered nurses working in a changed environment. Interviews and focus group discussions were used to collect data. The analysis, coding and interpretation were done manually.

3.2 RESEARCH DESIGN

The design was non-experimental with the primary interest being to understand and describe (Polit & Hungler 1995: 33) the coping skills of registered nurses. A qualitative, exploratory, descriptive and contextual research design has been followed. Descriptive experiences were elicited from the participants, using the interview method, with the aim to achieve richly articulated and in-depth understanding (De Wet 1998: 142) of the coping skills of registered nurses.

The explorative research was conducted by using a carefully phrased questionnaire which (Annexure 1) guided the respondents to talk about their coping skills in the workplace. As a friendly and spontaneous atmosphere between researcher(s) and respondent(s) developed more probing questions were allowed. The contextual framework placed the problem, which is the identification of coping skills, within the changed health environment.

The aim was to illicit greater depth, scope and understanding of individual aspects of the respondents' experience and the understanding (Polit & Hungler 1995: 16) of their coping skills. Primary data was obtained by using two techniques for data gathering namely three focus groups discussions and unstructured interviews.

The nature of the data-gathering process in this survey research provides in general two types of information about the respondents. The interviews were used to gather demographic data and in depth opinions about effective coping skills (refer to Annexure 1). The focus group discussions were used to gather information on the discussions around the effective coping strategies of registered nurses. Discussions prior to the interviews ensured that all participants understood the aims of and operational definitions used in the research.

3.2.1 Qualitative research

A qualitative approach to the research was followed which included individual interviews and focus group discussions to obtain data on coping strategies used by nurses in primary health care clinics and the development of potential support systems.

Qualitative research, the approach followed in this study, is concerned with the meaning of phenomena and experiences, which are not readily observable. Qualitative research allows for a holistic approach, without reducing respondents to parts. It also emphasises an understanding of the social world as perceived by the

respondents. Qualitative study aims to determine the depth and complexity of a phenomenon (Uys & Basson 1991: 55).

The phenomenological approach was used. In this approach human experiences are examined through the detailed description of the people being studied. As a method it involves studying a small number of subjects extensively and in depth to develop patterns and relationships of meaning (Creswell 1994: 12).

According to Polit and Hungler (1993: 444) qualitative analysis is “the organisation and interpretation of non-numerical, narrative data for the purpose of discovering important underlying dimensions and patterns of relationships”.

The study aims to explore the coping skills of registered nurses. Registered nurses have rich and diverse experiences of how they manage to cope within a changed environment. Using this method, it was possible to develop an in-depth understanding of perceptions, attitudes and motivations of respondents within the context of primary health care in the Cape Metropole.

3.2.2 Non-experimental research

The approach to this study was non-experiential thus aiming to describe various characteristics and to explain the phenomenon (Polit & Hungler 1993: 140) of coping strategies.

3.2.3 The target population

The target population studied was registered nurses working in clinics within the City Health Directorate central health district (refer to Annexure 3). The central health district in the City of Cape Town consists of five main primary health clinics and two satellite clinics. One satellite clinic has its own staff of two registered nurses and provides health services for five days per week. The other satellite clinic uses the staff of the main clinic and the primary health service is provided one afternoon per week.

3.2.3.1 Information on the target population

A list was compiled of the target population (refer to Annexure 3). Information of the target population was obtained from the City of Cape Town personnel section and verified by the respondents.

The characteristics required from the population include the registration status of the registered nurses, in particular the additional qualification obtained, a diploma in Community Nursing Science and a diploma in Clinical Nursing Science: Health Assessment, Treatment and Care (refer to Annexure 3).

3.2.3.2 Selection of participants

3.2.3.2.1 Unstructured interview

For the individual interviews, sampling with specific inclusion criteria occurred. Professional nurses were selected using the purposive sampling method by virtue of the identified specific inclusion criteria.

Purposive sampling is the conscious selection of certain registered nurses to participate in the study. “Typical” respondents in typical situations were included (Burns & Grove 1993: 246). The respondents were selected from registered nurses working in five main and two satellite primary health care clinics in the City Health Directorate. The criteria for selection were:

- registered nurses working in Local Authority primary health care clinics in the Central Health District of the City Health Directorate;
- nurses registered in General Nursing and Midwifery; and
- nurses registered in General Nursing and Midwifery, whom have an additional diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.

Other general criteria included registered nurses who work in diverse socio-economic communities with different disease profiles, registered nurses working in clinics that have an attendance of over four thousand clients per month and clinics with an attendance rate of under two thousand clients per month (refer to Annexure 4). The sample consisted of all the above characteristics in more or less of an equal nature. One registered nurse per clinic was selected for the individual interviews (n=6). The sample of six registered nurses comprised of three registered nurses with

a diploma in Clinical Nursing Science: Health Assessment, Treatment and Care and three registered nurses without the diploma in Clinical Nursing Science: Health Assessment Treatment and Care. This balance was necessary during the individual interviews to elicit how registered nurses cope given their different experiences and qualifications. In clinics registered nurses with various qualifications work together in teams and in different clinical settings. These diverse coping experiences were uncovered.

The selection was done on a voluntary basis. Each clinic manager was approached to discuss an appropriate time to discuss the research with the registered nurses in the clinic.

In the next phase of the selection process, registered nurses were approached individually to identify their eligibility in terms of their qualifications. A list was compiled from the registered nurses who volunteered to participate in the study (refer to Annexure 3). The list was analysed to assess appropriate subjects. The identified participants were contacted by telephone. Informed consent was obtained. Two alternatives (respondents) were on standby for the focus group discussions, in the event of drop out of any of the participants.

Fewer subjects were used than in quantitative research, as data was gathered in depth rather than in quantity. It was difficult to predict how many subjects would be

required, as it depended on the saturation and in-depth knowledge revealed of the phenomenon being studied (Hale, Eales, Steward & Fritz 1999: 12).

The depth of the information could reveal how registered nurses cope with the challenges in the health care system.

3.3 RESEARCH METHOD

3.3.1 Unstructured interview method

In an unstructured interview broad guidelines were prepared to focus the interview but the discussion were freely and flexible around the main themes under discussion. During the unstructured interview, attention has been given to the coping experiences and its effects on registered nurses.

The researcher interviewed the respondents using an interview guideline and a tape recorder. Consent was obtained from the participants. During the interviews (Annexure 1) the respondents were asked to motivate and explain their personal feelings, perceptions, problems, attitudes and experiences on how they cope with the changed work environment in detail. During the interviews questions were rephrased and probed to give clarity in certain instances that were unclear.

3.3.2 Focus group discussion

3.3.2.1 Definition of the focus group discussion

It is the collection of data from a group discussion ranging from between five to eight participants who share their thoughts and experiences on a topic selected by the researcher.

3.3.2.2 Objective of the focus group discussion

The following objectives were achieved using the focus group discussion:

- To encourage debate on coping skills.
- To study the views of registered nurses about their coping skills.
- To assess the interaction and dynamics when people share different individual experiences.
- To analyse coping strategies shared by participants.
- To encourage participants to raise their opinions on a particular point under discussion.

3.3.2.3 Process of the focus group discussion

The second method of data collection used was to conduct three focus group discussions. Two questions were discussed: “How do you cope in the clinic?” and “Which coping skills is of benefit to you and why?” The researcher was present during the group discussions. A tape recorder was used to capture data, with the permission of participants. An assistant, currently in her third year of the Masters program at University of South Africa and who was employed at the City Health

Directorate, assisted in making the field notes of the proceedings. A training session was conducted with the assistant prior to the focus groups. Her role was to observe the non-verbal behaviour of the participants during the focus group discussions, to change the cassette when needed and to discuss the focus group session with the researcher afterwards and to ensure objectivity and completeness of data.

Three focus group discussions were conducted to ensure saturation of data as evidence by repeating themes. Each of the focus groups consisted of five registered nurses. One registered nurse was selected per clinic. Group 1 consisted of two registered nurses with a diploma in Clinical Nursing Science: Health Assessment, Treatment and Care and three registered nurses without a qualification in Clinical Nursing Science: Health Assessment, Treatment and Care. Group 2 consisted of two registered nurses with a diploma in Clinical Nursing Science: Health Assessment, Treatment and Care and three registered nurses without. Group 3 consisted of three registered nurses with a qualification in Clinical Nursing Science: Health Assessment, Treatment and Care and two without. In this study typical subjects were selected based on their qualifications and the community they serve. Purposive sampling with specific inclusion criteria occurred. Purposive sampling was to ensure that participants complied with the inclusion criteria.

The group that was selected, reflected diversity in terms of demographics, experience as registered nurses and appropriate post-graduate diplomas. A balance was created to elicit debate from registered nurses with different

perspectives based on their different clinical settings, communities, norms, values and experience (refer to Annexure 4). It was explained to the participants what is meant by coping skills prior to commencement of the focus group discussions.

3.3.2.4 Moderator and assistant

The moderator conducts the focus group discussions and in this instance the moderator was also the researcher. The moderator sets the pace and tone for the interview and controls the procedures. The role of the assistant was clarified before the focus group discussions. Some of her functions were changing of audiotapes, taking of field notes (obvious body language, group mood), time keeping and the numbering of tapes.

Trustworthiness of the data was ensured through transcribing the recordings of the interview, the findings were discussed with five of the participants and there was agreement on the findings.

3.3.2.5 Conducting the group

The participants were welcomed and thanked for participating. Thereafter the process was explained to the participants. The research question, the aims and the objective of the focus groups were discussed, to encourage debate and discussion regarding thoughts, feelings and insight of the registered nurses regarding their coping skills.

Three focus groups were conducted. Two central questions were asked to the group:

1. Tell me how you cope in your clinic?
2. Which coping skills are of benefit to you and why?

The viewpoints of many registered nurses were obtained regarding the coping skills of registered nurses in the changing health care environment.

Clinics were used to conduct the focus group discussions. A central venue was used to ensure the convenience of the respondents. The clinics were selected by using the following criteria: it had to be comfortable, quiet and non-threatening. A circular seating arrangement was prearranged to allow for eye contact. Numbers from one to five was used to identify the participants. In the report numbers were used. The assistant drew a plan of the seating arrangement using numbers. The tape recorder was tested prior to the arrival of the participants.

Trust and openness was created at the beginning of the interview through:

- welcoming of the participants;
- icebreaker was done;
- the role of the assistant was explained to the participants;
- the purpose of the group discussion was explained and re-enforced;
- the need and the use of the equipment was explained;
- an explanation of how the respondents will be protected;

- ground rules were discussed, for instance, one person to speak at a time and respect others' opinions; and
- it was agreed by the participants to speak in English. If respondents wanted to express themselves in their own languages they could do so. There was agreement from the participants to translate the Xhosa to English if the need should arise. All the participants communicated in English.

Viewpoints on coping skills of respondents were obtained and recorded on tape. The assistant observed and documented non verbal behavior of the participants during the discussions. After the focus group discussions the researcher and the assistant discussed important non-verbal behavior and other significant observations, which occurred. The assistant was selected because of her experience with research and her experience working in primary health care.

The moderator concluded the group discussion by debriefing and thanking the participants. Arrangements for follow-up conversations to clarify the interpretation of information were arranged with five participants.

The focus group discussion lasted between one and one and a half hours. All documents and tapes were marked immediately after the participants have left. The results of the study will be shared with the organisation and the participants.

The following ethical principles were maintained throughout the interviews:

- Numbers were allocated to each respondent prior to the commencement of the focus group discussion to ensure confidentiality and anonymity of respondents.
- The focus group interviews were tape recorded and transcribed (Annexure 5).
- Five respondents were approached to read the findings. One respondent from each focus group was used. There was agreement from the five respondents that the findings confirmed the findings reached by the researcher.
- A researcher from Statistics South Africa read through the transcripts and verified the findings.

3.4 DATA ANALYSIS

The data from the interviews and focus group discussions were recorded, transcribed and analysed manually. The data was then assessed, categorised and manually coded into central themes that emerged (open coding process). The themes were further categorised into sub clusters. Links and relationships between the themes were determined and further analysed (selective and actual coding process). Results have been compared with and recontextualised within the literature. This process served to enhance the reliability of the data and to guide recommendations. An independent researcher was consulted to validate the coding.

The emphasis was on the coping skills and the description of the range of experiences as they relate to each other.

The central themes were the following:

- The legislative changes and the impact on the health care system
- Coping skills of benefit to the respondents
- The factors which threaten or affect coping skills

The sub clusters or sub themes were the following:

- The implementation of a district based health service using the principles of the PHC approach
- The provision of free services
- Teamwork and support
- The respondent
- Family support
- Quality of care
- Regular breaks
- The influence of religion on coping skills
- Support programs for staff
- The importance of continuing education
- Reorganisation of services in clinics

3.5 ASSESSMENT OF QUALITATIVE DATA

It is important that information collected by the researcher reflects the truth and is of high quality. The trustworthiness of qualitative data can be assessed through credibility, transferability, dependability and conformability (Polit & Hungler 1995: 359-363).

