FACTORS CONTRIBUTING TO THE NEGATIVE BEHAVIOURS OF NURSES

IN A SPECIFIC PUBLIC HEALTH CARE FACILITY IN NAMIBIA

by

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submitted in accordance with the requirements for the degree of

MASTER OF PUBLIC HEALTH

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF K A MABOE

SUBMITTED ON: SEPTEMBER 2017

DECLARATION

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I declare that the study on **FACTORS CONTRIBUTING TO THE NEGATIVE BEHAVIOURS OF NURSES IN A SPECIFIC PUBLIC HEALTH CARE FACILITY IN NAMIBIA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Tomas N

SIGNATURE

20/09/2017

DATE

MR. NESTOR PN TOMAS

DEDICATION

This dissertation is dedicated to my lovely wife, Theolinda Tomas, for her unwavering support during my studies and for having taken on the added responsibilities for providing guidance to our children during my absence from home.

To my children (Junior Tomas and Theolinda Tomas) for their understanding and patience throughout my study journey.

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ABSTRACT

It is important for nurses to show acceptable behaviour when interacting with the patients. The purpose of this study was to explore and describe the factors that contribute to nurses' negative behaviour when rendering patient care and to determine the effects of nurses' behaviour on patient outcomes.

The study used a non-experimental explorative and descriptive quantitative design. Data collection was done using a structured questionnaire. The sample comprised of 64 respondents which consisted of 25 registered nurses and 39 enrolled nurses.

The study found that besides the known contributing factor, that is, the shortage of nurses, further identified contributing factors to nurses' negative behaviour when rendering patient care are failure to retrain nurses identified with negative behaviours, poor condition of employment and patients' behaviours and cultural beliefs.

These results suggested a need to train more nurses, improve conditions of employment, as well as support and retrain nurses identified with negative behaviours.

KEY TERMS: Enrolled nurse; Health; Negative behaviours; Nurse; Nursing; Patient; Patient outcome; Public health care; Registered nurse; Patient advocacy.

ACKNOWLEDGEMENT

I would like to thank my supervisor Prof KA Maboe for her support and guidance during this study. I would have not managed to acquire the needed competencies to complete this degree without her assistance. May God continue to give her all the strengths and wisdom.

I would also like to thank the Unisa Masters and Doctoral Bursary programme for granting me financial assistance to complete this study.

I would further like to thank my friends and colleagues particularly Mrs Muyenga for her support during my study. May the almighty bless you all.

Lastly, I thank you, Mrs R Matlou for your kindness in assisting me to format my dissertation in preparation for the final examination submission. Your efforts are not unnoticed. May God bless you.

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ABBREVIATIONS AND ACRONYMS

CPD	Continuous professional development
EHRs	Electronic health records
EN	Enrolled nurse
HPP	Harambee Prosperity Plan
IUM	International University of Management
KPI	Key performance indicator
MOHSS	Ministry of Health and Social Services
NDP	National Development Plan
NQS	National Quality System
PA	Performance agreement
PA	Performance appraisal
PFPS	Patients for Patient Safety
PTB	Theory of planned behaviour
RN	Registered nurse
SPSS	Statistical Package for the Social Science
UNAM	University of Namibia
UNISA	University of South Africa
WHO	World Health Organization
WU	Welwitchia University

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

This chapter gives an overview of this study by outlining the background to the problem, the problem statement, the theoretical grounding, the study objectives, the research questions, the research design, and the methodology. It also discusses issues related to validity and reliability, ethical considerations, definitions of concepts, the scope and limitations of the study and structure of the dissertation.

In Namibia, the vision articulated for the public health care facilities is to be the leading provider of quality health care in Africa and beyond (MoHSS 2014b:2). However, the negative behaviour displayed by nurses compromises the quality of health care in Namibia's public health care facilities and is thus a pressing issue.

If nurses have a negative attitude it can affect patient care and therefore it is essential that nurses display positive attitudes during their interaction with patients. Some researchers have identified poor nursing care while others have identified dissatisfaction among patients as the contributory factors. The identified poor nursing care and dissatisfaction among patients were related to the poor attitudes of nurses (Haskins, Phakathi, Grant & Horwood 2014:32). From 2014 to 2015, 25% of cases against nurses reported to the Health Professional Council in Namibia were related to negative behaviours, which ranged from shouting, scolding the patients, showing a lack of respect and ignoring patients in need of assistance (The Namibian newspaper 2015:11).

The Namibian newspaper (2015:11) stated that in 2012, a Presidential commission of inquiry to investigate the poor state of Namibia's public health sector found that negative behaviour in nurses was unacceptable and needed to be addressed. Accordingly, this study sought to address the factors contributing to negative behaviours nurses and the consequences of such behaviours for patient outcomes.

The researcher identified the negative behaviours displayed by nurses when rendering patient care as a problem; this led to an investigation of the factors contributing to their negative behaviour in a specific health care facility which employed 200 nurses. On conclusion of the study, the results were sent to the specific health care facility and the MoHSS in order to make them aware of this problem and to assist in formulating strategies to mitigate negative behaviour by nurses in Namibia.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

Namibia inherited a fragmented healthcare system from the colonial and the apartheid governments. The policies of the colonial regime not only violated human rights but also discouraged black people from receiving education and training in the field of nursing. Blacks were limited to six months' in-service training which qualified them as assistant nurses and allowed them to perform basic nursing care such as feeding, carrying out bed baths and making beds (Van Dyk 1997:21). In terms of these policies prior to independence, blacks were treated as second-class citizens and were only allowed to attend selected hospitals where they were subjected to violence, discrimination and were both physically and emotionally abused. Nursing profession was regarded as being for women only and thus doctors (who were mainly male doctors) looked down on them (Van Dyk 1997:22).

After independence, the nurses' scope of practice was reviewed and broadened, leading to nurses playing an important role in preventative, curative and tertiary services. Nursing became an important profession in addressing various health challenges and nurses became more involved in the provision of health care services. The shift in the nurses' roles contributed to the curbing of both communicable and non-communicable diseases but also brought dissatisfaction among the public, particularly those receiving health care services at public health care facilities countrywide (The Namibian newspaper 2015:4).

The MoHSS responded positively to the call by the Presidential Commission of Enquiry's 2013 report by addressing issues identified as priority areas in the delivery of nursing care services. One of the priority areas identified among others was the shortage of nurses which led to burnout among nurses and negative nurses' behaviours (MoHSS 2013:24).

In response to the shortage of nurses, in 2014 the International University of Management (IUM), Welwitchia University (WU) joined the MoHSS and the University of Namibia (UNAM) in the training of nurses. The government was the main sponsor nursing courses in the country and bid all graduates who benefited from government funding to work for the government for a specific period equal to the number of years spent in training (The Namibian newspaper 2015:4).

The MoHSS further introduced a health extension programme for training health extension workers to assist nurses to control the emerging of new diseases and chronic diseases, namely, cancer and human immunodeficiency virus (HIV), which exacerbated the shortage of nurses (MoHSS 2014d:260). In 2012-2013, a total number of 444 nurses graduated from the UNAM (UNAM 2012:14) while about 460 nurses graduated from the five MoHSS training centres (MoHSS 2013:26). The report had indicated that 85% of nurses were absorbed into the public health care sector by the government while 15% were absorbed by the private sector (MOHSS 2013:30). During the same period, a total of 31 cases were recorded at the Health Professional Council against nurses' behaviour at public health care facilities (Health Professional Council 2016:2).

In the fight against unemployment, government intensified programmes that reduced unemployment from 37.6% in 2008 to 27.4% in 2017. This helped many citizens to afford medical costs and to relieve the burden resulting from their reliance on public health care facilities (Trading economics 2017:1).

Although the scarcity of nursing professionals is a critical challenge in both the public and the private health sectors, as indicated by O'Hanion, Freeley, De Beer, Sulzach and Vincent (2010:6), about 90% of cases reported to the Health Professional Council are related to nurses working at public health care facilities with private health facilities relating to about 10% of cases (Health Professional Council 2016:2).

This study investigated the factors that contribute to negative nurse behaviours when rendering patient care in a public health care facility.

The researcher assumed that beside the shortage of nurses, there were other unknown factors contributing to the negative nurse behaviours that have led to persistent public dissatisfaction noted at public health care facilities.

1.3 STATEMENT OF THE RESEARCH PROBLEM

According to the Namibian newspaper (2015:11) the Presidential Commission of Inquiry report stated that issues related to health workers' conduct, ethics and attitudes pertain mainly to nurses and these were found to be unacceptable. The report further indicates that nurses are overworked which could be linked to burnout and negative nurses' behaviour. The report further points out that more than 50% of the public comments surveyed were of the opinion that nurses' negative behaviour requires immediate attention from the Ministry of Health and Social Services (Vries 2013:1).

Prior studies conducted in Namibia had covered topics related to this study but no standalone studies have been identified specifically with a focus on factors contributing to nurses' negative behaviours. There is therefore a need to seek information on the various factors that contribute to nurses' negative behaviour in rendering patient care. This study emerged because of public dissatisfaction and inadequate information pertaining to the factors contributing to nurses' negative behaviour when rendering patient care particularly in public health care facilities in Namibia.

As the researcher is a nurse, he assumed that, as there had been a substantial reduction in the nursing shortage in public health care facilities, there had to be other factors that contribute to the negative behaviour of nurses that results in persistent public dissatisfaction with public health care facilities in Namibia. This assumption was based on the researcher's observation of an increase in negative nurse behaviours at the specific health care facility in which this study was conducted.

1.4 THE THEORETICAL GROUNDING OF THE RESEARCH

Research questions formulated from a positivist stance were deductive in nature and were subjected to scientific inquiry. This ensured that the study has followed strict rules of logic, truth, law and predictions of logical positivism (De Vos, Strydom, Fouché & Delport.2011:6). In terms of this study, the focus of the research questions was to ascertain the factors contributing to negative nurses' behaviours in rendering patient care in a public health care facility in a specific region of Namibia.

1.4.1 Assumption underlying the study

The following assumption served as a starting point for this study:

- Apart from the shortage of nurses, there are other factors contributing to negative nurse behaviours in rendering patient care in a public health care facility in a specific region of Namibia.

1.5 DEFINITIONS OF KEY CONCEPTS

1.5.1 Conceptual definitions

1.5.1.1 Behaviour

Behaviour refers to the way in which one acts or conducts oneself, especially towards others (Berman & Snyder 2014:69). The study explored theories related to motivation and behavioural change that promote the conducive environment in which the provision of quality nursing care can be rendered.

1.5.1.2 Enrolled nurse

An enrolled nurse (EN) (in Namibia) is a nurse who has completed two years of training in nursing education (Republic of Namibia 2014d:s 1). Enrolled nurses were among the category of nurses sampled for this study.

1.5.1.3 Health

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (Berman & Snyder 2014:323). The promotion of health was found to be of vital importance, thus decision of the researcher to investigate factors contributing to negative nurse's behaviours.

1.5.1.4 Negative

Negative refers to acts that are undesirable or unwanted or disliked (Burnes & Pope 2007:287). Undesirable acts by the nurses that were labelled as negative behaviours were explored and documented in this study.

1.5.1.5 Negative behaviours

Negative behaviours refer to acts that have a negative effect on outcomes (Burnes & Pope 2007:287). The study explored negative behaviours of nurses that were found to compromise provision the quality of nursing care.