3.5.1 Credibility

Credibility involves two aspects: namely carrying out the investigation in such a way that the believability of the findings is enhanced and taking steps to demonstrate credibility. Credibility refers to the truth of the data collected. This includes prolonged engagement. The interviews were conducted in sixty minutes. The focus group discussions were conducted in seventy-five minutes. Sufficient time was spent with the collection of data on the coping skills of the registered nurses for the following reasons:

- to test for misinformation and distortions;
- to build trust with informants to ensure that data rich in depth are revealed; and
- to develop a good understanding of the meaning of data within the culture and dynamics of the group.

After the first individual interview and group discussion the time allocated was evaluated to assess whether or not an hour was adequate. One hour was adequate to allow the respondents to debate their coping skills. Audio and written recordings of the individual interviews and focus group discussions occurred during the proceedings. The participants were consulted on the findings of the results. There were general agreement that the results reflected the focus group discussions and the individual interviews.

The data was collected over two months to allow the researcher time to evaluate whether the data was adequate. This period of time was beneficial, interviews and group discussions were conducted only at the convenience of the clinics. The technique known as triangulation was used to improve the likelihood that the qualitative findings are credible. Triangulation is the use of multiple referents to draw conclusions about what constitute the truth. Method triangulation was used to address the research problem (interviews and focus group discussions). The use of multiple methods assists with sorting true information from the error information (Polit & Hungler 1995: 362).

3.5.2 Transferability

Transferability assesses whether the researcher has provided sufficient descriptive data in the research report to enable consumers to evaluate the applicability of the data to other contexts (Polit & Hungler 1995: 359-363). Transferability in qualitative research is not always possible, but in this research the sampling and context were described in detail to enable a certain level of transferability.

It refers to the extent to which the findings from the data can be transferred to other settings or groups. Sufficient descriptive data was reflected in the sample. Descriptive details were provided of the current roles and functions of registered nurses in clinics, the needs of the communities and the legislative framework that introduced changes. The research was conducted in an urban, clinic environment and the data is applicable to other contexts.

3.5.3 Dependability

The dependability of the data was assessed through the inquiry audit. This involves the scrutiny of the data and relevant supporting documents by an external reviewer, an approach that also has bearing on the confirmability of the data (Polit & Hungler 1995: 363). A researcher, who is currently employed at Statistics South Africa, scrutinised the data and supporting documents and verified the findings. Tape recordings and notes were taken during the individual interviews and the group discussions. These documents are available on request.

3.5.4 Confirmability

Confirmability is a concept which refers to the objectivity or neutrality of the data. It is the agreement between two independent people about the data's relevance or meaning. The investigator can develop an audit trial through the systematic collection of materials or documents that will allow an independent auditor to draw conclusions about the data (Polit & Hungler 1995: 363). An independent researcher working at Statistics South Africa was consulted during the analysis of the data. There was agreement on the findings based on the analysis of the data between the researcher and the independent researcher.

In addition, five participants confirmed the interpretation of the data collected.

3.6 ETHICAL MEASURES

The following ethical principles were adhered to:

- Participation was voluntary

- Informed consent was signed by each participant
- Using numbers instead of names during interviews has ensured anonymity. Aspects like confidentiality, anonymity, autonomy and respect were ensured (Brink & Wood 1988: 188)
- No financial rewards or incentives were offered to potential participants
- No coercion of participants occurred (Tudd, Smith & Kidder 1991: 448-505)
- All participants were treated fairly and with respect (Tudd et al. 1991: 512)
- Scheduled interview times were kept punctually
- The research results were discussed with the participants to validate the findings in a way that individuals remained anonymous
- The ethical principles of beneficence and justice were upheld. No harm was inflicted on participants (Woods & Cantanzaro 1988: 90)
- A letter was written to the City of Cape Town asking permission to conduct the study in their clinics (Annexure 6).

3.7 CONCLUSION

In this chapter the design of the empirical study was described. The research project was a qualitative, non-experimental study. Unstructured interviews and group discussions were used to collect data. Subjects were selected using the purposive sampling approach. Written notes and recordings were made during the interviews and group discussions. The results and findings are discussed in Chapter four hereof.

CHAPTER FOUR

4 THE ANALYSIS OF INFORMATION COLLECTED FROM THE INDIVIDUAL INTERVIEWS AND THE GROUP DISCUSSIONS

4.1 INTRODUCTION

This chapter focuses on the analysis of data in order to:

1. Identify coping skills used by registered nurses in Primary Health Care clinics
2. Identify existing and potential support systems to enhance effective coping skills.

The analysis was done manually. Documentation included transcriptions of recordings of the individual interviews and the focus group discussions and notes were taken during the interviews. Information was obtained from six individual interviews and the three focus group discussions that were conducted with registered nurses working at the City Health clinics. The interviews and focus group discussions focused on the coping skills of registered nurses working in the City Health clinics.

The process of data analysis occurs through the constructions that have emerged and are reconstructed into meaningful wholes. The data analysis occurs through categorising information into themes that emerged. The different categories that emerged were integrated and links and relationships between them were established.

The following extract serves as illustration of the manner in which the data analysis was done: *"The other problem is that we try to give quality service in less time because of the quantity. Quantity of clients that we are seeing and we do feel good if we able to achieve that if we putting in the amount of work and then not. We need to see that she come back well and the mothers with the better knowledge and that makes us feel good. That we have got the clients are demanding quality, the management is demanding numbers, numbers in terms of the amount of clients. We are seeing and the clients are demanding quality and we are getting pushed, getting pressurised in the middle."*

The following themes were identified*:*

1) The provision of quality service.

2) Quantity of clients/patients.

3) Improved knowledge of clients causes respondents to feel good about the outcomes.

4) Respondents are pressurised by the number of clients and by the Administration to manage and ensure large amounts of clients.

Links and relationships

1) The provision of quality care is linked with improved patient knowledge, improved patient outcomes and positive feelings of respondents.

2) Increased client numbers are linked to respondents being pressurised by clients and the Administration.

Quality of care, improved patient knowledge and positive feelings are characteristics that could contribute to positive coping abilities of respondents. Information obtained under the heading “impact of change” was increased patient numbers and pressurised respondents. These responds are interpreted as the impact of change on some respondents that negatively affect their coping ability.

4.2 A DIAGRAMMATIC PRESENTATION OF THE THEMES

These diagrams present main themes (listed in the middle columns) and their relationship to sub themes is related in the diagrams below.

DIAGRAM 1

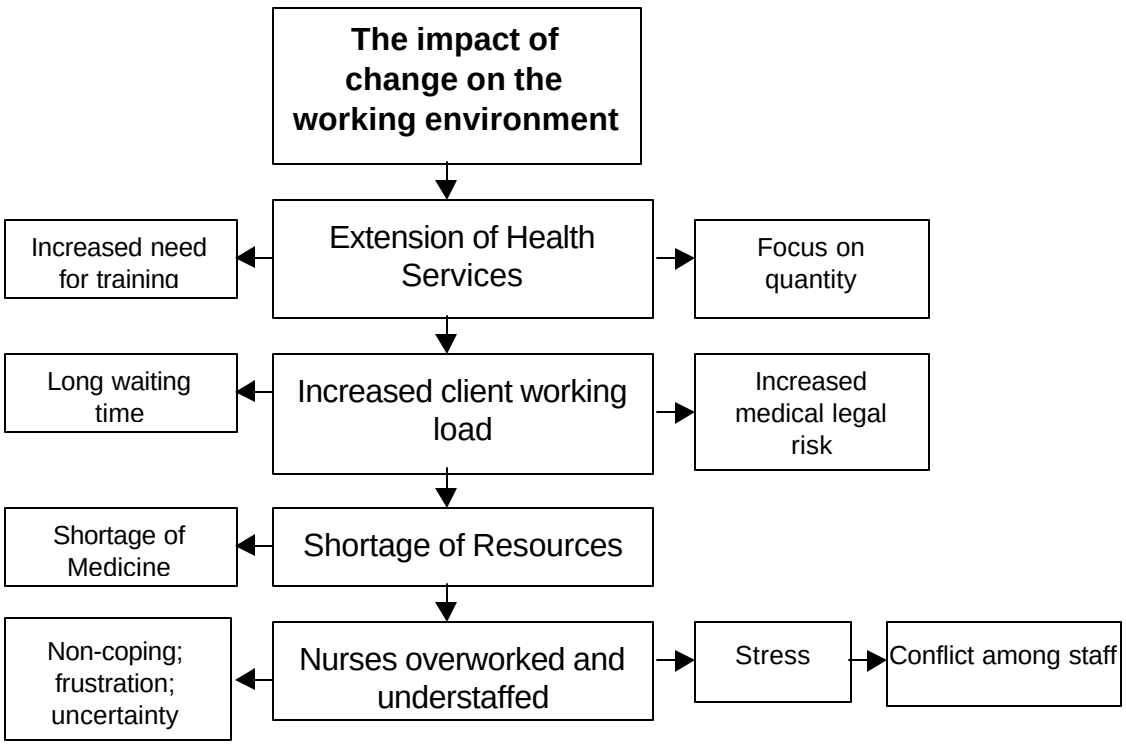


DIAGRAM 2

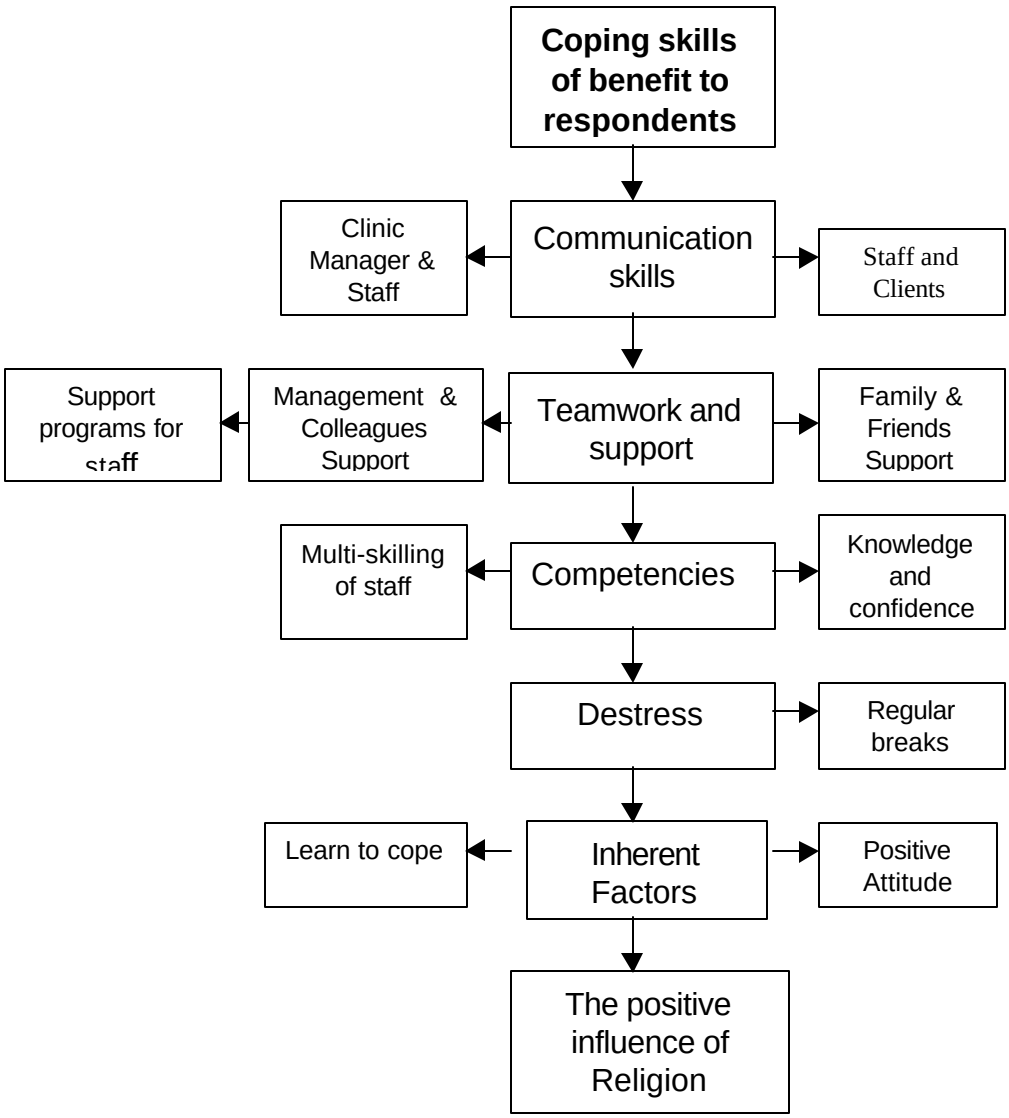
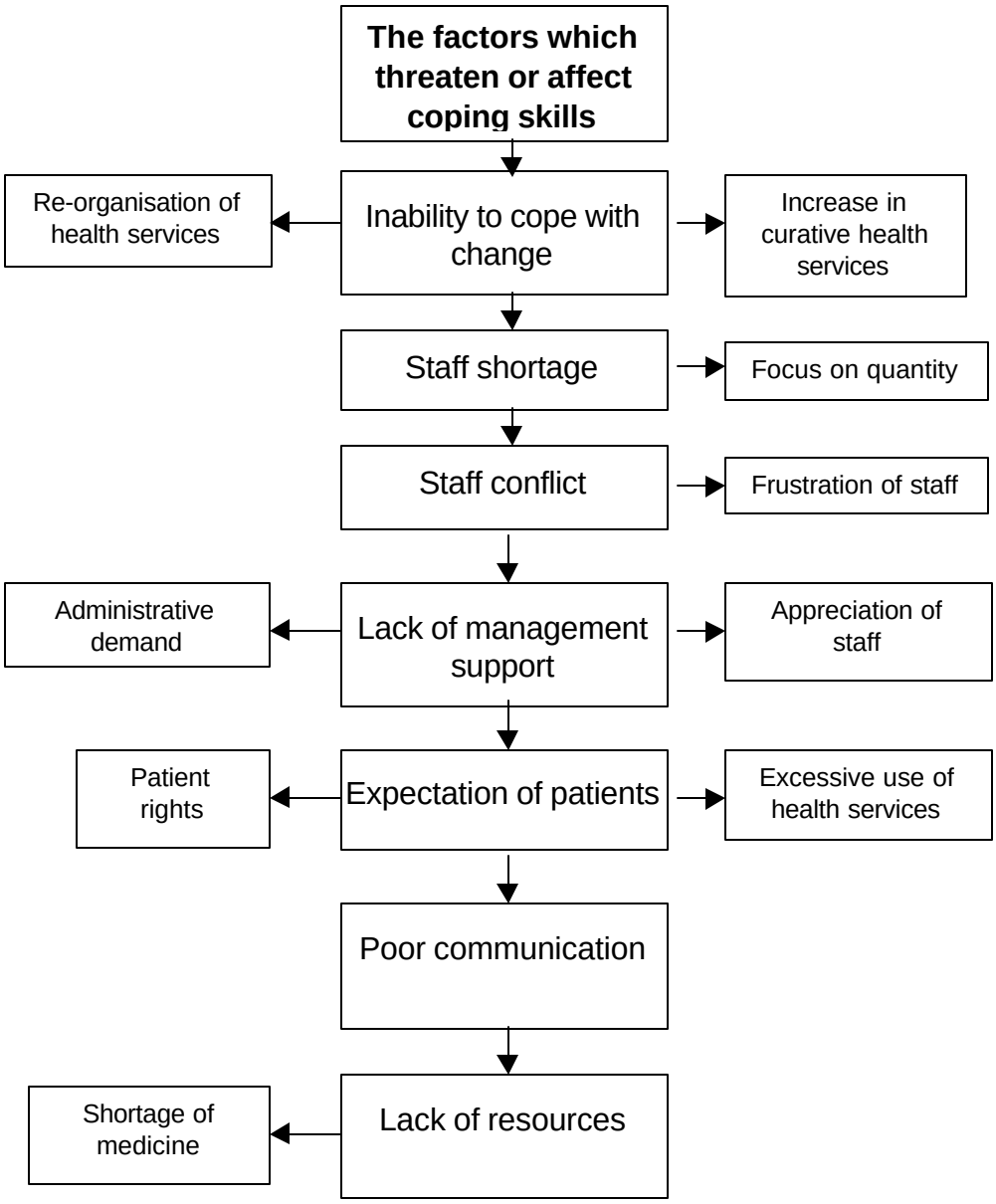

Coping skills of benefit to respondents
Communication skills
Clinic Manager & Staff
Staff and Clients
Teamwork and support
Support programs for staff
Management & Colleagues Support
Family & Friends Support
Competencies
Multi-skilling of staff
Knowledge and confidence
Destress
Regular breaks
Inherent Factors
Learn to cope
Positive Attitude
The positive influence of Religion

DIAGRAM 3


The factors which threaten or affect coping skills
Inability to cope with change
Re-organisation of health services
Increase in curative health services
Staff shortage
Focus on quantity
Staff conflict
Frustration of staff
Lack of management support
Administrative demand
Appreciation of staff
Expectation of patients
Patient rights
Excessive use of health services
Poor communication
Lack of resources
Shortage of medicine

4.3 DEMOGRAPHIC DATA

4.3.1 Age

The ages of the respondents (6) vary from 33 to 54 years.

4.3.2 Gender

All the respondents were female. No male registered nurses were employed in the Central Health District at the time of the research.

4.3.3 Race

The race of the respondents included the following: two coloureds, two blacks and two whites. There were no significant cultural differences in coping strategies.

4.3.4 Language

The home language spoken by the respondents include English (4), Xhosa (1) and Tswana (1).

4.3.5 Marital status

Four of the respondents were married, one respondent was single and one respondent was widowed.

The demographic data did not have any impact on the relevance of the data.

4.4 QUALIFICATIONS OBTAINED BY THE RESPONDENTS

4.4.1 Highest school qualification obtained by the respondents

One respondent obtained a grade ten certificate and five respondents obtained grade twelve certificates.

4.4.2 Academic qualifications/ registrations obtained by the respondents

All the respondents had obtained diplomas in General Nursing and Midwifery. Most participants have obtained additional qualifications which included diplomas in Community Nursing Science (five participants), Psychiatry (one participant), Nursing Administration (two respondents), Clinical Nursing Science: Assessment, Treatment and Care (two respondents), Health Service Management (one respondent) and Nursing Education (one respondent).

4.5 WORK PROFILE OF THE RESPONDENTS

4.5.1 Employment history of respondents

The employment history/experience of the respondents prior to employment in the City Health Directorate varies between four years and sixteen years. The professional experience of the respondents includes employment in clinics, community health centers, tertiary hospitals, pharmaceutical companies, and private hospitals in South Africa and in other countries. This contributed towards a wealth of experience gained prior to working for the Cape Town Directorate and was also enriching the discussions during the interviews:

“Previously I worked for the Glaxo-Anglo group. I was with them for about nine years, then I also went to the Salter’s Group.“ “Do you have any hospital experience (interviewer?” “At Grootte Schuur (Hospital) and Peninsula (Maternity Hospital)?”

“I worked for a general practitioner for five years.”

"I worked in Kimberly Hospital for ten years in the labour ward. In 1989 I worked for the Kimberly City Council."

"I worked for Somerset Hospital from 1983-1987. In 1988 I worked at Groote Schuur Hospital Maternity Obstetric Units. From 1990 to 1992 I worked for School Health Services."

"Private nursing oversea after I qualified in 1972 to 1977."

4.5.2 Professional experience of the respondents while employed by the City Health Directorate clinics

The experience of the respondents in the Cape Town Administration varied from between two years and six months to twenty-two years. The respondents also worked at different clinics and frequently moved between clinics as the need arose. Respondent was appointed to a clinic. All registered nurses are moved around for operational requirements or where staff request transfers for particular reasons for example, to move near their home. This could indicate a low staff turnover and those respondents have developed expertise in their field.

4.6 HEALTH SERVICES PREVIOUSLY (1994) PROVIDED BY THE CITY HEALTH DIRECTORATE CLINICS AS EXPLAINED DURING THE INTERVIEWS

According the responses obtained from the respondents it seemed that in 1994 the Cape Town Administration provided health promotion and preventative health services, immunisation of children, women's health, including family planning, the

management of the tuberculosis control program and limited curative services for children under five years of age.

4.7 HEALTH SERVICES CURRENTLY RENDERED BY THE RESPONDENTS AT THE CITY HEALTH DIRECTORATE CLINICS

Currently the provision of services includes:

- maternal and child health services;
- immunisation of children;
- health promotion and preventative services;
- the Syndromic Management of Sexually Transmitted Infections;
- women's health services, including family planning and pap-smears;
- voluntary testing and counseling services for HIV detection;
- the management of the Tuberculosis control program;
- the referral of social problems;
- limited curative services for children under 13 years of age; and
- home visiting.

The integration sites provide:

- adult and child curative services;
- chronic clinics; and
- emergency medical services in addition to the above mentioned services.

The above analysis indicates that there have been changes in the functions and responsibilities of registered nurses. The additional functions of registered nurses include:

- curative services for children from six years of age to thirteen years of age;
- the management of opportunistic infections for HIV/AIDS;
- the provision of voluntary counseling and testing for the detection of the HIV; and
- the Syndromic Management of Sexually Transmitted Infections.

These added functions include areas which could impact on the psychological status of the registered nurse, for instance HIV testing and the curative services provided which include the prescribing of drugs.

The information was verified by one of the senior officials currently employed in the City Health Directorate. The job descriptions verified the above information.

4.8 PERCEPTIONS OF RESPONDENTS REGARDING THE IMPACT OF CHANGES ON THEIR WORKING ENVIRONMENT

All the respondents indicated that change impacted on their daily activities at the health clinics. Some respondents could cope with these changes and some could not. These feelings and perceptions were articulated.

4.8.1 Implementation of a District Based Health Service using the principles of the Primary Health Care approach

The following factors are experienced as stressful by the participants and impact on their coping skills:

- Shortage of staff. Five of the respondents indicated that an increased number of clients are attending the clinics. During the focus group discussions it was also identified as an important issue:

  "Nurses are overworked and understaffed."

  "The shortage of doctors or whether they are giving us that extra load. It makes one feel good that you can do that, or giving one that extra responsibility."

  "More people attending."

  "Numbers increased."

  "So why is they're so few staff and we say, oh you see, the hierarchy decides."

During the focus group discussions, lack of resources was raised as an important factor that prevents the implementation of change:

"I don't cope when there is a request made from maybe the administration for us to have certain things done or to do certain things and they don't allow, they don't have staff to allow for such a duty to be carried out effectively and that makes me angry."

- Well-informed clients cause participants to feel threatened or insecure. These clients have expectations around the services to be provided and report the registered nurses if the client is dissatisfied with the care provided. Three respondents raised these concerns.

  "People come into the clinic with high expectations."

  "People felt they have a right to be here."

“Clients know they have rights, they want best service.”

“They are entitled to the best.”

“Clients have the right.”

- Excessive use of the clinic services by clients for minor ailments, which could have been managed at home. Three respondents raised the following:

  “The medication is not necessary.”

  “We find minor things like a plaster (clients request from the clinic), where they feel they don’t want to buy that extra headache tablet.”

  “As Doctor Toms (Director of City Health Directorate) has once said: ’You (clients) spend your time here for a headache tablet.’ ”

- Shortage of medicines because of high client workload and abuse of the free services. Four respondents raised the following:

  “Some medications are not available, like cough mixtures and Panado. There is a shortage of medicines, cough mixture, TB drugs, Amoxil syrup.”

  “I (client) want Demazine or Drixine. Unfortunately they should not have started off (free services) and of course we could not keep up.”

  “Rather start with something where you can have a continuity where it would always be available.”

  “Free services. It has caused problems.”

  “There is no money to buy these medications.”

  “If people were paying there would be medicines.”

- The changes occurring within the City Health Directorate cause uncertainty. It was raised by two respondents:

  "Uncertainty with what will happen to staff when we are integrated (Local government primary health care integration with the Provincial government primary health care to prevent the duplication of PHC services)."

  "Do I take the package, don't I?"

- Stress on the staff having to cope with high client workload.

  "Some people tend to flip out and say look what has happened, look at all these people waiting. It used to happen. I used to sit and write and get myself all stressed and tense and wait for the next person."

- One registered nurse experienced frustration in not being able to verbalise and communicate her frustrations towards clients.

  "Burden on clinics, rights of the client."

  "Feel angry and frustrated."

- The financial management of clinics without the necessary training also causes stress. One respondent said:

  "Financial burden, decentralisation of function. Insufficient training before it happens. The expertise to manage it."

4.9 COPING SKILLS OF BENEFIT TO THE RESPONDENTS

The identification of coping skills to assist the respondents in managing and implementing change is paramount. The following factors assisted some of the respondents with coping while performing daily functions in clinics.

4.9.1 Good communication skills between colleagues

The clinic manager is seen as an important person in the clinic and the leader of the team. The team relies on the clinic manager to update them and to initiate debate and allow staff to contribute towards discussions. Communication allows staff to express their feelings, even if they are not satisfied with the response. Communication was perceived as important to some respondents. Good communication between colleagues supports them in managing the workload. The respondents are able to voice their opinion and are in control of the situation.

“Whenever we have discussions with the clinic manager, she ask us for our input, because we try.”

“We, as a clinic, have actively debated new protocols and policies on Meningitis, deciding what dose of medication is necessary to manage a child with Meningitis.”

“I voice my opinion also when it comes to certain things but I suppose one is not always given full reason as to why.”

”I voice my opinion. Some staff members cannot vent publicly and talk to themselves.”

4.9.2 Teamwork and support

Group cohesion strengthens coping skills. According to four respondents, nurses need lots of support and time from supervisors and colleagues. Teamwork is valued by most participants and indicates support from colleagues. Respondents appreciate it when colleagues listen and understand what they are going through.