1.5.1.6 Nurse

A person educated and licensed in the practice of nursing; one who is concerned with the diagnosis and treatment of human responses to actual or potential health problems **(**Berman & Snyder 2014:323). The study population for this study were licensed nurses who were working at a specific health care facility.

1.5.1.7 Nursing

Nursing is the attributes, characteristics and actions of the nurse providing care on behalf of, or in conjunction with the client (Republic of Namibia 2014d:s 1). Issues of ethical standard and issues affecting the provision of quality nursing care were discussed. This study focused on issues affecting the nursing profession.

1.5.1.8 Patient

A patient is defined as a person who is a recipient of health care regardless of the state of health of the patient (Republic of Namibia 2014d:s 1). The study results were on the nursing issues which directly affect the recipient of nursing care, hence the inclusion those who receive such care.

1.5.1.9 Registered nurse

The registered nurse is seen as a person with unique knowledge who is licensed to practise nursing and is registered in terms of sections 20 and 64 of the Nursing Act No. 8 of 2014. (Republic of Namibia 2014d: s 1). Registered nurses were sampled for this study and gave their views on factors contributing to nurse's behaviours in a specific public health care facility.

1.5.2 Operational definitions

1.5.2.1 Negative behaviours

Negative behaviours refer to the acts or conduct that are undesirable or unwanted or disliked by the patients. In this study all acts or conducts not perceived as acceptable in the society or by the patients were regarded as negative behaviours.

1.5.2.2 Patients' outcome

In this study patients' outcome refer to the results of the nursing interventions that promote recovery or quality patients' care. The study investigated factors that negatively influence the nursing interventions that promote recovery or quality patient's care.

1.6 PURPOSE OF THE STUDY

The purpose of this study was to investigate the factors contributing to the negative behaviours of nurses in rendering patient care in a specific public health care facility in Namibia.

1.7 STUDY OBJECTIVES

The objectives of this study were to:

- explore and describe the factors that contribute to nurses' negative behaviours in rendering patient care at a specific health care facility.
- determine the effects of nurses' behaviours on patients' outcomes at the specific health care facility.

1.8 RESEARCH QUESTIONS

The research questions were as follows:

- What are the factors contributing to nurses' negative behaviours in rendering patient care in a public health care facility in a specific region of Namibia?
- What are the effects of nurses' negative behaviours on patients' outcomes?

1.9 RESEARCH SETTING

A research setting is the location in which a study is conducted (Burns & Grove 2011:40). This study was conducted in a specific health care facility in the Kavango region of Namibia.

The specific health care facility was selected because it serves as a referral hospital for three regions, namely, Kavango East, Kavango West and Zambezi region.

Some of the cases reported to the Health Professional Council came from the selected specific health care facility (The Namibian newspaper 2015:11).

1.10 RESEARCH DESIGN AND METHODS

1.10.1 Research design

A non-experimental explorative and descriptive quantitative design was used. The research design is a blueprint for conducting a study that maximises control over factors that could interfere with the study's desired outcomes (Burns & Grove 2011:49). Various factors contributing to nurses' negative behaviours in rendering patient care in a specific health care facility in Namibia were measured without examining cause-and-effect relationship (De Vos et al 2011:156).

1.10.1.1 Quantitative design

The numerical values were interpreted by giving meanings that can be generalised to the studied population. A quantitative study is defined as a formal, objective, systematic process in which numerical data are used to obtain information about the world (Burns & Grove 2011:43). The study used a quantitative design because it planned to quantify the results pertaining to factors contributing to negative nurse behaviours in a public health care facility in a specific region of Namibia.

1.10.1.2 Explorative design

The researcher incorporated an exploratory design in the study. An explorative research design is conducted to gain an understanding of a situation, phenomenon, community or individual (De Vos et al 2011:95). Thus, the researcher's interest in answering "what" questions on the factors contributing to nurses' negative behaviours led to the use of an explorative research design. This design was used because there was inadequate evidence from the literature reviewed with regard to factors contributing to nurses' negative behaviours in a public health care facility in Namibia.

1.10.1.3 Descriptive design

A descriptive design involves the exploration and description of a phenomena in real-life situations (Burns & Grove 2011:34). This design was preferred because it allowed the variables to be described and thus no manipulation of the variables was required.

In this study, the views and experiences of the nurses of the factors contributing to the nurses' negative behaviours in public health care facility in a specific region of Namibia's were explored and described.

1.10.2 Research methods

Brink et al (2012:24) define research methods or research methodology as a particular way of knowing about reality. It includes the target population, sampling, data collection and the specific steps of the research process that ensure objectivity and the minimisation of biases.

1.10.2.1 Population

According to Brink, Van der Walt and Van Rensburg (2012:131), a population is the entire group of persons or objects that are of interest to the researcher. The target population consisted of 200 nurses working in a public health care facility in a specific region in Namibia. Registered and enrolled nurses were chosen because they work with the patients on a daily basis and any factor that would affect nurses may have an effect on the delivery of care.

1.10.2.2 Sample and sampling technique

Sampling refers to the process the researcher uses to select the sample from a population in order to obtain information about a phenomenon in a way that represents the population of interest (Brink et al 2012:132). Sampling also makes it easier for the researcher to conduct a study with limited resources, time and finances. Furthermore, sampling makes it easy to analyse, interpret and generalise the results to the entire population that the sample represents (De Vos et al 2011:224). The samples from different segments were drawn according to the number of persons in that stratum; hence stratified sampling was applied. Stratification ensured that all the variables identified are represented in the population.

The strata in this study included the different categories of nurses (registered nurses and enrolled nurses) in a specific health care facility. Nurses were the target of the study because it aimed at investigating the factors contributing to their negative behaviours in rendering patient care (Burns & Grove 2011:301).

The sampling frame consisted of 77 registered nurses and 123 enrolled nurses, leading to a total of 200 nurses. A simple random technique was applied to select 32% from each category for the sample. In the registered nurse category, 32% of 77 represented 25 registered nurses, while 32% of the enrolled nurse category, namely 123, resulted in 39 respondents being included in the study (De Vos et al 2011:225).

A limitation of stratified sampling is that it requires an extensive knowledge of the population and a complete list of the sampling frame (Brink et al 2012:138). This was addressed as the researcher knew the population under study and a complete list of the sampling frame was easily obtained.

1.10.2.2.1 Inclusion criteria

The inclusion criteria were enrolled and registered nurses working at a public health care facility in Namibia, who were working directly with the patients on daily basis.

1.10.2.2.2 Exclusion criteria

The study excluded all registered and enrolled nurses who were part of the pilot study as previous exposure would contribute to hawthorn effect.

1.10.2.3 Development of an instrument

A data collection instrument is a tool or procedure for collecting data (Brink et al 2012:150). In this study, the researcher used self-developed questionnaires to collect information from the respondents. Questionnaires were used because they promote quick honest responses from the respondents and ensured anonymity, as each questionnaire was given a unique code instead of reflecting the respondents' names. Questionnaires were easier to test for validity and reliability as the format and questions were standardized for all the respondents

The questionnaires were in English and consisted of five sections, which included 13 closed-ended questions. The first five questions were intended to obtain biographical data. The following questions included questions based on a Likert-type scale and yes or no questions. Ten open-ended questions were also included, which addressed staffing and the work schedule, remuneration, reward, benefits and recognition, leadership and management style. The aspects addressed in the open-ended questions were also addressed in Likert-type scale and yes or no questions in closed-ended format (refer to Annexure 2). The questionnaire took about 20 to 30 minutes to complete.

1.10.2.4 Pre-testing of an instrument

After pretesting the instrument the researcher explained the purpose of pre-testing to the respondents. They were requested not to participate to the main study because the pre-testing may have contributed to the Hawthorn effect (bias) resulting from the respondents' prior exposure to the questions. The pre-testing of the data collection instrument was necessary because it allowed spelling mistakes in the questions to be corrected and the data collection instrument to be clarified to ensure validity and reliability.

Prior to appointments' dates, the researcher determined the number of respondents to be pre-tested and then grouped them into two groups (strata) being the registered nurses and enrolled nurses. From each category a sample was drawn using simple random sampling. Appointment for distributing and pre-testing of the data collection instrument were made at the gate of the specific health care facility as respondents were knocking off from work. On the appointed date, the researcher met with the respondents, identified himself and explained the purpose of the study, and the time allocated for completing the questionnaire, which was two days.

Respondents were further informed that participation in the study was voluntary and that they could withdraw from the study at any time without any penalty if they so wished to. After obtaining their verbal consent the researcher proceeded with pre-testing. The researcher was available for the entire period of pre-testing in order to clarify questions that were not well understood. A total of 15 questionnaires were distributed. The questionnaires were pre-tested on fifteen (15) nurses being, seven (7) registered nurses and eight (8) enrolled nurses. The questionnaires were first completed by the respondents at the gate of the specific health care facility on the 27th April 2017 and other respondents completed them at their respective homes on the 28th April 2017. Privacy was maintained by allocating the room to those respondents who completed their questionnaires at the gate of the health care facility. Permission was verbally granted to the researcher by the medical superintendent to use the room. To those who completed the questionnaires at home privacy was maintained as the respondents themselves allocated special rooms to complete the questionnaire. Completion of the questionnaire took between 20 to 30 minutes.

All the respondents adhered to the two days given for the completion of the questionnaire and all 15 questionnaires that were distributed were returned. To maintain confidentiality and anonymity questionnaires were identified by using unique codes.

The results of the pre-tested questionnaires were used to make amendments to the structure of the questionnaires and correct grammatical errors. Ambiguous questions with difficult words were noted in items 10.4 and 19.1 and these were replaced with simpler words.

1.10.2.5 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of the study (Burns & Grove 2011:52).

Appointments for data collection were made after the data collection instrument had been pre-tested and ethical approval had been granted by the Research and Ethics Committee of the Department of Health Studies at the University of South Africa (Unisa) (refer to Annexure 1).

Permission was also obtained to conduct the study from the Permanent Secretary of the Ministry of Health and Social Services in Windhoek (refer to Annexure 3) and the Medical Superintendent of the specific public health care facility (refer to Annexure 4).

Before making appointments in preparation for the main data collection the researcher grouped the respondents into two categories being the registered nurses and enrolled nurses and selected them using simple random sampling. The number of the respondents from each strata were then, determined and then a sample was drawn from each category using simple random sampling prior to appointments dates. The research further, ensured that the pre-tested instrument is ready to be used for the main data collection. Introduction was done by the researcher and explanation of the purpose and significance of the study to the targeted respondents. This was done at the gate of the specific health care facility when the respondents were knocking off from work. Respondents were divided into two groups, those who preferred to complete the questionnaires at the gate of the specific public health facility and those who preferred to complete the questionnaires at homes. Appointments made were for a period of three weeks being from the 15th May 2017 to the 2nd June 2017. The respondents were informed that the questionnaire would take 20 to 30 minutes to complete.

At the agreed upon date and time for data collection, the respondents were requested to complete the questionnaires either at the gate of the specific health care facility or at their respective homes.

Respondents who agreed to participate to the study were further requested to sign the informed consent form (refer to Annexure 5) and were also informed that the decision to take part in the study was voluntary and they could withdraw from the study at any time should they wish to, without penalty.