Respondents appreciate the fact that colleagues care for them. This caring and respect is reflected in the support for each other. Respondents learn from each other, which indicate that they value and acknowledge the competencies of their colleagues. This could boost morale of respondents and contribute towards coping. Respondents take pride in performing their duties and responsibilities.

"Working together not let one person do the work."

"The nursing staff at Clinic Y work well together. So I think all levels of staff irrespective we do get on well."

"My colleagues, management, doctors, referral hospitals that helps us with queries and my family. As a source of information and also just being there as friendly happy people."

"We (team) have a good relationship, we support each other."

The group discussions comments were similar:

"I can cope with a lot of people in the clinic, if I have sufficient support from my colleagues and also sufficient time and equipment."

"Working together, not letting one person does the work."

"Teamwork and support of colleagues are important. Problems and solutions are discussed between colleagues. We must all work together. The situation needs all of us."

"Talking to other colleagues going through the same changes."

"I discuss with my colleagues any problems."

"We gripe, complain to each other."

“Talking to colleagues about it.”

“Trying to learn from others whom are cool, calm and collective.”

4.9.3 Inherent factors within the respondents that assist them to cope

Some respondents indicated that they do not know why they are able to cope, they just cope because of their strong spiritual and emotional genetic make up. It might be that some of the respondents have never thought about their coping skills. There is also a fatalistic attitude that because nurses are caring they just have to cope. Patients need care and care is provided, irrespective of how many patients or what services must be provided. However, portraying a positive image, respondents that initiate changes and the ability to rationalise behaviour and treating clients with respect assist respondents with coping.

“Is it not because of my make-up, am I not perhaps a stronger person spiritually and emotionally?”

“I am that type of person who tries changes. Nurses just learn to cope. ”

“The love for nursing and the positive image which are reflected assist with one’s coping skills.”

“I rationalise my behaviour, remain courteous and treat clients as individuals.”

During the group discussions the respondents agreed that their personalities allow them to cope or not to cope.

"I think I differ from number three's concern because my personality allow (sic) me to cope with stress situations and coping with the curative needs in the clinic and that is just who I am."

Support from management in understanding the constraints, which the staff have, was raised in the group discussion as an important area that could improve patient care because the staff know that their efforts are appreciated, by management.

"It is fine to make demands, but with demands must come the support and with support I don't just mean standing next to me holding my hand, I mean there must be. If somebody asked for a whole lot of stats, they need to bare in mind I still have to do my basic work, so don't demand the stats right on the spot. I need the time to do it, that is just an example."

"Can I just say something also? I've also found that when you do have the support in whatever way, whether its staff wise or equipment wise, you turn out a better service, that makes you feel good. You are also then motivated to do even better, so that is just adding to what I said earlier, that if you are restrained in any way, it does not benefit anybody."

Various changes have been implemented at clinic level. These changes are not welcomed and accepted by some of the respondents. It appears as if the theory of change is known but the difficulty is to implement the changes. There is an awareness of the dynamics of nursing and the need to change, as the community needs are changing all the time. Two respondents indicated:

"I do not like change. The impact of change. The sense of instability that results because of change. We study about changes and how to cope with change. "

"The theory of change is not easy to put into practice. I find it difficult to cope with changes. The sense of instability. I like to know where I am."

"*To cope is in one's nature. The continuance of the job becomes important*". There is a fatalistic attitude about not coping. One respondent said: *"I did not cope."* The reason for not coping was not apparent by even the respondent.

When one is not part of the team, relationships become tense amongst team members. Respondents are aware that they are not contributing to the same extent that their colleagues do. Over time, staff shortages, changes and increased number of patients may take its toll and respondents may stop doing the extra bit.

"I don't give my fullest to the team, they doubt if I am still here. Relationships are at stake. They might understand. It is an extra burden; I am not part of the team." (This response came from an integration site, where the Provincial Health staff works together with the Local Authority staff members).

Conflict amongst staff gives rise to unhappiness. There are days respondents feel despondent and do not give their best to the team. This becomes an extra burden to the other staff. When the other staff members become aware of this behaviour, conflict arises in the work situation: *"There are days I feel down, I don't give my fullest to the team."*

Staff attends scheduled training sessions leaving their colleagues behind to attend to the demands of the clients. This causes shortages of staff, although temporary staff

members still cause some disruption at clinics: *"There is no replacement. There is an additional impact of training on the shortage of staff."*

4.9.4 Family support

Support from family and most participants acknowledged friends as an important aspect of providing a stable supportive environment to talk about experiences and feelings. The sharing of experiences with spouses assists with catharsis. Friends that are also registered nurses appear to understand what the respondents are going through, thus the support from those friends is valued and contributes towards coping with daily demands at work.

"My supportive family which listens to my problems, which we discuss, and helps me to make decisions."

"When I get home I share my experiences with my husband."

"To talk to friends who are in similar situations and whom understanding the experiences being experienced."

4.9.5 Quality of care

The maintaining of quality of care, even when there is shortage of staff, contributes towards a wellness feeling of achievement. It is rewarding to know that they (respondents) are providing a quality service to patients, notwithstanding the constraints, especially when positive patient outcomes are experienced. There appears to be pressure on respondents to manage large patient numbers and respondents are aware that these pressures can compromise quality of patient care.

Respondents, however always strive to provide quality services. *"Clients that feel (sic) good make you feel good*." This quotation was used in the context of providing a quality service by one of the respondents. The group discussion raised similar points.

"The other problem is we are trying to give quality service in less time because of the quantity of clients that we are seeing and we do feel good if we able to achieve that, if we putting in the amount of work and then not. We need to see that she comes back well and the mothers with better knowledge, and that makes us feel good."

"With the increase of patient numbers, quality control measures are neglected."

Two respondents stressed the following:

"Focus is on quantity";

"I would go and if you explain (to the clients), my emphasis is on quality, irrespective." This quotation was used in the context of the patients becoming impatient with waiting long hours to be seen by the respondents. The respondent explains to patients that good care is given to patients, thus the long wait.

4.9.6 Regular breaks

Respondents said that they work for eight hours per day and should take a morning tea break at 10:00 for ten minutes and an afternoon tea break at 15:00 for ten minutes. Lunch-break starts from 12:00 for three-quarters of an hour. Respondents indicated that sometimes it is difficult to take breaks because patients are waiting to be managed and at times continue working to reduce the waiting time of patients.

Patients also cannot understand why personnel must take breaks because during the breaks the queues move slower. The staff staggers their breaks. Half of the staff goes on the first break and the others on the second break. Regular breaks were identified as important, it allows for relaxation. Staff must take their tea- or lunch-break and cannot work for eight hours without a break. Medical legal risks could increase because of exhaustion of the respondents, thus the importance of regular breaks is important to manage the increased patient workload.

“Relax when you have your lunch break.”

Within the group the following were raised:

”I communicate with them (clients), I explain to them that I need a break to dehydrate myself or just to have a rest and do it all very pleasantly and come back and help them with all the enthusiasm.”

4.9.7 Positive influence of religion on coping skills

Three respondents indicated that the church and their spirituality play a role in the way they cope at work. The assistance and support for the ill congregation from professionals (respondents) ensure them some prestige in their communities. This positively impacts on their self-esteem and acceptance of their role as providers of care.

“Being a spiritual and emotional strong person improves coping skills.”

“The initiation of a women’s group at church and visiting the sick assist with coping skills.”

"The church is approachable" (They actually assist the respondents in coping through group support).

4.9.8 Support programs for staff

The Cape Town Administration has a contract with the Non-Governmental Organisation, Lifeline, to provide a debriefing service once a month for two hours to all the staff in the Central Health District. A psychologist employed by Lifeline provides monthly support for all the staff involved with the programme (Voluntary Counseling and Testing) for HIV detection. The mentorship program was introduced to assist staff mainly with the debriefing after HIV/AIDS counseling. However, respondents used this opportunity to discuss general problems and concerns. The support programme provided some emotional support for respondents through which the respondents could discuss their fears and concerns.

"It brought some relief, being able to share the problems encountered in the clinical setting."

"Mentorship program with Mrs. X from ATTIC. Bring some relief. Being able to share what happened. The mere fact that you have people you can share."

"The mentor used music to relax the staff."

"Study support groups provide some social support network." Inevitable, respondents discuss their work, although the primary reason is to assist each other with understanding the study material. I think it help respondents to know that they are not alone, working under difficult circumstances.

4.9.9 Importance of continuing education

In-service training was identified as an important tool that enables respondents to perform their functions. It appears as if sufficient in-service training occurs but staff constraints do prevent respondents from attending scheduled in-service training. The in-service training provides an opportunity to discuss problem cases, which can assure respondents that they are managing the patients appropriately. The in-service training sessions also provide support for respondents, especially where there are uncertainties in the management of certain cases. The interaction at these sessions is beneficial and problem cases can be discussed. Respondents know they are not alone in managing difficult case scenarios and it assists respondents with coping.

Training plays an important role in the development and ensuring competencies of respondents.

"There is staff constraints but training must continue."

"Further education to improve my skills."

"Do some study about changes and how to cope (the respondent's response on how she cope with the changes)."

"We had lots of updates on hospital zoning, different areas, which hospital takes which client (referral hospitals)."

"New updates for STI and HIV clinical management. All staff is updated on curative skills to give them more confidence."

"The updates we receive, with more active knowledge which enable you to treat clients more effectively."

Within the group discussion there was agreement on the importance of in-service training.

"I think the in-service training does help a lot because that is where you get from the other people with experience and also from if you have some doctors there, some professors that will help us with the problems that we've experienced and if we all sit around and then from different areas, different things with the different problems, then we can deal with the problems."

"The importance of continuing education to improve existing skills is beneficial which provide registered nurses with confidence through knowledge."

4.9.10 Re-organisation of health services in clinics

The ability of registered nurses to re-organise and plan their services assists them to manage and control factors, which can be managed. Respondents at the clinics re-organized the services in different ways. Respondents made attempts to re-organise the services to suit patients and assist the smooth flow of large numbers of patients through the clinics. Some respondents changed the sexually transmitted services and others prioritised the curative services for children in the mornings. Extended family planning services were after hours provided at one clinic. There appears to be a commitment to service delivery.

"No clients are turned away."

"Open door policy."

"*Each staff member given a specific duty.*" This provides structure and support for staff.

Home visits are limited to priority visits:

"Stopping of district (visiting) because the staff were less."

Multi-skilling of staff resulting in the mother or father and the children seen by the same registered nurse:

"Multi-skilling of staff with the one stop approach (a patient attending the clinic can be managed by one professional nurse for all her health needs):"

"Referral of clients" unable to be managed by the registered nurse.

The clinic sessions were reorganised. "Changes were made to cope with STD numbers. There are lesser clients on Thursdays and Fridays because we went over the sessions of clients' attendances. We then changed the Family Planning and Child Health to Thursdays and Fridays."

Respondents indicated that the following coping strategies assisted them:

- Good communication skills at the clinics between colleagues and between the clinic manager and the subordinates.
- Teamwork and support from colleagues contribute towards group cohesion, which provide a supportive environment to deal with change.
- Respondents with strong genetic make up cope with changes.
- Support from family and friends provide a supportive and understanding environment to discuss problems.

- The maintaining of quality of patient care provides a feeling of achievement. Positive feelings about the services that the respondents are providing make the barriers worthwhile to overcome.
- Taking regular breaks allows the respondents to manage their workload in a manner in which they can cope.
- Religious respondents become involve with women groups and assisting the sick. These activities acknowledge respondents in society and inspire confidence that strengthens respondents, which can assist them with coping.
- Support programs assist respondents with working through their concerns and problems, thus it affords respondents an opportunity to analyse, debate and accept change.
- In -service training ensures that respondents are updated, competent and confident to provide services to the patients as required.
- Respondents re-organised the provision of specific services, which contributed towards coping with the high patient demands for those services.

4.10 CONCLUSION

Various coping skills have been identified and discussed by registered nurses. The development of a system to address the needs of registered nurses should be implemented as soon as possible. Good communication skills, team-work and support, the importance of continuing education and taking regular breaks are some of the important coping skills identified by registered nurses.

The coping skills of registered nurses are compromised because of the stressful situation at work. These stressful conditions include shortages of staff, high patient workload, over utilisation of services, shortages of medicines, lack of financial management of staff and the high expectations of patients.

CHAPTER 5

5 CONCLUSIONS AND RECOMMENDATIONS.

5.1 INTRODUCTION

This chapter contains the conclusions and recommendations of the research study that focus on the coping skills of registered nurses working in a changed environment. The research was conducted in the City Health clinics in Cape Town.

The literature search indicated coping strategies in various clinical specialties and health services.

A qualitative, exploratory, descriptive and contextual research design was followed. Six interviews and three focus group discussions were used to collect data. The data from the interviews and focus group discussions were recorded, transcribed and analysed manually into central themes that emerged.

Various coping skills were identified that could assist registered nurses with coping while performing daily functions in clinics.

The attainment of the research objectives will be discussed. The formulation of guidelines relating to the coping mechanisms will be introduced.

5.2 THE ATTAINMENT OF THE RESEARCH OBJECTIVES

The nurses in primary health care facilities do not adequately cope with major changes in health care delivery. The aim of the research was to explore and describe the coping skills of registered nurses in primary health care clinics in the Cape Metropole area. The identified coping skills can assist management in initiating support structures and programs to assist registered nurses to support change

initiatives and implement policy in a positive manner. The implementation of the research findings could contribute towards healthy registered nurses that can provide in the health needs of the communities.

The objectives were:

- to identify strategies, which nurse, utilize to cope with the changes in the health services.
- to explore appropriate support systems that will strengthen the coping skills of registered nurses in clinics in the City Health Department;
- and to deduce guidelines on how to support staff from the literature study and the results of the research.

Qualitative research was conducted and the following was determined:

- Working within a well-organised environment, could contribute towards a positive, stable work environment. This stable environment allows registered nurses to cope with change and the increase of client numbers. Refer to 4.9.10 pages 93-94.
- Registered nurses with a positive attitude appear to manage stressful situations and changes in the clinic in a positive manner. Refer to 4.9.3 first paragraph page 87.
- In-service training could assist with providing the necessary skills to provide the service in an integrated manner. Refer to 4.9.9 pages 91-93 and page 84 the last bullet.

- Teamwork improves coping skills. Teamwork creates a positive working environment where registered nurses discuss their problems with colleagues and this could elevate stress. Bowman (1995: 113) concurs with these findings. Refer to 4.9.2 pages 85-86.
- Supportive family and friends could provide an opportunity for respondents to talk to people who are concerned about their well being. Respondents feel relieved if they could share their negative work experiences with others. Refer to 4.9.4 page 88.
- Respondents need support from management, which could create a positive environment where they could deliver a quality service. Refer to 4.9.3 pages 87-88. Bowman (1995: 113) agrees that controlling workload, job satisfaction, support and counseling assist nurses with coping. This could be because the pressure factors are under control.

5.3 RECOMMENDATIONS

5.3.1 Recommendations for the clinic managers

The following are recommendations, which could be implemented at a clinic:

- to develop and maintain team building initiatives. Refer to 4.9.2 pages 85-86;

- to reinforce mechanisms that will strengthen existing communication at a facility level. Refer to 4.9.1 page 84. Bowman (1995: 113) indicates that nurses could prevent stress through discussing and sharing problems and supporting their colleagues. Team dynamics are important, and every member is an important

player in the team. Communication amongst staff is very important. Refer to 4.9.4 pages 85-86 and page 88.

- to develop debriefing or counseling sessions with clinic staff. Refer to 4.9.8 page 91. Bowman (1995: 108) indicates similar findings in assisting staff to cope with stress. Petermann in 1995 had similar findings in a qualitative study. He analysed job demands and coping strategies in two groups. The group that took ownership for work stress, prioritise workloads and practice self-care techniques coped with demands of the clinical environment Petermann (1995: 52). Also refer to 4.9.10 page 93.
- to develop sound drug management skills which could ensure the maintenance of minimum and maximum stock levels and which could prevent the clinic from running out of stock when the medical stores run low or out of stock on essential drugs. Refer to 4.8.1 first bullet on page 83;
- the adequate management of staff shortages which should include a staffing plan with relief staff for when staff is off sick, on leave or on study leave. Refer to 4.8.1 page 81; and
- to implement a roster system whereby registered nurses are allocated breaks according to a stagger approach, which could ensure that there are staff managing patients during tea and lunch breaks. Refer to 4.9.6 page 89. Govender (1999: 17) discussed the importance of taking proper breaks as essential in the self-nurturing process. One of the positive self-care practices and coping skills identified by a nurse in Peterson's qualitative study (1995: 53) indicated that when one is stressed or overburdened, one is unable to perform

a good job. Refer to 4.8.1 page 81. There are benefits in taking a thirty-minute break for instance to reassess demands, adjust, prioritise and plan patient care. Govender (1999: 16-17) agrees with the above findings. Refer to 4.9.6 page 89.

The above was identified by registered nurses as support systems that could contribute towards positive coping skills. The literature indicates the benefits of facilitation and support from supervisors as important for staff to require new skills to implement change. Support implies that management should make the transformation as easy as possible and will constantly encourage people's efforts to change (Trofino 1995: 46; Bowman 1995: 113; Naude 1996: 42). The participants in the study, however, did not mention this.

The researcher believes that financial and emotional support from management can contribute towards alleviating the current stressors experienced by the staff.

The results concur with the literature study with reference to coping skills of registered nurses as indicated above.

5.3.2 Recommendations for individual nurses

- Registered nurses must take responsibility to manage their individual stress levels. A philosophy of self-care and the creation of a balance with a healthy lifestyle are coping skills which could assist registered nurses to manage the

problems of the health care system that contribute to the stress of nursing (Smythe 1994: 30-70).

- Effective communication between registered nurses could assist with developing coping mechanisms to support each other. Clients and frustrations could be discussed with possible recommendations to solve the problems.
- Securing family support and the support of friends could assist registered nurses to realise the value of seeking assistance when needed. Family and friends could provide a secure and safe environment to express feelings and anger. Many studies have shown that social relationships could “buffer” stress (Frydenberg 1999: 81). The social support from family and friends allows registered nurses to relax and be themselves at home. The balance is thus restored and it could improve the coping skills of registered nurses.
- Spirituality assists registered nurses to cope with the demands of the health services. The rationale, feelings and care for clients in need of health services supersede the feelings of stress and anxiety experienced by registered nurses. It is in the interest of registered nurses to develop themselves spiritually and emotionally.
- Registered nurses must be satisfied with the quality of the health services provided. If registered nurses could provide a quality service under difficult circumstances they feel good about themselves. This good could suppress the pressures experienced by registered nurses and could assist the registered nurse to cope in managing the demands from clients.

- Registered nurses must take regular breaks. It allows nurses to relax and regain their energies to continue the nursing care plans. Regular breaks assist nurses to cope with the pressure inherent in the caring role of nurses.

5.3.3 Recommendations for the profession

- Coping skills should be included in the basic and post basic curriculum of registered nurses. Coping skills can be learned and could assist registered nurses to consciously use the coping skills in stressful situations.

5.3.4 Recommendations for the City health Directorate.

- Changes in the health system should be introduced slowly and sufficient time allowed managing the process and the impact of change. The development of a strategy to manage and support registered nurses to enhance their coping skills is necessary to ensure the implementation of the changes.
- Effective organisation of patient flow and activities in clinics.
- Empowering staff who felt threatened by changes through an effective employee assistance programme.
- The City health Directorate should determine nurse patient ratios in various clinical settings. The determination of nurse-patient-ratios should prevent continuous understaffing of clinics and the achievement of quality of patient care.
- The community should be informed about the changes in the health system and the benefits for the community through the media and workshops.

- Empowering communities on self-care practices through health promotion strategies.

5.3.5 Recommendations for the community

- Continuous education on the role and responsibility of clients through community health committees or the local media is required to facilitate co-operation and prevent difficult clients from placing additional stress on registered nurses.

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

- The attitudes of registered nurses to implement the District Health System should be researched because some respondents indicated that nurses lack capacity to manage sick patients.
- The management skills needed to support staff in the performance of their duties.
- The empowerment of registered nurses to develop the necessary confidence as frontline providers of the District Health System in terms of their clinical capacity to implement such a system.
- The skills and resources needed to deliver a comprehensive primary health care service that would provide in the needs of communities.
-

5.5 LIMITATIONS IDENTIFIED DURING THE STUDY

- The focus group discussions were difficult to conduct. Respondents cancelled at the last minute because of staff shortages caused by ill health or in service training.
- Respondents came late for the group discussions causing some tension and less available time to be spent on the group discussions.
- The respondents knew each other and the clinics that they were from. This limited the debate in one group discussion where one respondent tried to control the group. The other participants were encouraged to participate in the debate and express their opinions.

5.6 SUMMARY

The situation outlined by nurses and the concern raised by them indicates urgency in developing coping skills of registered nurses. The development of coping skills is in the interest of registered nurses, their colleagues, patients and the profession as a whole. The literature indicates that nursing is a stressful profession. The added burden of change could affect the coping skills of registered nurses. Individual questionnaires and focus group discussions were conducted to understand how respondents cope with the impact of the legislative changes. The mechanisms described by registered nurses to help them to cope with their stressful environment include effective communication between colleagues, taking regular breaks, support from family and friends, appropriate in-service education and voicing opinions.

Respondents identified shortage of staff, financial constraints and conflict between colleagues as obstacles to coping.

The recommendations included support programmes for staff, appropriate in-service education and the development of a staffing plan, which includes the development of patient staff ratios and education of the community.

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ANNEXURE 1

QUESTIONNAIRE USED DURING INTERVIEWS

The following questions will be asked:

Demographic data

How old are you?

Sex

Race

Marital status.

Home language.

School qualifications

What are your highest school qualifications?

Academic qualifications/ registrations held by the respondents

Diploma in General nursing, Midwifery, Community Nursing Science, Primary Health Care or Health Assessment.

Employment history

The year in which the respondent qualified as a registered nurse

Briefly discuss your previous employment history.

Briefly discuss your current employment history in the City of Cape Town.

- At which clinics did you work?

- For how long?
- What were your key performance areas at those clinics?

Current clinic of employment

At which clinic are you currently employed?

How long have you been employed at that clinic?

What are your current key performance areas?

The services that is provided at the clinic

What services are provided at the clinic?

Legislative changes

What legislative changes occurred in the health service?

What effect did the legislative/policy changes have on the clinic inter alia free health care for children less than five years of age?

The effects of legislative changes

What effects did these legislative changes have on the clinic?

What effects did these legislative changes have on you?

Coping skills

How do you cope with the changes in the clinic?

What coping skills have been of benefit to you and why?

What mechanisms did you put in place to manage these changes?

Responsibilities of the respondent

Do you have any pressing social, family or professional commitments?

What are those commitments?

Does these commitments affect your coping abilities at work?

If yes, how does it affect your work?

What support system do you need in place to assist you to cope?

How does your ability or inability to cope affect the team?

How does your ability or inability to cope affect your business plan targets?

Thank you.

ANNEXURE 2

CONSENT FORM

Consent form to participate in the research: The coping skills of registered nurses in the City Health Clinics in Cape Town.

I, the undersigned, consent to volunteer to participate in the research as explained by Mrs. Elloker.

Date: Signature:

ANNEXURE 3

INTERVIEWEES QUALIFICATIONS

The qualifications of registered nurses working for the City of Cape Town Central Health District was obtained from the respondents during the interviews and confirmed by the distinguishing devices worn on uniforms.

1.1 Langa Clinic

1. Diploma in General Nursing and Midwifery.
2. Diploma in General Nursing and Midwifery; Diploma in Community Nursing Science; Diploma in Clinical Nursing Science: Health Assessment Treatment and Care
3. Diploma in General Nursing, Midwifery and Community Nursing Science.
4. Diploma in General Nursing and Midwifery.
5. Diploma in General Nursing and Midwifery, Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
6. Diploma in General Nursing and Midwifery
7. Diploma in General Nursing, Midwifery and Community Nursing Science

1.2 Spencer Clinic

8. . Diploma in General Nursing Science and Midwifery; Diploma in Community Nursing Science; Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
9. Diploma in General Nursing and Midwifery and Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.

10. Diploma in General Nursing and Midwifery; Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
11. Diploma in General Nursing and Midwifery.

1.3 Chapel–street Clinic

12. Diploma in General Nursing and Midwifery; Diploma in Nursing Administration and Community Nursing Science and Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
13. Diploma in General Nursing and Midwifery; Diploma in Community Nursing Science; Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
14. Diploma in General Nursing and Midwifery; Diploma in Community Nursing Science.
15. Diploma in General Nursing Science, Midwifery, Community Nursing Science and Psychiatry.
16. Diploma in General Nursing Science, Midwifery, Community Nursing Science and Psychiatric Nursing Science.

1.4 Claremont Clinic

17. Diploma in General Nursing, Midwifery, Diploma in Community Nursing Science and Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
18. Diploma in General Nursing and Midwifery; Diploma in Community Nursing Science.
19. Diploma in General Nursing and Midwifery; Diploma in Clinical Nursing Science: Health Assessment: Treatment and Care.
20. Diploma in General Nursing Science and Midwifery;

1.5 Factreton Clinic

21. Diploma in General Nursing, Midwifery, Community Nursing Science and Diploma in Clinical Nursing Science: Health Assessment, Treatment and Care.
22. Diploma in General Nursing, Midwifery and Community Nursing Science
23. Diploma in General Nursing, Midwifery and Community Nursing Science
24. Diploma in General Nursing and Midwifery

1.6 Maitland Clinic

25. Diploma in General Nursing
26. Diploma in General Nursing, Midwifery and Community Nursing Science

1.7 Civic center Clinic

27. Diploma in General Nursing, Midwifery and Community Nursing Science

1.8 Greenpoint Clinic

28. Diploma in General Nursing, Midwifery and Community Nursing Science

ANNEXURE 4

SELECTION OF PARTICIPANTS FOR INTERVIEWS AND GROUP DISCUSSIONS

- The following participants were selected for the individual interview numbers 2, 10,15, 19, 22 and 25.
- The following respondents were selected for the focus group discussion:

Group 1: the following respondents were selected: numbers 5, 9, 14, 20, and 26.