A pre-tested questionnaire (refer to Annexure 2) was used to collect data for the main study. The researcher collected data at two points, namely, at the gate of the specific health care facility and at the respondents' homes. The researcher was available throughout the main data collection in order to clarify questions which were misunderstood. Since the questionnaires were written in English which was the language which the respondents know and understand no interpreter was used.

Privacy was maintained by allocating the room to those respondents who completed their questionnaires at the gate of the health care facility. Permission was verbally granted to the researcher by the medical superintendent to use the room. To those who completed the questionnaires at home privacy was maintained as the respondents themselves allocated special rooms to complete the questionnaire.

All the questionnaires distributed were returned to the researcher. Of the 64 questionnaires distributed, 25 were completed by registered nurses while 39 were completed by enrolled nurses. The completed and returned questionnaires were identified with a unique code to ensure the confidentiality and anonymity of the respondents and were kept in a lockable cabinet which was accessible to the researcher only.

1.10.2.6 Data Analysis

Data analysis is aimed at reducing, organising and giving meaning to the collected data (Burns & Grove 2011:52). The data collected from this study was analysed using frequency tables and measures of central tendencies such as the mean, mode, median, variance and ranges in accordance with the objectives and research questions. Data was analysed using a computerised statistical technique, Statistical Package for the Social Science (SPSS) version 23.0 and in consultation with a statistician (De Vos et al 2011:251).

1.11 VALIDITY AND RELIABILITY

1.11.1 Validity

Burns and Grove (2011:334) define validity as a determination of how well the instrument reflects the abstract concepts being examined. Validity seeks to ascertain whether an instrument accurately measures what it is supposed to measure, given the context in which it is applied (Brink et al 2012:165). The validity of this study was determined by the use of approved data collection tool, pretested to respondents who are homogenous to the sampled population with regard to the two categories of nurses found at the specific health care facility. Each category of nurses was sufficiently represented in the sample. The validity of the data collection instrument was necessary.

1.11.1.1 Internal validity

The data collection instrument used to gather information about the factors contributing to negative nurse behaviours in a public health care facility incorporated both face and content validity to ensure a true reflection of reality. In addition, all the respondents received similar questionnaires to ensure that every respondent get an opportunity to answer the same questions. The relevance of face validity and content validity are discussed below:

1.11.1.1.1 Face validity

Face validity was assured by submitting the questionnaires to the statistician who approved the data collection instrument for the study.

1.11.1.1.2 Content validity

Content validity was assured through the review of literature that made it possible to come up with a self-developed data collection instrument with the assistance of the statistician.

1.11.1.2 External validity

The results of the study were generalised to all nurses working in the specific public health care facility where the study was conducted. To ensure the generalisability of the results of the study, all respondents were selected using simple random sampling.

1.11.2 Reliability

Brink et al (2012:171) define reliability as the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time.

To ensure the reliability of the data collection instrument, the researcher conducted a pilot study on 15 nurses (8 enrolled nurses and 7 registered nurses) and the results were in line with the objectives of the study. These nurses each completed a questionnaire in order to measure the accuracy and consistency of the data collection instrument. After pre-testing the instrument, ambiguous and unclear questions were changed so that misinterpretations by the respondents would be avoided in the main study.

When compiling the questionnaire, the researcher also involved the supervisor and the statistician in determining its stability, internal consistency and equivalence before the main study was conducted.

1.12 ETHICAL CONSIDERATIONS

Ethical considerations imply preferences that influence behaviour regarding human relations, conforming to a code of principles, rules of conduct, the responsibility of the researcher and the standards of conduct of a given profession (De Vos et al 2011:114).

1.12.1 Researcher-focused ethical considerations

The research proposal was submitted to the Research and Ethics Committee of the University of South Africa's (UNISA) Department of Health Studies for ethical clearance, which was approved (refer to Annexure 1).

The researcher further requested permission to conduct the study from the Permanent Secretary of the Ministry of Health and Social Services (MoHSS) in Windhoek (refer to Annexure 3) and from the Medical Superintendent of the specific public health care facility in conformance with ethical standards (refer to Annexure 4).

1.12.2 Respondents'-focused ethical considerations

In this study, respondent-focused ethical considerations refer to researcher behaviour that conforms to the code of principles and the profession in order to protect the respondents during the research process.

The researcher at all times ensured that the study adhered to the three fundamental principles of ethical research, namely, respect for persons, beneficence, and justice (Brink et al 2012:34).

1.12.2.1 Avoidance of harm

De Vos et al (2011:115) state that research has the potential to harm subjects physically or emotionally. Hence the researcher was responsible for weighing the risk involved, to protect respondents against any harm, inform the respondents on the potential impact of the investigation, identify and eliminate vulnerable respondents from the study and allow respondents to withdraw from the study at any time they wished to do so.

1.12.2.2 Informed consent

The researcher obtained written consent from the respondents after an explanation of the study had been given (refer to Annexure 5). Consent was obtained from the respondents, who were deemed to be psychological and legally fit, who gave voluntary consent after having the purpose of the study as reflected in the informed consent form (refer to Annexure 5). Respondents were also made aware that they could withdraw from the study at any time without any penalty (Brink et al 2012:38).

1.12.2.3 Deception of the respondents

Deception takes place if respondents are misinformed for research purposes (Burns & Grove 2011:110).

Deliberate deception was prevented while any deception that occurred without the researcher being aware was immediately discussed with the respondents before or after debriefing.

1.12.2.4 Right to privacy

The privacy of respondents was respected by avoiding the use of hidden cameras, videos and microphones during the study.

Respondents were informed that their private information would be shared with the supervisor, UNISA, the Permanent Secretary of Health and Social Services and the Medical Superintendent.

1.12.2.5 Anonymity

Anonymity was enhanced as the researcher was not able to identify the respondents afterward as they were identified with codes instead of disclosing their names on the questionnaires.

1.12.2.6 Confidentiality

De Vos et al (2011:119) indicate that confidentiality is viewed as a further extension of privacy, where an agreement is made to limit the access of others to private information. The respondents have the right to know how or decide when, where, to whom and to what extent the information obtained from them is used.

To ensure confidentiality, information obtained was only shared with the supervisor, UNISA, the Medical Superintendent and the MoHSS in Namibia. The data collected was kept in a lockable cabinet of the researcher for data collection purposes.(hard copies) while electronic data was password protected. All the questionnaires did not reflect the respondents' names or any identifiable identifier. They were coded in order to keep the respondents' information confidential.

1.12.2.7 Compensation

During the study, neither financial nor material benefits were offered to the respondents.

This was explained to the respondents before the study was conducted while emphasising the need for honest responses that could contribute to improved quality of care and the Namibian Vision of 2030.

1.12.2.8 Scientific honesty

The scientific honesty of this study was maintained by ensuring that referencing was done according to the Harvard referencing style and by listing all sources of scientific information relevant to this study. The researcher was regarded as competent to conduct the study as the researcher had passed the modules Health Measurement and Research Methodology at postgraduate level in 2014.

1.13 SIGNIFICANCE OF THE STUDY

Once the final results have been obtained the researcher will send the final report to the specific health care facility and the MoHSS headquarters, in order to assist these bodies to formulate strategies that address the factors contributing to nurses' negative behaviours when rendering patient care.

The study also contributed to the achievement of the National Development Plan (NDP5), the Harambee Prosperity Plan (HPP) and Namibia's Vision of 2030, which emphasise improved quality health care.

1.14 SCOPE AND LIMITATIONS OF THE STUDY

The results of the study were only generalised to the nurses at the specific public health care facility.

All aspects related to the factors contributing to negative nurse behaviours may not have been addressed owing to lack of resources and limited time for carrying out this study.

1.15 THE STRUCTURE OF THE DISSERTATION

CHAPTER	CHAPTER NAME	DESCRIPTION OF THE CHAPTER
1	Overview of the study	The background, purpose, significance, research design and method, and ethical considerations of the study are discussed.
2	Literature review	The theoretical grounding of the research was discussed in detail, and relevant empirical studies and commission of inquiry reports are reviewed.
3	Research design and methods	The quantitative descriptive design, population, inclusion and exclusion criteria, sampling, data collection approach and method, development and pre-testing of data collection instrument, characteristics of the data collection instrument, data collection process, and ethical consideration related to data collection, data analysis, validity, and reliability are discussed in detail.
4	Analysis, presentation, and description of the research results	The data management and analysis, research results, sample characteristics and overview of the research results are discussed.
5	Conclusions and Recommendations	Research design and method, summary and interpretation of the research results, conclusion, recommendations, contributions of the study, and limitations of the study are discussed.

1.16 CONCLUSION

Chapter 1 presented the overview of the study, and discussed the background of the problem.

The purpose, the objectives of the study were introduced and stated the problem identified and addressed the significance of the study. Furthermore, the assumptions on which this study was based and relevant concepts were clarified.

The following chapter, chapter 2, will discuss the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In chapter 1,being an overview of the study, an introduction, background, research purpose, objectives, statement of the problem and the methodology were discussed. In this chapter, a review of the relevant literature will be presented. A literature review is defined as an analysis of the existing available knowledge related to the study (Burns & Grove 2011:10).

Limited literature focusing specifically on the factors contributing to negative behaviour in nurses was found. However, the existing knowledge regarding the variables related to the study was reviewed. These variables included public health care facilities, patient outcomes, ethics related to patient care, shortage of nurses, nurses' negative behaviour, disciplinary measures and motivational theories, management of staff and leadership style.

Information was obtained from the existing literature which was identified in journals, research papers, government publications, newspapers and Google scholar.

The following aspects will be discussed:

- Public health care facilities
- Caring versus uncaring behaviours
- Patient advocacy
- Patient care
- Shortage of nurses
- Negative nurse's behaviours
- Patient outcomes
- Ethics related to patient care
- Disciplinary measures
- Analysis of various conceptual frameworks and models focusing on factors affecting motivation and behaviour change in nurses
- Management of staff

- Performance management of staff members in an organisation and
- Management and leadership style.

2.2 PUBLIC HEALTH CARE FACILITIES

Public health care facilities are government health institutions that are funded and controlled by the state (Republic of Namibia 2014d: 2). Public health care facilities in Namibia cater for about 85% of the Namibian population, especially the unemployed, as well as patients from neighbouring Angola (McQuide, Kolehmainen-Aitken & Foster 2013:1).

The public health care facilities charge a minimum amount, depending on the class of health care facility and the level of care it offers. Classes A and B health care facilities include intermediate hospitals or referral hospitals, class D includes the district hospitals while classes E and F include clinics, health centres and community health posts (MoHSS 2014b:11). The public health care facility in which this study was conducted falls under class B, serving as a referral hospital.

Awases, Bezuidenhout and Roos (2013:5) noted that the majority of people in Namibia depend on public health care facilities for their health needs, making it difficult for the nurses to be able to meet patients' demands, thus leading to work overload and burnout. Negative behaviours are associated with work-related stress arising from the conflict that arises due to the shortage of nurses and the expected level of care.

2.3 CARING VERSUS UNCARING BEHAVIOURS

Caring is defined as intention or action that conveys physical and emotional security and genuine connectedness with another person or group of people (Berman & Snyder 2014:4).

In a study conducted by (Peng & Liu 2013:8) on caring and uncaring behaviours from the perspective of the patient, concluded the findings into two categories namely; caring behaviours and uncaring behaviours from nurses. The category of caring behaviours included psychological support, mutual respect, consideration, effective communication, and excellent nursing skills and quick response from the nurses.