Group 2: the following respondents were selected: numbers 4, 8.13, 18 and 23.

Group 3: the following respondents were selected: numbers 3, 11,12, 17 and 21.

ANNEXURE 5

REQUEST TO CONDUCT RESEARCH

Dr Toms

21 Floor Civic Center

Cape Town

1999-06-10

Request to conduct research

I am currently registered in the Master Of Arts In Nursing Science program at UNISA. Part of the requirements for the program is the dissertation of limited scope. I am thus requesting to conduct research in one of the health districts of the City of Cape Town. The topic of the research is to **identify the training needs of primary health care workers (Registered Nurses) in an identified district.**

Thanking you

Mrs. S. Elloker

ANNEXURE 6

VERBATIM REPORT OF AN INDIVIDUAL INTERVIEW

The following fonts were used to identified the themes and sub-themes in the verbatim reports of the individual interviews and the focus group discussions: **bold;** *italics;* underline; *italics and underline;* ***bold, italics and underline*****; bold and underline;** SHADOW; ALL CAPS; shadow; SMALL CAPS; ***ALL CAPS, BOLD AND ITALICS;*** ***SMALL CAPS, BOLD AND ITALICS.***

A verbatim report of an individual interview as recorded from number 22.

Interviewer: "How old are you?"

Respondent: "54 years old".

Interviewer: "Are you married?"

Respondent: "Yes"

Interviewer: "What is your home language?"

Respondent: "English".

Interviewer: "What is your highest school qualifications?"

Respondent: "Standard eight"

Interviewer: "What is your academic qualifications as registered by the South African Nursing Council?"

Respondent: "As a General nurse, Midwifery and Community Health"

Interviewer: "In which year have you qualified as a registered nurse?"

Respondent: "Now you taking me back, 1969 General, 1970 Midwifery and 1981 Community Nursing Science."

Interviewer: “Where have you been employed previously?”

Respondent: “Previously I worked for the Glaxo-Anglo group, I was with them for about nine years then I also went to the Salter’s group, those are all pharmaceutical and surgical companies who employ nursing sisters. Two and a half years when I went of with my son as a baby because of his birth and my parents have died I was at home for three years and then I was asked to join the Salter’s group by a friend of mine who have worked together and I suppose knowing working for them together we were all nursing sisters working there, then I thought I was not utilising my qualifications to its full potential because it is fine utilising your knowledge and your experience but I just felt I was not utilising and my inner spirit said to me you would give more of yourself so when I saw the advert in the Nursing News I applied to City Council almost thirteen and half years ago.

Interviewer: “When did you start at City Council?”

Respondent: “1988, the beginning of 1988”

Interviewer: “All your previous experience was with pharmaceuticals?”

Respondent: “Yes”.

Interviewer: “Do you have any hospital experience?”

Respondent: “Very short, very short.”

Interviewer: “Where did you have?

Respondent: ”At Groote Schuur and at Peninsula.”

Interviewer: “After you qualified?”

Respondent: ”Yes, I worked for a few months, that’s right.”

Interviewer: “Only a view months?”

Respondent: "I suppose when I got married my husband said oh the night duty and then they were very strict, as much as one wanted to stay they would not accommodate you, I feel it was more sort of home circumstances because if he works and this is what I see, you kind off always missing each other, and back on night duty you prepare, that type of thing. "

Interviewer: "Did you start with Glaxo immediately after you qualified?"

Respondent: "Yes, a few months, yes".

Interviewer: "Then again with the Salter's group."

Respondent: "With the Salter's group, yes."

Interviewer: "Four and a half years."

Respondent: "Yes, there is a eight-year gap between my children, so you can see where it goes back from."

Interviewer: "Since 1988 you have been working for the City of Cape Town."

Respondent: "Yes, yes."

Interviewer: "At which clinics did you start work?"

Respondent: "I start work at Chapel street."

Interviewer: "For how long did you work at Chapel Street?"

Respondent: "Two and a half years."

Interviewer: "Two and a half years and then you came to Kensington and you have been here ever since."

Respondent: "That's right, and we just relieved, I just relieved for about two weeks in Mitchell's Plain, they were short of staff so we really worked in the clinic."

Interviewer: "What were your key performance areas or your duties at Chapel Street?"

Respondent: "Look we had to do everything. Immunising, until I did my Community Nursing Science, which is weighing, Immunisation, I also did the family planning course, within a year. Once I did that I could move on to family planning. So it was weighing, immunisation and family planning."

Interviewer: " At Chapel you just did the immunisation, weighing and family planning."

Respondent: "And it was TB care and DOTS and all the other little things that goes with it."

Interviewer: "And at Kensington?"

Respondent: "I was there for about six to nine months when I was actually in-service trained. Because of your scope of practice you only had General Nursing and Midwifery, you only work in the dispensary we sold milk, years ago, so it was a little bit of administration we did and statistics.

Interviewer: "At what stage did you see the sick children?"

Respondent: "Because you had what we called the health visitor then, everybody they saw the sick children and had a doctor working on a regular basis, I am not sure everyday, we had a doctor."

Interviewer: " Was all the sick children seen by the doctor?"

Respondent: "No."

Interviewer: "May be you need to distinguish between Kensington and Factreton."

Respondent: "Yes, we believe because the totally separate, and you know the socio-economic, one could actually see the distinct difference between Kensington people and Factreton, when we had it in the civic center."

Interviewer: "What is your current role and function in Factreton, how long have you been here?"

Respondent: "Since November 1997, yes."

Interviewer: "What are your current key performance areas?"

Respondent: "Basically curative. Like for example, today we do everything. If we have taken a child and be it for weighing and its is a sick child, needs immunisation. I would do immunisation and screening.

Interviewer: "What services are provided at this clinic?"

Respondent: "Those as I said for children. The well baby clinic, which is weighing, and prevention, which is immunisation. We then also do the sick children. Because having the moms, having the pediatric, we are now qualified, authorised to prescribe, those that can prescribe. Also the TB, we do the TB, on doctor's recommendation per telephone, we can then prescribe, until doctor comes to the clinic to write up the prescription. I am waiting at the moment to be authorised, but I have done the syndromic course, whereby we can see and issue medicines for Sexually Transmitted Infections. On that we can prescribe, but the social problems that we can't handle we refer, as I said services that is beyond which we can do and beyond our scope of practice. Example, the lady I just had now, she had repeated episodes of tonsillitis and she was referred to secondary level. Any defects or delays are referred to Red Cross Hospital or Conradie.

Interviewer: "I spoke about the legislative changes and what impact it has had on the health services. The next questions relate to these changes. What legislative changes occurred in the health services?"

Respondent: "Pertaining to the legal point?"

Interviewer: "Yes."

Respondent: "Changes which I know for example I am not sure if it is legislative regarding like example, we were alerted to the things we could not do, with prescribing for example. The Act is it 38 where in certain instances we could prescribe, where before we could not. So those were changes, which also have taken place. The shortage of doctors or whether they are giving us that extra load. I t makes one feel good that you can do that or giving one that extra responsibility."

Interviewer: "If we talk in terms of legislative changes, the changes which the country are going through in terms of the reforms."

Respondent: "What I have noticed is where they say health is free. For example the under six's are free, for everybody it is free. For adults it is also free. Not just for the under six's. Our services are free to everybody. What it has done I feel from a point, it had made people totally dependent. It is good and bad, we find it has not taught people to become independent and taking the responsibilities. We find minor things like a plaster, where they feel they don't want to buy that extra headache tablet. As Doctor Toms (Director of City Health Department) has once said you spend your time here for a headache tablet. It seems unfortunately it had taken away, as a lecturer once said to us at Cape Technicon; we have taken people's dignity away from them because of handouts. I feel that one has to re introduce in that because it

gives you a sense of worth also. Unfortunately what I have noticed, it is very sad when one see, not particular pertaining to this clinic, where you find how long people have to wait. Or sometimes certain medicines which we are fortunate in this clinic, but if you see in other clinics. I am not sure if you watched last night's special assignment also. You know, the amount of people leaving, nurses. The amount of people leaving nursing, also nurses are over worked, are under staffed. And when you see where you come from, your background years ago, it sometimes make you very disappointed. When you think you have tried as much and people focusing on stats. I want to ask the question, and I once asked the question, is your focus on quality or quantity? And so, one find who ever the lawmakers are, are working on numbers.

Interviewer: "Do you think it's because of legislative changes."

Respondent: "Yes."

Interviewer: "You mentioned the fact that people are waiting long."

Respondent: "Yes."

Interviewer: "Do you think it's because of the legislative changes. Why are more people coming to the clinic?"

Respondent: "Why, I think because of the free services, that is definitely. People are saying, one lady said to me yesterday, she had to pay ninety-eight Rand for the visit at the general practitioner. That is beside the medicine, she was issued with a prescription. I said to her, is it because she is on medical aid? She said "no". I was charged ninety-eight Rand without medicines and then she came here. I don't know. It might be perhaps a bit harsh, I suppose one should go back again and evaluate, what we used to do when we charged the people. It was a minimum amount. We said

if you can afford you couldn't get an antibiotic for two Rand. But I remember when this was introduced, the free services, and people were saying **"**don't I pay anything". We could feel this awkwardness; if I could afford it or the person I was busy with and they say **"**don't I pay?" They feel uncomfortable and I say: **"**We are not allowed to handle any money anymore". I think those people felt if they can contribute, it's not a handout any more. That's why I think we can introduce to assess the person if they felt they wanted to pay. People did try before, even if it was fifty cents. They at least tried to contribute towards something. Unfortunately what have started off here, we see this, medicine were freely available, all fancy things, and people will dictate to you. I want Demazine or Drixine. Unfortunately they should not have started off, and of course we could not keep up. Rather start with something where you can have a continuity where it would always be available".

Interviewer: "You have mentioned the fact that because of the free services, the changes in policy, people are getting the primary level clinic services free. It makes people dependent and they are not taking responsibility. In addition to that are there any other effects that you feel the legislative changes had underpinned, besides those which you have mentioned."

Respondent: "Not really. I am not sure whether this is legislative, the patient charter. Is it legislative?"

Interviewer: "I think part of the White Paper says the community involvement and the right to health to the providers and users, I think this is part of introducing the legislative changes."

Respondent: "That is the only thing I found regarding that is fine. I often said regarding the patient charter, is that you have a nurses charter also. If you read carefully, I think people read selective and read the first section on what their rights are, not their responsibilities. I think that should be emphasised much. I speak up, although I give up much of my time. I forfeit my tea breaks, just because I cannot sit there while a client is waiting I find if it rolls over into lunch time, you find people come up and one lady said: we know what our rights are and you must see us. They don't realise that the nurse also has rights you know, as much as they do. I think they should also put this on the responsibility. The community participates when it comes to health and as much as you can't get anything, but they are really part of deciding and should give us input, and you find there is this apathy."

Interviewer: "Discuss the legislative changes, for example the curative services under thirteen, the free services, you have mentioned your scope has extended in terms of STI's. What effects did these legislative changes have on you, and on your daily activities at the clinic?"

Respondent: "Not me personally because I have always said I will not drop my standard. I know the focus is stats and one do feel a bit despondent. It depends on you personally because I have always taken a stance and said I will not drop my quality. The next person must just understand that when they come, and also have a problem, how would you feel when you leave the room. You would want to be treated with respect and dignity and quality. My focus is as much changes that have taken place, one has to abide by it but one have also voiced your opinion and said look unfortunately because of nurses being re deployed your staff have dropped. There is

so much, it is not only seen as a person, they are not a conveyer belt. I mean just to mention of the hook, one lady came to me yesterday and she said I was at the Station clinic and she said: “Sister, I would rather come back here and come in the morning.” I said to her rather come back because she said she is treated like an animal you are hardly in and they say right next, ready with the injection. She says, “Here if I have a problem you are there to listen to me and she says I would rather come back because of the service.” That is what one must focus, not always on numbers, it is the quality. It make you then think, oh well forget all the demands which the hierarchy put on you. If a client feel good it makes you feel good.”

Interviewer: “I am going into the next section which is going to deal with coping skills. How do you cope with the legislative changes? That is my next question. How do you cope with the changes in the clinic?”

Respondent: “Look, I voice my opinion also Mrs. Elloker when it comes to certain things but I suppose one is not always given full reason as to why. We have always been told your numbers do not qualify for so many. I feel as long as one can understand like we have done, what we have put up there saying there are only two sisters on duty. We will go out and say to the patients please be patient and bare with us. You can see it is not just in and out, if you want **quality service** there is so much we have to render. We explain to the person that we take it in number order be it for immunisation, sick babies, family planning or STI and they would understand. Their reason was I think they say we don’t sit as long as at the day hospital, all day, and they do appreciate it. If we explain to explain to them that unfortunately. So why is they’re so *few staff* and we say oh well you see, the hierarchy decide. We just have to

abide by it. I think the focus is, as much as one can try to maintain the quality of the service, the client will understand. Sometimes it is very despondent when you think you have to rush and go out."