The findings that were found relevant to this study included the expectation that nurses reassure patients during difficult times, protect patient's privacy, be sensitive to patient's needs and be in possession of good nursing skills in order to avoid pain and wasting more time that could be used to care for other patients. The caring behaviours is associated with high level of professionalism, the provision of quality nursing care and therapeutic relationship between the nurses and patients.

In the category of uncaring behaviours, issues relevant to this study were the lack of effective communication skills, insufficient professional knowledge and poor maintenance of ward environment.

2.4 PATIENT ADVOCACY

Advocacy refers to the process of providing support, referral, liaison and representing and protecting the interest of patients and families who may not be aware of the need or are unable to coordinate or organise health care for themselves (Republic of Namibia 2014d:1).

A study conducted by (Smith & Mee 2017:7) indicated that it is the nurse's responsibility to act as an advocate for the vulnerable, to challenge poor practice and discriminatory attitudes and behaviours related to the care of patients. Further, the study indicated that nurses were often reluctant to act as advocacy due to factors such as age, gender, personality, attitude to power and conflict regarding professional roles. Advocating for patients enable nurses to fulfil their legal obligation and ensure therapeutic communication between patients and nurses

2.5 PATIENT CARE

Patient care refers to the rendering of health care services for the benefit of the patients. This concept is at the centre of activities rendered by health care facilities, with international standards focusing more on the quality of care to be rendered to patients (WHO 2014:10). The World Health Organisation (WHO) advocates for a patient-centred approach in responding to health care needs and meeting peoples' expectations. This approach is an initiative that requires patients and health workers to work as partners through the Patients for Patient Safety (PFPS) programme, which should be implemented by all member states.

The PFPS intends to ensure that family and patient voices are heard when reporting errors, health care failures and health care risks, as well as to create public awareness and participation in decision making and share solutions that may prevent patient harm and ensure quality health care (Australian Commission on Safety and Quality in Health Care 2010:23).

In order to promote patient-centred care, in the United Kingdom and United States of America financial incentives are attached to quality services or those who adopted improved quality practice with the care experienced by the patients being the determining factor. Points were assigned based on patient care experience. Ninety-seven per cent of health care workers in United Kingdom were reported to have collected the highest points to earn an average of AU$40 000.00 in incentives. Financial incentives have been linked to positive nurse behaviours and may contribute to patient care as nurses strive to remain polite and helpful and to allow patients' participation in decision-making regarding their care (Australian Commission on Safety and Quality in Health Care 2013:24).

2.6 NEGATIVE NURSE BEHAVIOURS

Nursing interventions aim at protecting, preventing illness, promoting health, and diagnosing and treating illness. As discussed in chapter 1, nurses' negative behaviours are on the rise in Namibian public health care facilities. The literature reviewed for this study covered studies on nurses' negative behaviour in Namibia, South Africa and the United States of America.

2.6.1 Negative nurses' behaviours in Namibia

According to the MoHSS (2014c:41), the National Quality Management Systems report that was conducted to assess the national quality management systems established that 200 out of 205 clients who took part in the exit interviews, 56% indicated that nurses do not introduce themselves to patients and 44% of the respondents felt that nurses were rude to the patients. Nurses speak to adult patients without considering their age, shout at patients and listen to patients in a disrespectful manner.

Nurses' negative behaviour is also linked to pre-independence policies that suppressed the nursing profession, viewed nursing as a female profession and as being inferior to the medical profession.

Different cultural beliefs and practices were stated to cause conflict among nurses and patients. Some nurses may delay the patient treatment on basis of the language they speak, educational level, cultural belief or skin colour. The findings also indicated that many new graduates had no interest in the job while some senior nurses had also lost their passion in the work as they were slow in executing their duties. Moreover, the general use of the word "sister" to refer to male nurses negatively influence the attitude of the male nurses and patient outcomes as some male nurses find the word sister intimidating. Further, some patients call male nurses sister with a connotation that nursing is a female profession and all nurses are females or bisexual (Van Dyk 1997:23).

2.6.2 Negative nurses' behaviours in South Africa

There are several reasons contributing to nurses' negative behaviour. Some of them include choosing nursing because of the financial constraints that prevented candidates from pursuing the field of study they really wanted to enter, while others choose nursing because of the payment received during training (Haskins et al 2014: 35). Nurses who started nursing with no interest in the nursing profession may not be committed to the work and show no dedication in rendering patient care.

Van Wyk & Leech (2011:52) indicated that although culture is recognised in South Africa, "there is little effort from health service providers to accommodate the socio-cultural aspects of care from a patient perspective". The religious affiliation of a community nurse influence the health advice a nurse will give to the patients, so the patient or family religion have an influence on the patient's behaviours. The differences in cultural beliefs and religious beliefs may cause conflict between nurses and patients which can be labelled as negative behaviours from the patient's perspective.

Although social significance of the culture of apartheid and segregation gave some people more power and resources than others, the constitution of Republic of South Africa encouraged nurses to implement the *Batho pele* (people first) principles that emphasis equal treatment of all citizen (Van Wyk 2011:52). This was

In addition, some nurses start to turn against the nursing profession after they have experienced the heavy workload, shortage of staff, complex patient disease profiles, poor communication and lack of support from management (Haskins et al 2014:35). Consequently, nurses develop work-related stress as they are dissatisfied and stressed and displace their anger by ignoring, shouting at or insulting patients in need of care (Mkhwanazi 2012:1).

Mkhwanazi (2012:1) reported that patients interviewed during a visit at Daveyton Main Clinic, on Gauteng East Rand by Health-e News Service complained that nurses behaviours are not good as nurses are not patient, they did what they liked and not bothered to assist patients who spent long hours waiting for medical attention.

Pera & Van Tonder (2013:135) indicated that moral distress resulted from when nurses being involved in morally significant relationships with patients, but have limited or no power to do what they think is right. Although nurses are expected to protect the vulnerable often they are unable to protect their patients often due to the fact that they are unable to protect their patients as a result of institutionalised obstacles such as lack of time, lack of supervision, insufficient staff or stock, lack of adequately trained staff and abuse of power and institutional policy. The effect of moral distress leads to harm to health care users in the forms of pain and suffering.

Other related literature on the nurses' experiences on caring for children with HIV/AIDS in South Africa has indicated that the feeling of helplessness and work related stress were related to loneliness when confronted in difficult situation and the increased health care demands due to HIV/AIDS (Fagrell 2012:16).

2.6.3 Negative nurses' behaviours in the United States of America

In the USA, negative behaviour among health care workers, including nurses, is now under scrutiny.

The American Association of Critical Care Nurses states that any physical or verbal conduct that affects or potentially affects patient care negatively is regarded as negative behaviours (Budin, Brewer, Chao & Kovner 2013:309). Threatening or abusive language, rolling eyes, ignoring attempts at conversation and physical assaults are among the commonly reported disruptive behaviours that have negative effects on patient care (Budin et al 2013:309).

Nurses' negative behaviour is also associated with a lack of power in decision making. Because the profession is primarily female but is dominated by a male-controlled system headed by doctors and male administrators, the nursing profession has been oppressed. Oppressed nurses, who are often female, in turn take out their frustrations on the patients under their care (Budin et al 2013:309).

2.7 IMPROVING PATIENT OUTCOMES

Patient outcomes refer to the results of nursing interventions that promote recovery or quality patient care (Improving Patient Outcomes Strategy 2015:5). The following sections will discuss aspects related to improving patient outcomes:

2.7.1 Quality improvement framework

Nurses are expected to be able to classify patients according to the type and urgency of their conditions in order to provide safe, clinically effective and reliable care (Improving Patient Outcomes Strategy 2015:5).

The National Quality System (NQS) report has indicated that nurses often do not get out of their consulting rooms to assess a patient who may need urgent assistance, making it difficult to provide clinically effective care. MoHSS (2014c:41) stated that the negligence of nurses at one public health care facility resulted in a death when nurses failed to assist a snake bite case despite plea by the family members. The nurses were not considerate of the patient's need for urgent treatment resulting in what is regarded as negative behaviour towards the patients.

Electronic health records (EHRs) provide complete and accurate information and thus assist in improving patient outcomes.

Namibian public health care facilities all use manual health records, which result in a loss of medical history, misdiagnosis and unreliable care (MoHSS 2014c:42). Nurses may be frustrated by the loss of important information which can lead to improper diagnosis and poor management of patients' illnesses. Moreover, the process involved in completing patients' record manually is time consuming.

2.7.2 Culture of continuous improvement

Patient outcomes are central to everyday practice. Public health care facilities learn from the mistakes made and encourage nurses to open up and discuss their concerns so that they can be acted upon fairly (Improving patient outcomes strategy 2015:12). A regular assessment targeting all nurses will ensure, that learning needs are discovered. Programmes should be in place for nurses identified with learning needs related to negative behaviours, ranging from training in cognitive skills, psychomotor skills and behaviours, and affective skills to attending in-service training and refresher courses.

2.8 ETHICS RELATED TO PATIENT CARE

Nurses are expected to make sound judgements and to have a strong sense of what is right or wrong regarding the patients under their care. Often nurses are confronted with difficult decisions to make for which there are no easy, quick or correct answers. However, nurses remain accountable for the actions they carry out actions and the decisions when faced with ethical dilemmas (Searle, Human & Mogotlane 2009:55).

All health care workers, including nurses, are guided by four the main ethical principles, which are discussed below.

2.8.1 Autonomy

Autonomy refers to the right of the patient to make their own decisions regarding treatment. The nurses' role in respect to patients' right is to advise or suggest but not to persuade or coerce the patients into making a decision (Searle et al 2009:55).

Lack of advice, disrespect towards patients and lack of patient involvement in decision-making are all regarded as negative nurse behaviours, as in such cases the nurse does not conduct him/herself as expected by the public and the profession.

2.8.2 Beneficence

Beneficence refers to do good to the patient, that is of the patient's interests. The nurses should have the necessary knowledge and skills to carry out interventions which can benefit the patient (Searle et al 2009:56). One of the reasons nurses may ignore patients' concerns or are rude to them is because they are unable to provide appropriate answers to patients' questions or unable to carry out the necessary interventions.

2.8.3 Non-maleficence

Non-maleficence refers to not causing harm to the patients under one's care. The end goal is for the nurse to ensure that neither the family nor society is harmed by the decision that is made, even if it is to the benefit of the individual patient (Searle et al 2009:56). One of the acts constituting malpractice and negative nurse behaviours is failure to advocate for quality patient care.

2.8.4 Justice

The principle of justice encompasses treating other equitably and the fair distribution of work and benefits. This is to ensure that all health care workers uphold applicable laws and legislation in making decisions pertaining to patients' treatment (Searle et al 2009:56). As a result of the shortage of nurses, work overload may lead to errors, work-related stress and shouting at patients.

2.9 DISCIPLINARY MEASURES

According to the Republic of Namibia (1999:3), a nurse's action is constituted as misconduct if the nurse omits or neglects to carry out acts relating to monitoring, diagnosing, treating, prescribing, collaborating, coordinating and advocating as per the Nursing Act.

The nurse who neglects to maintain the health status of the patient under his/her care, omits or neglects to keep clear and accurate records of his/her actions, divulges patients' confidential details and performs an act outside the scope of practice is also committing misconduct.

According to the Health Professional Council, 25% of cases reported to that organisation involve cases against nurses that are related to their negative behaviours (Health Professional Council report 2016:1).

2.10 THEORETICAL FRAMEWORK

A theory is an assumption or system of ideas that is presumed/proposed to explain a given phenomenon (Berman & Snyder 2014:25). A conceptual framework/model is a group of related ideas, statements or concepts (Berman & Snyder 2014:5).

The literature review conducted covered a number of theories, caring versus uncaring behaviours and advocacy in relation to the factors contributing to negative nurse's behaviours namely:

- Motivation theories which link motivation to how employees view their importance toward the contribution at work place.
- Behavioural change theories – theory of planned behaviour

2.10.1 Motivation theories

2.10.1.1 Herzberg's two-factor theory

The main emphasis of Herzberg's theory of motivation falls on factors that promote work motivation and job satisfaction (Tan 2013:19).These factors heighten work motivation and are categorised as intrinsic and extrinsic factors (refer to Figure 2.1).

Herzberg's two-factor theory is divided into two main factors being the intrinsic factors and extrinsic factors. The theory focuses on motivation as the main driving force to productivity and job satisfaction at work place. High level of motivation was linked to positive attitude toward work. Thus low level of motivation may be associated with negative behaviours and leading to low or poor productivity.

The theory was found relevant in investigating factors contributing to nurse's negative behaviours by exploring the intrinsic and extrinsic factors of motivation below.

2.10.1.1.1 Intrinsic or motivational factors

Intrinsic factors are factors related to recognition and praise, which promote autonomy and a sense of individual achievement for a job well done. If the intrinsic factors related to a job category are assured, employees will reach their highest potential.

Moreover, if intrinsic factors are present, employees will have a sense of autonomy in the workplace, will feel motivated, develop positive attitudes and increase productivity (Tan 2013:19). Aspects of recognitions and awarding nurses who performed as per expectation of the employer were incorporated in this study to determine if registered and enrolled nurses were motivated to perform tasks the best way possible in their specific job categories.

2.10.1.1.2 Extrinsic or hygiene factors

Extrinsic factors include aspects such as satisfactory pay, adequate supervisors, job promotion, job security and good working conditions (Tan 2013:19). When extrinsic motivational factors are present, an employee will be satisfied of their working conditions and will come to work, there will be fewer grievances and fewer resignations.

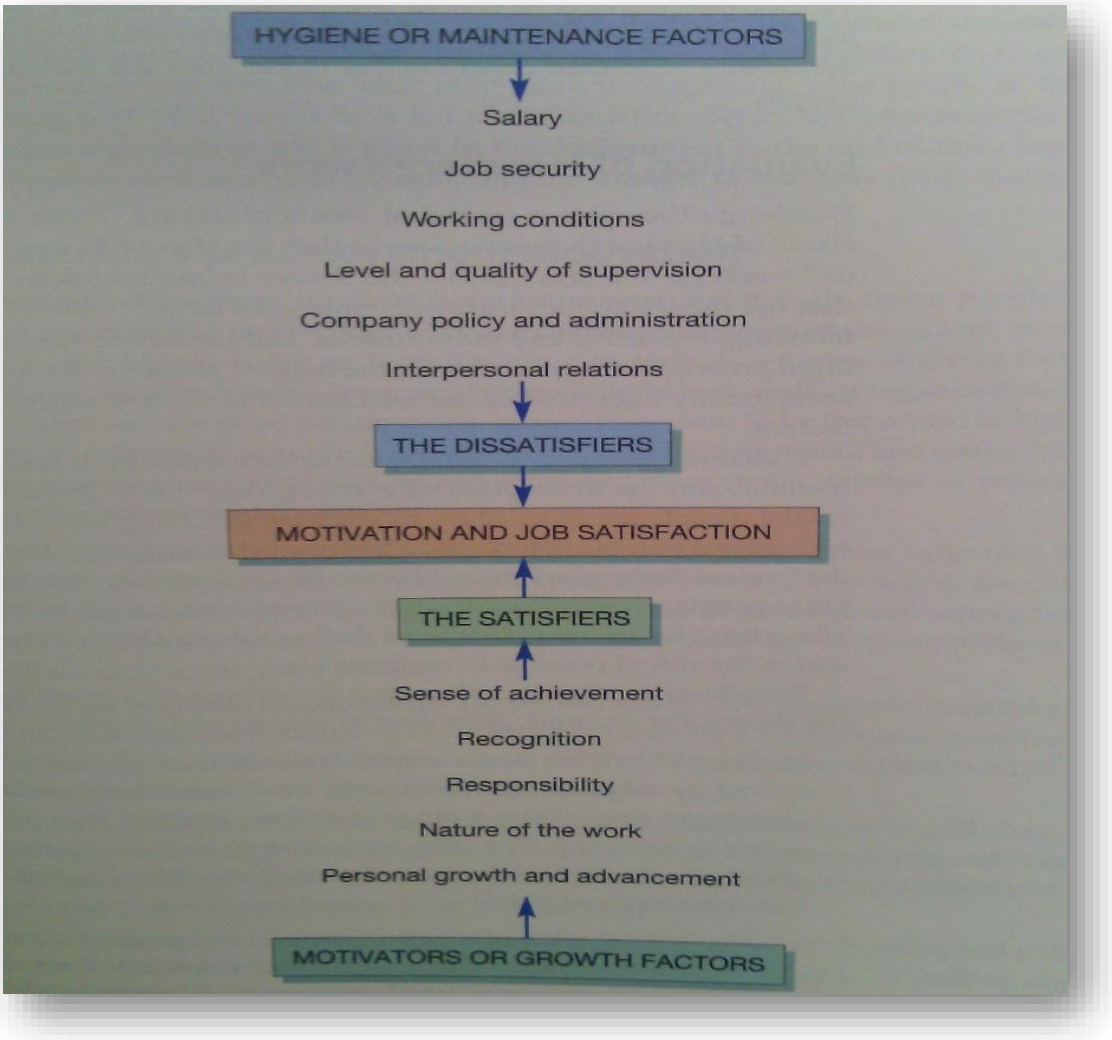

Figure 2.1 Representation of Herzberg's two-factor theory

Source: (Mullins 2013:750).

Motivational theories play an important role in ensuring job satisfaction and behaviour changes in employees.

If employees are well motivated with regard to their job categories, they will be encouraged to reach their highest potential, will have a sense of autonomy in the workplace, which in turn will develop positive attitudes and increase productivity. High level of motivation help to prevent negative behaviours at work as employees will strive to perform to their best. The study investigated aspects related to nurses work conditions and work environment and related the results to negative nurse's behaviours.

2.10.1.1.3 The expectancy-valence theory

This theory is also known as a valence-instrumentality-expectance theory (refer to Figure 2.2). It states that the employee's motivation is an outcome of how the individual wants to be rewarded (valence), the assessment that the effort will lead to the expected performance (expectancy) and the belief that the performance will lead to reward (instrumentality) (Mullins 2013:262). Valence can be positive when nurses have a strong feeling that they will attain a reward; on the other hand, lack of interest in attaining a reward is regarded as negative valence.

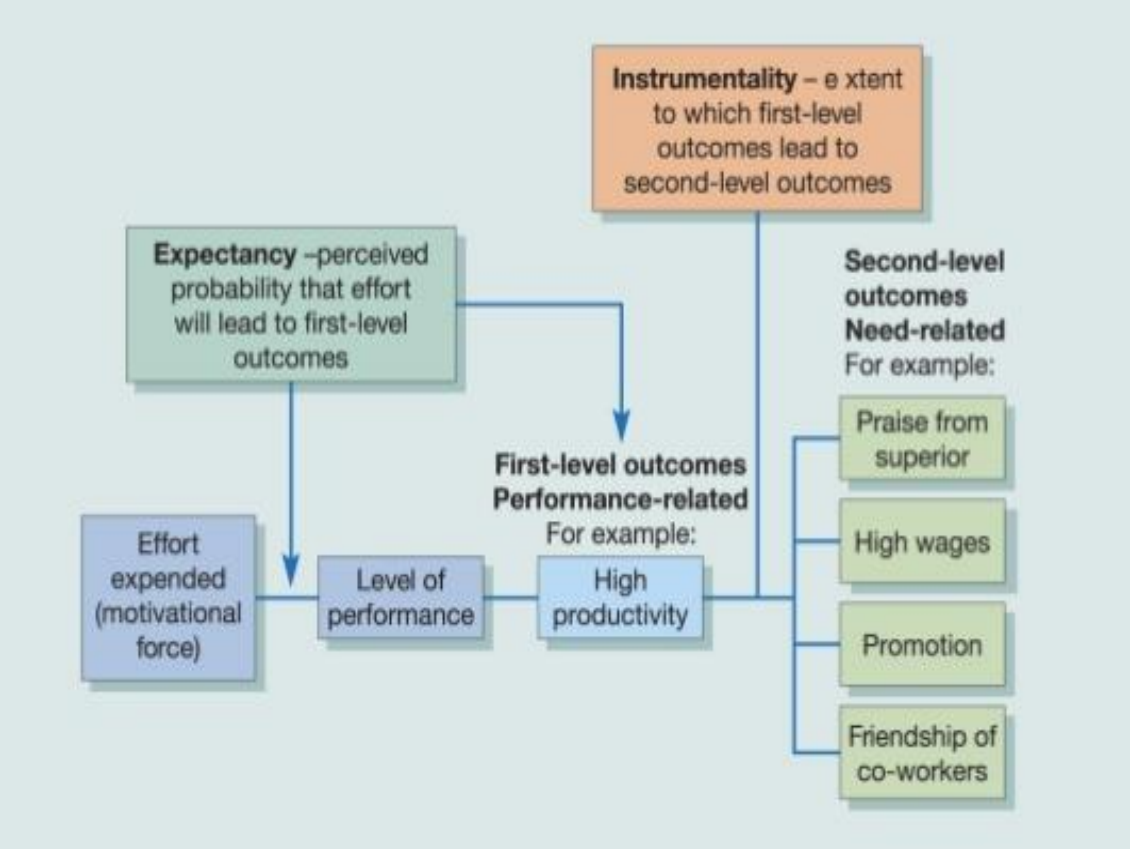

Figure 2.2 Basic model of expectancy-valence theory

Source: Mullins (2013:262).

Expectancy theory further states that employees may be motivated to work toward the organisational goals once they believe that their performance will make a meaningful contribution to their personal goals.

Hence, employees who believe that their personal goals are met will feel that the outcome is worth their time and effort (Lunenburg 2011:4).

According to Mullins (2013:262), it is imperative that the health service manager assesses the expectancy of the employees, remains sensitive to employees' feelings of self-worth and continues to improve them through various continuous professional development (CPD) programmes. Employees' expectations can be met by conducting periodic assessments with employees and privately discussing their career goals, as well as by giving reward or recognition for a job well done. Another way to motivate employees is by discussing the relationship between work and the expected outcome, while emphasising the desirable behaviours that will elicit either internal rewards (feelings of self-worth) or external rewards (pay and promotion) (Booyens & Bezuidenhout 2014:323).