Interviewer: "How do you cope with that?"

Respondent: "How do I cope? **I suppose I love nursing and if a person can compliment just on the manner they are handled, and this is what I was focused on**. I remember in my student days, when the tutor said that you are part of healing, your whole mannerism, and the way you present yourself. This is why it comes back, that you have to **sell yourself first**, and I find if you can build up that rapport with somebody, as sometimes they request to see you, and you feel good about your work. I feel already it is part of your coping skills. Instead of saying what goes on, what are we going to do about it fine, it has happened before, what am I going to do about it? I will have to go and explain to the clients.

Interviewer: "What strategies and processes did the clinic put in place to cope with the new changes?

Respondent: "What we have tried***, I see they have put up a notice that only babies to be seen, sick babies in the morning***. Sometimes babies can get sick in the afternoon, so I suppose one have to assess each case on its merit also, and just explain. We ***have extended our family planning service. We have the evening session until six o'clock and we do not turn anybody away***. Whether it is in your lunchtime, the DOTS or some ill person, we have never turned anybody away. We try to emphasis to people and say will you come on a certain day. For example what we have done now is say to everybody not to come on a Wednesday, because the clinic

look a little disorganise. We have all the TB Patients and doctor is here and it does look a bit. We try and it and I say to Mrs. X write up the sputum immediately, don't let it all congregate at the back because it looks. So one try if you can organise something. What it has done, what Mrs. Y, the clinic manager has done is each one has been given ***a specific duty and I think we are responsible for that.*** For example, everyone is responsible because I am not always at the scale. Everybody must be familiar with the two monthly sputum, or what I will do with Mrs. X is go through the folders, check the two monthly sputum's, recall them and do the quarterly reports."

Interviewer: "The next question, what strategies or coping skills have been of benefit to you?"

Respondent: "I suppose it does not allow me, *I can only thank God for giving me the ability,* not that I tried to boost myself. When it comes to stress I can handle it. Okay I find you do go home and try to load of and the rest of it but I am fortunate."

Interviewer: "Why do you cope so much?"

Respondent: "Is it not because of my make-up, am I not perhaps a *stronger person spiritually and emotionally*. That makes up the person. Some people tend to flip out and say look what has happened, look at all these people waiting. It use to happen. I used to sit and write and get myself all stressed and tense, and wait for the next person. I would go and if you explain, **my emphasis is on quality**, irrespective. I think emotionally and spiritually, I don't say I don't cry and all the rest of it, from a spiritual point inwardly I am a strong person."

Interviewer: "You answered this question. What system did you put in place to manage these changes?" "The next question is personal. Do you have any pressing personal, social or professional commitments? These all relate to your coping abilities."

Respondent: "You said social commitments."

Interviewer: "Yes."

Respondent: "That's my home?"

Interviewer: "Yes." "Do you have any pressing social, family or professional commitments? May be in church you have a lot of duties that keep you busy during the week."

Respondent: "I do, if you say pressing, I won't say it is pressing. It might be commitments, but I won't say it is pressing. For example on Friday I did the youth presentation on Aids but because one of the tables were PPSA (Planned Parenthood Association of South Africa) and I think that was why I was asked to do that. Not really pressing I mean I suppose people think because I work in nursing in the community so I am asked to join a prayer group at church also. That is every Sunday during communion. I have been asked to do the presentation with the youth, but because and I previewed the videos myself, and because I thought it's because of a poor self-esteem. I thought I would have to work on that. I did the video first on the poor self-esteem. So I am asked occasionally when it comes to church to do that. Also with my son that will be twenty one August, when it comes to home. I don't see it, as pressing commitments as such it really is demands that neither affect my social or

my work. No, nothing that is going to affect me negatively. Al my commitments, although pressing is all positive."

Interviewer: "Does your commitments affect your coping ability?"

Respondent: "No it does not."

Interviewer: "How does your ability to cope, or inability to cope, affect the team? The way you have answered the questions, it appears as if you cope well. So how does that affect the team?"

Respondent: "Positively. THE NURSING STAFF AT X CLINIC WORK WELL TOGETHER. We don't have anybody, you know if you can say, a thorn in the flesh or what ever it is. We don't. Whenever we have discussions with the clinic manager she ask us for our input, because we try. Another feather in my cap is if I can do administration, I will do it myself. Be it if the attendant cleaner is busy elsewhere, I don't look at it that it is your duty, if I can do it I quickly fetch the mop, somebody spilled the water and it was a mess. I fetched the mop and mop it because the attendant cleaner was off yesterday. Even here I might have broken a vial, I will wipe it up myself. So I think it is not beneath me to rinse out my own mug or take out a folder or even file a folder. So I think all levels of staff irrespective we do get on well."

Interviewer: "How does your ability or inability to cope affect your business plan targets?"

Respondent: "I feel when it comes to the business plan for example we just mentioning the LVC (local venue committee) we some how or other have, we have done certain, regarding the business plan, certain duties we have carried out. Where it comes we sometimes find that at local level it seems as if certain business plan

may not have the capacity here to make decisions when it counts because it has to go through your levels of communication for your different levels of management. You can make suggestions but it is not a deciding factor at our level, which is at the LVC."

Interviewer: "So how does because you cope well affect your business plan targets?"

Respondent: "Well, look at the immunisation it has increased, the blue letters (standard recall letters) have fallen away, where many times people have moved out (the TB patients they give addresses but they have no fixed abode) we have tried, I am not sure if the letters go a stray or that they don't respond at least I file it under home visit. The time again because of time constraints you can't always go because we have a set period to do a home visits. So there again you could have been told at that home which you visit, sorry the person has moved or you could do something. But with a letter you don't know is the person not responding because of not wanting to do so, or whether they have moved on. But we are striving particular in that field and even to our TB."

Interviewer: "Thank you very much for answering my questions. Is there any thing else you want to mention?"

Respondent: "I hope I have given you the information you do require. Was it adequate? I hope it was adequate for yourself."

END

ANNEXURE 7

VERBATIM REPORT OF AN INDIVIDUAL INTERVIEW

The individual interview conducted with number 19

Interviewer: "My name is Mrs. X, thank you very much for allowing me to interview you. I have explained the reason why. The focus of the research is coping skills of registered nurses in clinics. My first question, how old are you?"

Respondent: "43 years old".

Interviewer: "Your race?

Respondent: "Coloured".

Interviewer: "Home language?"

Respondent: "English".

Interviewer: "The next question is. What is your highest school qualification?"

Respondent: "Standard ten."

Interviewer: "The next question relate to your academic qualifications."

Respondent: "Diploma in General Nursing, Midwifery, Primary Health Care or Health Assessment."

Interviewer: "The following questions relate to your employment history: In which year did you qualify as a registered nurse?"

Respondent: "In 1983."

Interviewer: "Briefly discuss your previous employment history?"

Respondent: "I worked for a general practitioner for five years."

Interviewer: "Briefly discuss your current employment history within the Cape Town Administration. At which clinics did you work?"

Respondent: "At Lentegeur."

Interviewer: "For how long have you been working at Lentegeur (clinic). What were your key performance areas at those clinics?"

Respondent: "At Lentegeur as a health visitor, I did screenings, nine months and neonatal, immunisation, social problems and referral. And then changed to Claremont (clinic) in 1997."

Interviewer: "Where are you currently employed?"

Respondent: "At Claremont clinic."

Interviewer: "What are your current key performance areas?"

Respondent: "STD (Sexually Transmitted Infections), FP (family planning), curative, TB dots (daily observed treatment), immunising, screening."

Interviewer: "What services are provided at this clinic?"

Respondent: "TB dots, immunising, screening and curative services for under thirteen."

Interviewer: "Thank you very much. The next question relate to the legislative changes and the impact on the health care system. What legislative changes occurred in the health care system?"

Respondent: "TOP legislation, Termination Of Pregnancy, the EDL (Essential Drug List) and medicines were more available to the under thirteen year olds.**"**

Interviewer: "What effect did the legislative and policy changes have on the clinic?"

Respondent: "The clients were more open to tell me what they want. They are requesting termination of pregnancy and children get better services. Increase in requesting of curative services."

Interviewer: "Thank you very much. What effects did this legislative changes have on your daily activities?"

Respondent: "We had lots of updates on hospital zoning, different areas which hospital takes which client. More people attending. Clients are more aware of their rights, therefore request services that they are entitled to, such as termination of pregnancy."

Interviewer: "How do you cope with the changes in the clinic?"

Respondent: "I FIND DOCTORS OR THE NURSES TELEPHONICALLY OR IN THE CLINIC, HELPS ME TO TREAT THE CLIENT CORRECTLY AND CONFIDENCE IN MYSELF. The available medication and treatment that are available, and giving the client the correct services they request. If I am unsure of the treatment for clients <u>I consult with other nurses in the clinic."</u>

Interviewer: "What strategies or processes did the clinic put in place to cope with the changes?"

Respondent: "New updates for STIs and HIV clinical management. All staff is updated on current strategies that give me more confidence. <u>We as a clinic have actively debated new protocols and policies of Meningitis, deciding what dose of medication is necessary to manage a child with Meningitis."</u>

Interviewer: "What coping skills and strategies have been of benefit to you and why?"

Respondent: “7KHDXSGDWHVZHUHFHLYHZLWKPRUHDFWLYHDNQRZOHGJHZKLFKLHQDEOH \RXWRPDNHDVFLHQWLPRUHHIIHFWLYHO. My supportive family which listens to my problems, which we discuss and helps me to make decisions. I DON’T LET SMALL IRRELEVANT PROBLEMS AFFECT ME. I DEAL WITH PROBLEMS AS THEY ARISE.”

Interviewer: “What mechanisms did you put in place to manage these changes?”

Respondent: “I explain to clients why they need to wait, which put them at ease. I RATIONALISE MY BEHAVIOR remain courteous, treat clients as individuals.”

Interviewer: “The following questions relate to your responsibilities of you that you have. Do you have any pressing social, professional or family commitments?”

Respondent: “No, I am there to love my children and see that they go to school and dress properly.”

Interviewer: “What support systems do you need in place to assist you to cope?”

Respondent: “My colleagues, management, doctors, referral hospitals that help us with queries and my family.”

Interviewer: “Your colleagues and doctors, what role do you think they should play in supporting you?”

Respondent: “As a source of information and also JUST BEING THERE, as friendly happy people.”

Interviewer: “How does your ability to cope affect the team?”

Respondent: “We have a GOOD RELATIONSHIP, WE SUPPORT EACH OTHER. If I was unable to cope, we would have a negative energy in the clinic.”

Interviewer: “How does your ability to cope affect the business plan targets?”

Respondent: "I am proud that we are reaching our targets. I don't like the business plan, it makes me feel frustrated to be monitored and checked what we are doing and what we are not doing."

Interviewer: "Why are you frustrated with the business plan?"

Respondent: "I feel that when we work so hard. We have done our best. Then we find that we have only reached 60%. Then I query is it right, is it possible that we have only done that amount of work."

Interviewer: "Thank you very much for your co-operation. Is there any other questions or areas of clarity?"

ANNEXURE 8

VERBATIM REPORT OF A FOCUS GROUP DISCUSSION.

"I am Soraya Elloker, I will be facilitating the discussion. This is Sister Jacobs, she is going to be my assistant. She will observe all the non-verbal behavior and after the discussion, we will sit together and agree on the outcome of this group discussion. Sister Jacobs will also change the tape if need be. Okay, thank you. Each person has a number so if you would mention your number before you talk and then contribute towards the discussion. As you know my focus of the research is how does registered nurses working in clinics cope with the legislative changes, which we have undergone. One of the legislative changes which has impacted on the clinics, based on the individual interviews which I have conducted with staff, is the free services for children under five, the open door policy, thirdly has the extended function of registered nurses, the curative services under thirteen and the HIV positive clients that we currently managing at all our facilities. The aim of the discussion is to raise how we cope, and is the way I am coping, the way you are coping. The results of the research will be used to develop some strategy for us to initiate and develop to secure that registered nurses cope with the changes. Are there any questions before we start? Given the background which I have sketched can we say based on the demands at the clinic how do you cope with the current services."

Number three: "Definite changes that are taking place, I have no problems with that, MY PERSONALITY DON'T ALLOW ME TO COPE WITH THE FRUSTRATIONS IN DOING THE JOB. The problem is and as somebody has suggested, they say to me don't let it get

to you, we see children that are being neglected, or not being brought for treatment when they should. They say don't let it get to you, I feel something. I feel positive or I feel negative and I find it very difficult not to feel anything. I need to care about these children, I do worry about them."

Interviewer: "But how do you cope with that?"

Number three: "That is the only thing, I find I can cope with. Everything else I find that is the frustration. That I find very difficult to cope with, because I feel powerless to do anything further about this. I know from my own experience how that is when I feel helpless. I am not in control of that situation. That is my only problem."