There is a need for healthcare organisations to involve employees in policies on aspects that affect them directly to allow opportunities for employees to satisfy their needs through their work. To individualise the operations of different branches of the same organisation to suit the needs of their employees, it is of the utmost importance to design a clear pay and reward system that will reward employees for a job well done (Booyens & Bezuidenhout 2014:324). Expectance-valence theory is related to behaviour change, as it accommodates nurses' feelings and concerns and link the specific desired performance to reward. Aspects such the implementation of Performance Appraisal (PA) at work place and if the reasons for conducting PA were known by the employees were incorporated in this study. Thus, this study was found expectance-valence theory relevant in exploring factors contributing to negative nurses' behaviours.

2.10.1.1.4 Equity theory

Equity theory is concerned with what employees consider to be either fair treatment or unfair treatment by the employer or organisation. Employees' expectations are proportional to their contribution or the effort they invest in their job (Booyens & Bezuidenhout 2014:324).

Nurses who work in institutions that are understaffed, or who are situated in remote areas with long and challenging shifts, need to feel that they are treated fairly when they compare themselves with nurses in urban areas, working short shifts and in environments where understaffing is not prevalent. Such treatment may be in the form of incentives, recognition, praise, promotion and prestige. Issues related to incentives, recognitions or promotions were incorporated in this study in relation to factors contributing to negative nurse's behaviours.

According to Booyens and Bezuidenhout (2014:324), the main focus of equity theory is to encourage behaviours that increase the effort and job performance. Equity theory has four basic assumptions:

- Individuals make and maintain a state of equity.
- When a person perceives inequity, it creates tension that a person feels motivated to reduce.
- The higher the degree of inequity an individual perceives the higher motivation to reduce the tension.
- Individuals perceive inequity more readily than they perceive favourable treatment.

Equity assumptions describe the stages through which employees go whenever they perceive inequity. Booyens and Bezuidenhout (2014:324) emphasise the importance of organisations to take care of nurses with more years of experience, those that operate in challenging situations and those that perform or have added responsibilities than those with fewer years of experience and with no added responsibilities. If nurses perceive unfair treatment from their employer they may go through behavioural and cognitive changes. Behavioural changes may include reducing the quantity or quality of work, convincing the manager to increase the salaries or even resigning from the job. Cognitive changes include changing work input in future. Although reducing inequity is hard to achieve in nursing owing to the daily variation in patient flows and the number of nursing personnel, it is important to carefully identify those nurses who perform exceptionally well and to recognise them, either in monetarily or by giving them an award (Booyens & Bezuidenhout 2014:325).

As the quality of work can be the result of behavioural and cognitive changes due to inequity at work place, the study integrated issues related to the provision of quality nursing care namely; staff allocation and remuneration based on responsibilities.

Fair treatment and remuneration regarding nurses play an important role in motivating them to work in different work setting with different challenges.

Nurses working in difficult work environments, or with added responsibilities, need to be remunerated and rewarded accordingly as this has an influence on how nurses behave towards their work.

2.10.2 The behaviour change theories

2.10.2.1 Theory of planned behaviour

According to Morris, Marzano, Dandy and Óbrien (2012:5), the theory of planned behaviour (TPB) is widely known for using a cognitive approach to explaining the relationship between attitudes and beliefs as central to an individual's behaviour (refer to Figure 2.3). The focus is on the intentions or planned actions which are the outcome of attitudes towards behaviour, which can be evaluated as positive or negative behaviour. The results of negative or positive behaviour is influenced by what individual perception of what others perceive as acceptable behaviour. In order to be perceived as trustworthy, nurses would want to be seen as loving, good listeners, caring and well-behaved professionals.

Another factor affecting individual intentions or planned behaviour is the degree to which an individual can carry out the expected behaviour. The intention will be met depending on how much easier or difficult an individual perceives carrying out of the expected behaviour to be.

Morris et al (2012:6) indicate that TPB is best suited to predicting, analysing health behaviours retrospectively and that variance in behaviours of between 20% and 30% were due to interventions and a high proportion of intention. There is a correlation between attitudes towards behaviour and perceived behavioural control components.

Therefore, the TPB is considered to be more useful in identifying cognitive influences on the behaviour that can be targeted for a change than in planning and designing the type of intervention for behaviour change.

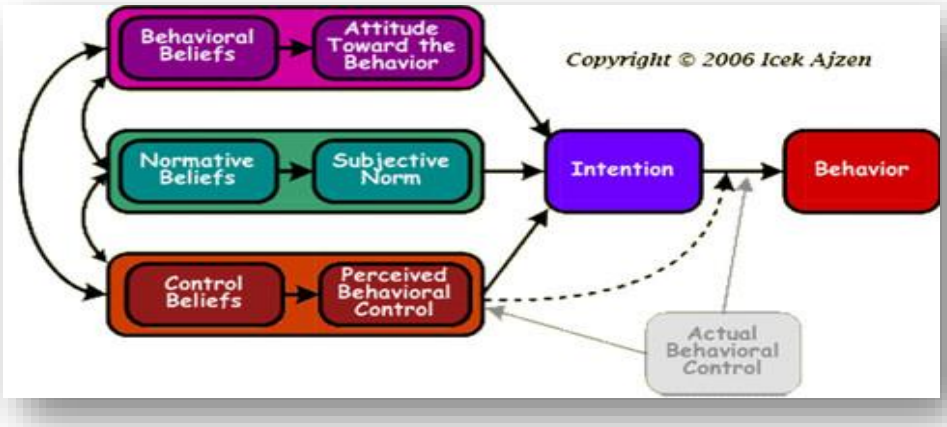

Figure 2.3 Theory of planned behaviour

Source: (Tolma, Reininger, Evans & Ureda 2006:1).

TPB purports that a person's intentions to change their behaviour are an important aspect when behaving either negatively or positively. Negative nurse behaviours are related to how nurses planned to behave in consideration of their attitudes, beliefs and social pressure. If nurses' attitudes and beliefs are targeted at a positive change of being loving, caring and well behaved professionals then it may lead to the expected behaviour. The study however, investigated how easy or difficult for nurses to change their behaviours by incorporating issues related to patients cultural beliefs or practices, management style, working environment, staffing and work schedule.

2.10.2.2 Integrated tools and frameworks of behaviour and behaviour change

This theory is particularly important in assisting non-expert policymakers to understand behaviours and how to engage with them when developing design interventions. The integrated tools and frameworks of behaviour and behaviour change assist supervisors and nurse's managers who may not have the expertise in policymaking to understand how to engage subordinates before interventions are developed. According to Morris et al (2012:17) in 2005, Jackson conducted a study focusing on behaviour changes under the four categories, referred to as the 4E Model: enable; encourage; engage and exemplify (refer to Figure 2.4).

The 4E model further emphasises the need for organisations to catalyse behaviour changes through incentives and leading by example.

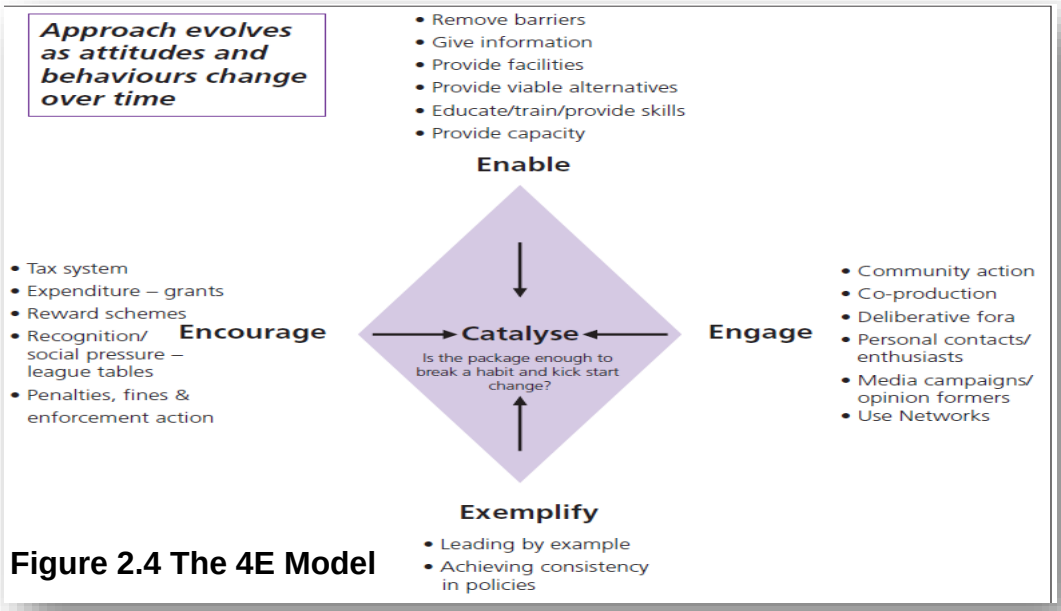

Figure 2.4 The 4E Model

Source: Morris et al (2012:17).

In addressing the first "E" of the 4E organisation enable behaviour changes by removing barriers, providing necessary facilities and capacity to effect the needed change. Secondary, the employees need to be encouraged to perform to their level best by introducing reward and punitive measures to discourage unwanted behaviour changes. Thirdly, an organisation must step up and engage with employees on what it wants to achieve and lastly, the organisation must lead by example and achieve consistence in achieving policies, Negative nurses' behaviour arising as a result of improper policies that guide them at work would be addressed if supervisors and nurse managers were aware of and were to implement the 4E Model of the integrated tools and frameworks of behaviour change.

The study integrated aspects related to leadership and management with specific focus on whether nurse managers give immediate feedbacks and whether nurse managers were viewed as role model in order to determine if the needed behaviour change was promoted at work place. Addressing the 4E would enable organisations to achieve the needed behaviour change,

2.11 MANAGEMENT OF STAFF

Booyens and Bezuidenhout (2014:1) define management as the attainment of organising goals in an effective and efficient manner through planning, organising, leading and controlling organisational resources.

The most difficult, complex and yet an important task of management is the organisation of human resources, in other words, human resource management (Mullins 2013:570).

According to the Mullinss (2013:570), human resource management focuses mainly on the following:

- Staff utilisation and retention
- Education and training on the conduct of nurses

2.11.1 Staff utilisation and retention

It is important that organisations deploy, distribute and utilise staff appropriately. Employees feel respected and valued when deployment and utilisation of staff are done according to staff's area of expertise, hence placing them in the right positions that will promote growth and quality nursing care (MoHSS 2013:52).

Various factors linked to motivation and staff retention in the workplace are discussed below.

2.11.1.1 Working conditions and work environment

According to Amakali (2013:34), working conditions refers to "the interaction of an employee with the physical work environment". Aspects of working conditions include physical aspects, such as tools and equipment, while the physical setting includes the storage space, cleanliness, workspace and noise level and the psychological aspects include work pressure and stress.

Namibia inherited various public health care facilities that were built specifically for blacks by the colonial master before independence. Many of those public health care facilities have poor ventilation and insufficient working space and have received little or no renovation (MoHSS 2014c:30).

The poor working conditions have led to many nurses leaving public health care facilities to work in private health care facilities, further exerting pressure on overburdened staff and developing work-related stress that may lead to negative behaviours in nurses (MoHSS 2014c:60).

2.11.1.2 Remuneration and incentives

Swanepoel, Erasmus and Schenk (2008:475) define remuneration as the financial and non-financial extrinsic rewards provided by the employer for the time, skills and efforts made available by the employee in fulfilling job requirements to achieve organisational goals. The WHO (2014:2) defines incentives as "all rewards and payments that providers face as a consequence of the organisations in which they work, the institutions under which they operate and specific interventions they provide".

Pay, pensions, health insurance, bush allowances, transport and housing allowances are among the financial incentives that an organisation may offer, while flexible working hours, study leave, support for education and training, opportunities for promotion, accommodation, occupational health and counselling are among the non-financial incentives available (Mullins 2013:720). The absence of improved work benefits may lead to reluctance to pay attention to patients' concerns and nurses losing their passion for their work.

In a study conducted by the MoHSS (2014c:14) on factors affecting nurses' motivation, 55% of nurses suggested a review of incentives for staff with special expertise or qualifications and those working at high-risk departments, while others suggested salaries to be linked to performance appraisal. The absence of performance appraisal (PA) discourages hard working nurses from keeping up positive behaviours.

A market related remuneration does not only retain staff but also enables staff members to pursue various courses to enable them to be equipped with the required knowledge and skills so that they effectively mitigate the effects of disease and offer the needed customer care to all clients (Amakali 2013:35). A good salary will motivate nurses to work harder and also take away financial stress.

2.11.2 Training and learning

Employees require on-the-job training in the form of being coached, empowered through project work and delegation. There is also a need for off-the-job-learning that can be given by attending both short and long courses where employees may be equipped with the needed cognitive, psychomotor and affective skills (Mullins 2013:750).

A learning environment is the one where there is mutual respect, trust, support and partnership between nurses and other health care team members. Training enriches the employee's feeling of motivation and develops positive attitudes towards work (Mullins 2013:750). In Namibia, the government continues to capacitate local health training institutions through various international organisations and making funding available for various health-related courses to ensure that staff shortages are addressed (MoHSS 2014b:18). However, attention should also be paid to identifying nurses who require additional training on appropriate behaviours or customer care.

Amakali (2013:72) states that employees who feel pressured by work demands and lack the needed knowledge and skills are at more risk of developing negative attitudes than those with the needed knowledge to manage a specific situation.

2.12 PERFORMANCE MANAGEMENT

Shafudah (2011:9) defines performance management as improving the performance of individuals and the organisation as a whole. It is a shared process between managers, the individual and the teams they supervise to improve the performance of an organisation and the people working within it.

Management is an engaged process of guiding others through a set of derived practices and procedures that are evidence-based and known to satisfy pre-established outcomes based on repeated clinical situations (Yoder-Wise 2014:5).

Performance management has three critical areas over which management has control and can introduce changes to motivate personnel and increase productivity and quality of return. These three areas are discussed below.

2.12.1 Organisation

Management needs to clarify the commitment and role of the employees towards work activities, explain the responsibilities of each employee in the organisation, and set the standards to be followed in order to have high-quality performance and to develop and achieve employees' highest capacity and potential to their own benefit. In addition, the organisation should further create a conducive environment and empower people in a way that they can discover their potential and promote positive change in the organisation (Booyens & Bezuidenhout 2014:276). The organisation's commitment and its value for human resources (nurses) have a positive impact on nurses' behaviours and productivity.

2.12.2 Performance appraisal (PA)

The organisation needs to plan with its employees in setting individual goals, training managers in conducting performance appraisal, coaching, and counselling, explaining to employees the purpose of performance appraisal, implementing and evaluating the performance of employees against the set key performance indicators (KPI).

Performance Appraisal (PA) focuses on linking recognition and incentives, or demoting employees' job descriptions. Implementation of PA may encourage nurses to perform and change their behaviours in order to obtain recognition or a promotion or to receive incentives (The Presidency Republic of South Africa 2009:14). In Namibia a PA system has not yet been implemented.

2.12.3 Reward structures

Organisations have different ways of rewarding their employees by using different reward structures. Those structures may include compensation that may be done according to job evaluation, through merit awards (a once-off payment in recognition of good performance), incentive rewards (based on job performance) and benefit rewards, which include pension, insurance, medical benefits and leave days.

In Namibia, performance management has been under discussion for possible implementation in future (MoHSS 2014c:23).

However, in South Africa there are “challenges to re-orient Performance Management System to focus on outcomes and to align the incentives of individual managers and to fully implement Performance Agreement (PA) for senior management” (The Presidency Republic of South Africa 2009:16).

2.13 LEADERSHIP

Leadership refers to the relationships through which one person influences the behaviour or actions of other people (Yoder-Wise 2014:783).

Leaders are expected to be at an advantage in terms of knowledge, skills, attitudes, and wisdom or any other competencies over their followers. Thus, a leader should display professional conduct that followers need to emulate. This should enable a conducive working environment, where problems are anticipated and necessary interventions taken to prevent problems and promote coping (Muller 2009:153). One important aspect lacking in many public health care facilities in Namibia is leadership skills. About 45% of senior nurses and nurse managers in supervisory positions were promoted mainly on the basis of years of experience rather than on their qualifications and ability to carry out the job (MoHSS 2014b:15).

Some important attributes that a leader must have are the ability to envision, to communicate using appropriate communication processes and strategies, to act as a custodian, to get the desired behaviour through empowerment, and to guide (Muller 2009:153).

According to Bal, Campbell, Steed and Meddings (2009:8), there are various sources of power in an organisation. The source of power used by the nurse’s leaders depend on the situation and the power they possess. The main sources of power are discussed below:

- **Reward power.** The leader’s ability to reward nurses (recognition, pay increase or promotion) based on appropriate behaviour or performance. The MoHSS (2014b:50) recommends that PA be implemented. If nurses who perform well are recognised and rewarded it will positively influence the behaviour of other nurses.

- **Coercive power.** This is the opposite of reward power. The leader has the power to punish, demote, withhold pay increases or terminate if an employee neglects their job or behaves inappropriately. Hospital managers need to recognise and reward hardworking nurses and punish nurses presenting with unprofessional behaviours. Enforcing coercive power can be a measure to ensure that all nurses adhere to the ethical standard of the nursing profession.

- **Expert power.** This type of power is delivered from the knowledge, skills and information an individual possesses. Supervisors and nurse managers need to be knowledgeable on how to assist nurses to maintain positive behaviour, by leading and by being exemplary, in order to be role models for nurses to follow.

- **Legitimate power.** This is based on the position a leader holds in a hierarchy, such as the nurse manager of a in a unity have the overall decision and is accountable for all issues pertaining to that unity. If supervisors and nurse managers are allowed to make independent decisions in situations, they may be able to control situations such as the negative behaviour of subordinates.

- **Referent power.** Based on a person's attractiveness, inspiration, impression and good speaking abilities as a leader (Bal et al 2009:8). A leader who is likable may be able to influence followers to cooperate, obey their instructions and demonstrate appropriate behaviours.

2.13.1 Leadership framework

There are various leadership frameworks that describe the core abilities needed for the leader. These are discussed in the sections below.

2.13.1.1 Intra-personal competencies

Intra-personal competencies refer to the abilities that leaders need to analyse their own worldview, be a role model, be self-confidence, be able to foster trust and credibility, be able to balance work and personal life and be committed, accountable and comply with ethical standards (Muller 2009:154).

Fifteen per cent of cases involving nurses that were reported to the Health Professional Council of Namibia involved professional nurses who were expected to be role models and shift leaders. The lack of intra-personal competencies is related to negative behaviours among nurses as they fail to uphold ethical standards and to be role models (MoHSS 2014b:60).

2.13.1.2 Conceptual competencies

Leaders should be able to envision and analyse issues, and question and debate critically to develop appropriate strategies. The analysis of issues pertaining to nurses' behaviours may assist in developing appropriate strategies and solutions.

2.13.1.3 Participative competencies

Leaders should have political skills to cope with different and conflicting beliefs, attitudes and views. It is further important that a leader has the ability to manage change and empower and influence their followers towards goal achievement. They should also possess appropriate communication skills, create harmony in the unit, motivate, inspire, and foster teamwork and collaboration (Muller 2009:155). The participation of all nurses in decision-making may contribute to behavioural changes as they are part of the decisions that are made.

2.13.1.4 Interpersonal competencies

Interpersonal competencies refer to the ability of the leader to convince and influence, facilitate, mentor and coach and build a trusting relationship (Muller 2009:155). Nurse managers require the ability to promote a trusting relationship between nurses and patients and also to convince and mentor nurses with negative behaviours to change.

2.13.2 Leadership styles

Leaders and managers have a wide range of leadership styles to choose from in order to influence their followers.

While some leadership styles are more suitable than the others, there may be a need for leaders to be flexible, analytical and choose the best leadership style for the situation at hand (Muller 2009:157).

The main leadership styles are discussed in detail below:

2.13.2.1 Autocratic leadership style

In an autocratic leadership style, the leader follows an egoistic approach for self-enrichment, sets objectives alone and puts his/her interest first in terms of what will be achieved by the followers. Such leaders prefer to be in control and may employ reward or punishment as a way of influencing followers. While this style is necessary during crisis situations when the time for consultation is limited, it is not generally preferred in nursing as it does not promote mutual relationships, causes nurses to become less committed to their job and develops work-related stress (Muller 2009:157).

2.13.2.2 Democratic leadership style

Democratic leaders cooperate with their followers and allow high participation from the members in order to serve the interests of the followers. If the members are unhappy with the leader's work they may not re-elect him to serve another term. This leadership style is applicable in nursing when nurse leaders are needed to represent a group of nurses in professional regulatory bodies that oversee and regulate nursing practice (Booyens & Bezuidenhout 2014:291).

It is important that visionary nurses with the necessary leadership skills be elected to represent the interests of others in nurses' trade unions and other nurses' organisations in order to organise, direct, lead and control the behaviour of other nurses (Haskins et al 2014:37).

2.13.2.3 Bureaucratic leadership style

Leaders who practise a bureaucratic leadership style are insecure and find security in following established policies.

They exercise power by commanding followers to follow inflexible rules and avoid making a decision, thus not following the standards as a guide (Booyens & Bezuidenhout 2014:291).

2.13.2.4 Laissez faire/free reign leadership style

A free reign leader is inactive or possesses no leadership skills. As a result, the leader sets almost no limits, is permissive and has no established goals. In addition, such leaders are unable to direct the group towards achieving the goals due to a lack of leadership skills or because he/she believes that followers have the choice and rights on how to achieve the objectives or the leader wants to promote independent decision-making among followers. Leaders who practise this style are often afraid to offend followers (Muller 2009:157).

2.13.2.5 Participative/interactive leadership style

A participative leadership style takes the main variables into consideration, namely, the leader, the follower and the environment. The first approach used in this leadership style is transformational leadership. The focus is to change the views, attitudes, needs and values of the followers by establishing a trusting relationship between the leader and the followers, and by empowering followers to make decisions and take risks in order to promote the ability to effect change and self-confidence (Muller 2009:158).

The second leadership approach is contingency/situational leadership which believes that the effectiveness of the leader to achieve high group performance is based on the degree of the leader's control and influence when a specific situation occurs (Booyens & Bezuidenhout 2014:291).

Whether nurses develop a positive or negative attitude depends a great deal on the type of leadership style a nurse manager is utilising. Although a participative leadership style is recommended in nursing there is no best single leadership style and it is therefore important that nurse managers use a combination of styles or act based on the situation (Booyens & Bezuidenhout 2014:291).