Interviewer: "Do you agree with what number three is saying?"

Number four: "I think I differ from where number three is concern, because **my personality allow me to cope with stress situations,** coping with the curative needs in the clinic and that is who I am."

Interviewer: "But how do you cope with that, how do you manage to cope with the curative needs? What in your personality make you to cope better than number three?"

Number four: "I think maybe it is the way I was brought up, and what I went through in life, that causes me to be a stronger person. And also the way they were brought up when they came to the clinic. Whether they emotional, whether they rude, I handle the situation as it arise."

Number two: "What number four does I notice in the clinic with a difficult situation where the clients came and they are abusive? What she does is she HANDLES THE SITUATION WITH HUMOUR and she is good at that. I think living in the community she

identifies with the clients, she knows them better and it is easier for her to deal with them in a humor way."

Interviewer: "Number two do you agree with that."

Number two: "I partly do and I partly don't. I find there are times when I can cope, and sometimes I am too angry at too many things to cope. And my anger is not directed towards anybody in particular. *Sometimes it is directed towards the system*, or sometimes it is directed towards the situation in the clinic and of course I might take it out on the client or I might take it out on my colleagues, but certain times I don't cope. Let me give you an example, I don't cope when there is request made from maybe administration for us to have certain things done or to do certain things and they don't have staff to allow for such a duty to be carried out effectively, and that makes me angry. I can cope with a lot of people in the clinic if I have SUFFICIENT SUPPORT FROM MY COLLEAGUES, and also *sufficient time and equipment.* I hate it when I am asked to do something and I am not provided with the facilities to carry out my duties and to do it effectively. I am a person that like to do it very proficiently and when I cannot do it that way, I seem not to do it half way, and do not cope."

Interviewer: "So support for you is important?"

Number three: "It is important and you know. It is fine to make demands but WITH DEMANDS MUST COME THE SUPPORT. And with support I don't just mean standing next to me holding my hand, I mean there must be, if somebody ask for a whole lot of stats (statistics), they need to bare in mind I still have to do my basic work. So don't demand the stats right on the spot. I need time to do it that is just an

example. Anything that is instituted, because every now and then a new management protocol is added on top of what we already doing. And sometimes they just, you know nurses have been so trained to accept the fact that they must do it. Do we ever question, does it fall within the training. Is it just another thing, which have been planted upon us. I don't think we question that enough, and I think it should be question."

Interviewer: "You are basically saying that the administrative demands place strain."

Number four: "Sometimes place strain on a person, yes."

Interviewer: "If you were able to manage the administrative demands or get somebody else to do it, do you think it would assist you to manage your clients for curative, immunisations and TB?"

Number four: "I think that the administration also have probably their own problems. They are trying to satisfy somebody even higher than them, or you know just do their duties, but the burden should not fall on the actual staff that have to do it. The administration should then be supplied with sufficient staff, so that they can allocate that staff to the people that have to do it, whether it is staff or equipment. What ever it needs, but you can not institute things and you don't foresee the long term outcome because you want something to work properly not institute that thing and see how it go. See whether they coping or not, and you know to me it does not work. I am just a person if something is brought upon me I will not just accept it, I try to analise it, to see if there is sense in it. Does it make sense to do something, is it going to benefit the client. Is it going to tear me apart, because if I am torn apart I can't provide an

efficient service. I am not here to prove to you I can cope with any amount of work. That to me is just absurd. I am not here for that. I am here to provide an efficient service, and I am not going to let my personality having to cope with something that I find harmful to me in any way. I feel it is also incorrect for administration to expect that of their staff. You know it is not going to benefit anybody in the long run."

Number three: "The other problem is that we try to give quality service in less time because of the quantity. **Quantity of clients that we are seeing and we do feel good if we able to achieve that if we putting in the amount of work, and then not. We need to see that she come back well and the mothers with the better knowledge, and that makes us feel good.** That we have got the clients are demanding quality, the management is demanding numbers, numbers in terms of the amount of clients. We are seeing and the clients are demanding quality, and we are getting pushed, getting pressurised in the middle."

Interviewer: "Do you think you cope better when you are assured you are giving a quality service to the clinic?"

Number one: "I think we feel a lot better, we feel like we have done a good job."

Interviewer: "Does that assist you with coping?"

Number one: "Yes it does, definitely."

Number two: "Can I just say something also, I have also found that when you do have a SUPPORT IN WHAT EVER WAY, WHETHER IT IS STAFF WISE OR EQUIPMENT WISE, YOU TURN OUT A BETTER SERVICE THAT MAKES YOU FEEL GOOD. You are also then motivated to do even better. So that is just adding to what I said earlier. That if you are restrained in any way, it does not benefit anybody.

Interviewer: "Do you agree with the quality issue that was raised?"

Number one: "Yes I do agree in every respect, in everything they are saying because it effects us emotionally and even spiritually, because if somebody comes in and tells you that you have not done a lot of work, your quality have not been done very well. Knowing very well what you have given up. Your whole mind and body to this people you have been looking after them efficiently, and you have been delegating everything the way you would have done to achieve the better curative assistance to the people. But it degrades you whenever they say something, they say **"**no your number do not compare with the number of staff you are having, as if you have not been doing anything. I must say if we are not working as a team, I am sure we would be stressing more and more. IS THE TEAM BUILDING WE ARE HAVING THAT HELPS US AND THE SUPPORT OF EACH OTHER."

Number three: "I feel if there is a balance, if we've got for instance with the children coming in that are sick and we seeing a good balance of **children that are coming back well and we know that they are improving.** And if we have a balance of SUPPORT, GOOD SUPPORT FROM MANAGEMENT and to balance the demands in terms of statistics, and numbers to balance the demands in terms of the statistics. And numbers, budget that is not sufficient. Then I feel that we can cope for better. I think at least even though we are adults and professional people, if you had a PAT ON THE BACK EVERY NOW and then; it balances out the negative aspects. You still need that, you still need to feel proud of what you do, if you get a PAT ON THE BACK IT DOES HELP."

Interviewer: "You saying recognition will assist you to cope with the negative demands placed on you, on a daily basis?"

Number three: "And it does not need to be a big thing just a pat on the just to acknowledge, somebody says to you don't worry we know how you feel and you recognise that. This is what you need to do, we still need to achieve that, even that small thing means that you recognised as a professional and people recognise that you do. They recognise that you are saying we do see what you are going through.**"**

Interviewer: "Number five what is your views on the points that we raised?"

Number five: "I think of the points that were raised I agree and I support that especially with regards to the tape and all the numbers we have to deal with, and with all the negativity that we get from the administration because really, sometimes it makes you, sometimes you just feel like dropping everything because of the negativity. If you can have that positive influence, maybe it will make our day even more, because at the grass root level that is what we try to do for each other but we don't get it from the administration."

Interviewer: "What positive factors would you like to see in place that will assist you with coping from the administration side."

Number one: "Recognition for what I am doing just as my friend said, you don't need something big just to know that what I have done is recognised."

Interviewer: "How do you cope?"

Number five: "I think I have coped through the support that we have each other and as number four has said personality because that also counts a lot. You must have a personality that will make you able to accommodate all kinds of problems and from

where you come, you have seen a bit of suffering. So the suffering we are almost, we see it everyday. It is not something new as number three has pointed out. It is something we have grown with. So we are able to deal with the problems that come to the clinic, and your attitude, everything keeps being positive with everything that you do and the support of your colleagues."

Interviewer: "How do you cope with the open door system, where clients can come to the clinic from 8:15 to four forty five (16: 45)?"

Number two: "I was just explaining how I cope with the open door policy and my fact on the matter is I communicate with them. I explain to them **I NEED A BREAK TO RE HYDRATE MYSELF** or just to have a rest and do it all very pleasantly and come back and help them with all the enthusiasm."

Number one: "We communicate with our clients and they understand what we are doing for instance if we say we have gone for tea or are doing something or we are having a meeting. They do understand the only people who do not understand is the management, because once a person from management sees clients sitting there waiting, they think that we are not looking after these patient. We are just ignoring them and yet we have communicated with them. If only the management would talk to us and asked when they come in and not to assume that we are neglecting the clients, otherwise the work is going well and the communication is good between nurse and client.**"**

Interviewer: "Number one, do you feel that assist you to cope with the pressure and the demand that the clients place on the service?"

Number one: "Yes, if you have taught your clients about how the work you is doing, the communication is good between staff and client. The communication is good, that makes us to feel that we can cope very well because the thing that is important is that there must be no harassment between those two."

Interviewer: "What other coping skills do you think have assisted you to cope with the current situation like we find our selves in."

Number two: "The other thing is that also help us cope, is that we have to [illegible] with what is happening in the country, with the health system. There are certain things you cannot fight but I find one must also not just accept and always participate and contribute to what is being planned, otherwise you can't blame anybody else if you not coping so you should voice your opinion and make sure it is heard."

Number three: "I am fortunate in that I have a mother and a sister who are nurses, so they understand, so when I go home and I'm angry about what have upset me even if they don't necessarily listen to every detail. They do understand the need for me to talk about it. My other non-nursing parts of the family find it difficult to deal with."

Interviewer: "Does that assist you to work through your trauma or negative experiences that you have been confronted with at work. "

Number three: "It does help although my ex- husband who was a health inspector could not stand me mentioning anything about work. So it does depend on what your support system is."

Interviewer: "How did that make you feel, the fact that he did not want you to mention work?"

Number three: "Very difficult, I felt that my work, my contribution was not recognised, to the point where my in-laws did not realise what I do. In fact even today my brother does not recognise what I do. I'm sure he thinks that I just go to work and see a few children and other people, and then go home."

Number five: "I wanted to say something about the support at home, because I've got my sister and my daughter, and my daughter has been staying with me all the time, and every day when I come from work she knows what has happen from work, for me so I think that helps me a lot. She listens since she was four and she is thirteen now. And she's been listening to all the things that have happened to mommy. And she'll sit there listening to what has happened. She will ask me what did you do mommy, and then did you feel all right after that, and then she will say okay. That's fine, now I'm feeling all right. Then I'll say yes, and then it's fine even though I'm speaking to a child. It's something because it relaxes me, then I feel much better."

Number two: "I just wanted to mention that sometimes we do see faces that are a little bit more difficult, complicated to deal with, and you know you hesitate to see them through, and on the other hand you also want to help the mother. So I feel that we not nurses and sometimes we are asked to deal with cases that do not fall in our jurisdiction, and that causes us, puts some pressure on us, which makes us sometimes not cope. I mean we not doctors and some cases we need more than our nursing knowledge.**"**

Number three: "Although we do get in-service training, we don't get in-service training that we used to have where we could take cases to a doctor at Red Cross Hospital and he would open the floor and say, we have particular problems, and we

would actually share, and he would advise us, and we would all learn. What is happening now is, we are isolated by running full day services, we don't even interact with other staff from other clinics any more, so there for we're not able to grow and learn the way that we used to."

Interviewer: "Does the in-service training assist us with coping, in-service training in terms of updates for family planning, updates for child health?"

Number five: "[illegible] around and then from different areas, different things with different problems then we can deal with the problems."

Interviewer: "How do you cope with the lack of in-service training? Appropriate in-service training?"

Number Four: "I don't have a problem at the moment because I'm coping well and I've just finished off the course. I've just finished a curative course skills so I don't know what lies ahead, so I can't talk now for things that's going to happen in the future."

Number Two: "I just wanted to add, regarding the treatment, curative treatments and the management that we're giving to our HIV babies for instance, this is also a new issue that we' re faced with, and we have to learn, as we go along you know, no amount of in-service training is really going to be adequate. We have to learn and see it as we go along. I have sometimes a problem with that because I find it just

faces me all of a sudden, and then I sometime don't know what to do. Although there are staff that I can contact, it is not always that easy."

Interviewer: "How do you cope with the shortages of staff at the facilities?"

Number One: "We had a shortage of staff, you find yourself being one doing the work of three people and after we done the job you just wonder how you have managed to do this work and to find yourself still sane. Even when you get home you are still in your good senses, you are still **able to laugh**. And I think once that your personality and your good support and ***YOUR BACKGROUND HELPS A LOT.*** I must say at times because you just wonder how would one be managing to do such work without collapsing."

Interviewer: "How do you cope with that demands, how do you manage to go on?"

Number One: "Well, I think somebody you know within yourself have got that humor you give yourself. YOU LAUGH EVEN WHEN YOU HAVE GOT TROUBLE. You know, you just smile with the client even if you feel you are angry, you find yourself laughing at times because they will ask you certain questions you feel that this one makes me laugh, then you feel yourself laughing and then that just goes away. Then you feel you are able to cope and manage."

Interviewer: "Do you thing that your faith support you with the stressful environment with nursing?"

Number five: "*Yes, I think the faith helps a lot with the good support*. I think faith can move the mountain, that's why I don't look at the workload, I look at the mountain. I know I must cross the mountain."

Interviewer: “Anything you’d like to add? How you cope with the demand at the clinic?”

Number five: “No.”

Interviewer: “Thank you very much for your contributions to this group discussion. Thank you all.”

END