While it is important for nurses to involve patients or the community in decisions regarding patients' treatment and in policy formulation, employers may also need to involve nurses at an operational level in policy formulation and decision-making, especially on behaviour changes, in order for nurses to own the decisions made (Muller 2009:158).

2.14 CONCLUSION

It is important that organisations explore and determine factors that contribute to negative behaviours in staff in order to achieve organisational objectives. In the absence of expected employee work behaviours, organisations will not be able to achieve their objectives.

This chapter discussed issues related to the negative behaviour of nurses in public health care facilities in Namibia, South Africa and the United States of America. The chapter focused on public health care facilities, patient care, the shortage of nurses, negative nurse behaviours, patient outcomes, and ethics related to patient care and disciplinary measures. The chapter further discussed various conceptual frameworks and models focusing on factors affecting motivation and behaviour changes in nurses, human resource management, and performance management of staff members in an organization, management style, and leadership style.

The next chapter, chapter 3, will discuss the research design and methodology.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

An overview of the research design and methodology was provided in chapter 1. This study aimed at exploring and describing the factors contributing to negative nurse behaviour in rendering patient care, as well as to determine its effect on patient outcomes. This chapter elaborates on the research design and methodology. It addresses the following:

- Research designs
- Assumptions
- Methodology
- Research setting
- Population
- Sample and sampling technique
- Development of an instrument
- Pre-testing instrument
- Data collection
- Data analysis
- Ethical considerations.

3.2 RESEARCH DESIGN

The research design is a blueprint for conducting a study that maximises control over factors that could interfere with the study's desired outcomes (Burns & Grove 2011:49).The purpose of the research design is to ensure control over factors that can interfere with the study outcomes (Burns & Grove 2011:49).

In this study, the researcher adopted a non-experimental explorative and descriptive quantitative design to explore other unknown factors contributing to negative nurse's behaviours. The study results were described using descriptive statistics in the form of charts, graph and tables.

3.2.1 Quantitative design

A quantitative research design was defined as a formal, objective, systematic process in which numerical data are used to obtain information about the research (Jooste 2016:297).

A quantitative study was used for this study in order obtain statistical numbers of the respondent's point of views on issues related to factors contributing to negative nurses behaviours. The results of the study were then quantified statistically and interpreted.

3.2.2 Explorative design

An explorative research design is conducted to gain understanding of a situation, phenomenon, community or individual (De Vos et al 2011:95). The researcher's interest in answering "what" questions on the factors contributing to negative nurse behaviours led the researcher to use an explorative research design for this study. Furthermore, an explorative research design was selected because there was insufficient evidence with regard to factors contributing to negative nurse behaviours in public health care facilities in Namibia. The researcher explored other unknown factors contributing to nurses' negative behaviour in public health care facilities particularly at a specific public health care facility.

3.2.3 Descriptive design

A descriptive design involves the exploration and description of a phenomenon in real life situation (Burns & Grove 2011:34). After the results of the study were obtained, they were then grouped and then described into meaningful statements. The variables relating to the study included opinions, attitudes, needs and facts in a descriptive form to provide a complete picture of factors contributing to negative nurse behaviours.

3.3 ASSUMPTIONS

Brink et al (2012:27) define assumptions as basic principles that are accepted on faith, taken for granted, or assumed to be true without proof or verification. Assumptions determine the nature of the study, the design and the interpretation of the results.

The researcher had noted an increase in negative nurses' behaviours at the specific health care facility in which this study was conducted. The researcher subsequently assumed that beside a shortage of nurses, there might be other factors contributing to negative nurse behaviours in rendering patient care in this facility. The analysis of the results will confirm or refute the researcher's assumption.

3.4 RESEARCH METHODOLOGY

Brink et al (2012:24) define research methodology as a particular way of knowing about reality.

Mateus (2007:22) states that data collection methods include questionnaires, tests, observations and interviews. In this study, the researcher used questionnaires to collect data related to negative nurse's behaviours.

3.4.1 Research setting

The research setting is the location in which a study is conducted (Burns & Grove 2011:40). This study was conducted at a specific health care facility, located in the Kavango west region of Namibia. The region has one referral hospital, two district hospitals, and 32 clinics, which serve a total population of 115 447 inhabitants. The specific health care facility has a bed capacity of 300.

3.4.2 Population

According to Brink et al (2012:131), a population is the entire group of persons or objects that are of interest to the researcher. The study consisted of two categories of nurses, that is, registered nurses and enrolled nurses.

The registered nurses and the enrolled nurses were chosen because they are the only categories of nurse at the specific health care facility rendering direct nursing care to the patients on a daily basis. The target population consisted of 200 nurses.

3.4.3 Sample and sampling technique

Sampling is defined as the process of selecting a group of people, events, behaviour, or other elements with which to conduct a study (Burns & Grove 2011:51). Sampling refers to the process the researcher uses to select the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink et al 2012:132).

In this study, the researcher used a stratified random sampling technique to draw a study population from two different segments or categories of nurses according to the number of persons in that stratum (Burns & Grove 2011:301). The strata were different categories of nurses (registered nurses and enrolled nurses) in a specific health care facility. From each strata a researcher determined the number of respondents to be selected and then draw the sample using simple random sampling to ensure that all respondents had equal chance to be selected for the study.

According to the guidelines for sampling, a study with a population of 200 required 32% (64 respondents) to be drawn from it (De Vos et al 2011:249). A sample frame consisting of 77 registered nurses and 123 enrolled nurses led to a total of 200 nurses. From each category, 32%, as reflected in the sampling frame, was selected using a simple random technique. Thirty-two per cent of the 77 registered nurses in the sampling frame represented 25 registered nurses, while 32% of the 123 enrolled nurses in the sampling frame represented 39 enrolled nurses, as the respondents for this study. Thus, the sample for this study was 64 nurses in total being, 25 registered nurses and 39 enrolled nurses.

3.4.3.1 Inclusion criteria

The inclusion criteria were enrolled and registered nurses working in a public health care facility in Namibia. The only categories of nurses at the specific public health care facility where this study was conducted.

3.4.3.2 Exclusion criteria

The study excluded all registered and enrolled nurses who were part of the pilot study as previous exposure would contribute to hawthorn effect.

3.5 Development of data collection instrument

Data collection is the process of acquiring the subjects and collecting the data for the study (Burns & Grove. 2011:361). Data collection may include the use of a variety of methods including the questionnaire, tests, observations and interviews. The researcher used a self-developed questionnaire to collect information from the respondents (refer to Annexure 2). A questionnaire is referred to as a printed self-report form designed to elicit information through the written or verbal responses of the subject (Burns & Grove 2011:353).

Jooste (2016:305) point out the following advantages of a questionnaire:

- It is quicker in collecting data from a large group of people.
- It is less expensive and can collect data in a short period of time.
- It offers a standard format of questions and does not depend on the mood of the interviewer.
- It offers respondents a great sense of anonymity and respondents are more likely to give honest answers.

At the same time Polit & Beck (2016:305) point out the disadvantages of a questionnaire as follows:

- Participants need to be literate in order to read and give their answers in writing.
- Mailing of questionnaires can be costly.
- If the questionnaires are mailed to respondents there is no opportunity to clarify questions.
- Respondents leave some questions unanswered.

In addition, questionnaires were used because they promote quick responses and ensure anonymity because each questionnaire was identified with a unique code instead of respondents' names. They also addressed the objectives of this study.

The researcher used similar questionnaires for both registered nurses and enrolled nurses. The questionnaires were formulated in English and consisted of six sections with a total of thirteen closed-ended questions and ten (10) open-ended questions (refer to Annexure 2). The closed-ended questions consisted of questions to elicit biographical information, and Likert scale and yes or no questions. The aspects addressed in the open-ended questions were also addressed in Likert scale and yes or no questions in closed-ended format. The entire questionnaire took about 20 to 30 minutes to complete. The following six sections were included in the questionnaire:

- *Section A: Biographical information*

Section A included items covering the professional rank/job category, age, highest qualifications and the experiences of registered nurses and enrolled nurses. This section consisted of five close-ended questions.

- *Section B: Staffing and work schedules*

Section B covered all items related to recruitment and nurse - patient ratio. This section consisted of one Likert-type scale question and two open-ended questions.

- *Section C: Remuneration, reward, benefits and recognition*

Section C covered items related to salaries, rewards, incentives, and recognition in the nursing profession. This section consisted of two Likert-type scale questions and two open-ended questions.

- *Section D: Leadership and management styles*

Section D covered all items related to continuous professional development. This section consisted of one Likert-type scale question and two open-ended questions.

- *Section E: Working environment*

Section E covered all items related to the working environment. This section consisted of one Likert-type scale question and two open-ended questions.

- *Section F: Patients behaviours and cultural beliefs*

Section F covered all items related to patient behaviours and cultural beliefs. This section consisted of one Likert-type scale question, two yes or no questions and two open-ended questions.

3.5.1 Pre-testing of an instrument

A pilot study is a practice run that is undertaken in order to identify any problems with the data collection methods and the data collection instruments (Jooste 2016:300). Polit & Beck (2012:296) defined pre-testing as a way of refining and evaluating the data collection instrument. To maintain validity and reliability the data collection instrument was sent to the researcher's supervisor and statistician who approved it for content validity. Furthermore, pre-testing of the data collection instrument was necessary to ensure its modification with regard to its structure and even the correction of grammatical errors.

Prior to data collection the researcher determined the number of respondents for the study and from each strata as per the sampling guidelines described under sample and sampling techniques. The researcher further divided the categories into strata being the registered nurses and enrolled nurses, of which from each strata simple random sampling was used to select respondents. As the characteristics of the respondents were known appointments for pre-testing of an instrument were made by the researcher at the gate of the specific public health care facility with the targeted respondents. This was done when the targeted respondents were knocking off from work. The purpose of the study and for pre-testing of an instrument was explained to them. Furthermore, the procedure for pre-testing was explained. They were requested not to participate to the main study. They agreed to the request. This was done because their exposure to the questionnaire might contribute to the Hawthorn effect (bias).

The 27th April to the 28th April 2017, were the dates finally agreed upon for pre-testing. This final date agreement was done at the gate of the targeted health care facility. The researcher explained again the purpose of the study as an emphasis and a reminder to those respondents' who might have forgotten about the study.

Verbal consent was obtained after an explanation was given to them by the researcher that, taking part in the study was voluntary and they can withdraw from the study at any time without any penalty should they wish to.

The researcher was available for the entire period of pre-testing in order to clarify questions that were not well understood. The questionnaires were pre-tested on fifteen (15) nurses being, seven (7) registered nurses and eight (8) enrolled nurses. The questionnaires were first completed by the respondents at the gate of the specific health care facility on the 27th Aril 2017 and other respondents completed them at their respective homes on the 28th April 2017. Completion of the questionnaire took between 20 to 30 minutes.

Privacy was maintained at the venues where the questionnaires were pre-tested. Those respondents who completed the questionnaires at the gate of the specific health care facility, were allocated a room by the researcher after verbal permission was granted to do room allocation by the medical superintendent. Those who completed the questionnaires at their homes did that in their self-allocated separate rooms.

The questionnaires were collected personally by the researcher. All questionnaires were identified with a unique code instead of a name to maintain confidentiality and anonymity. Finally, questionnaires were secured in a lockable cabinet which was accessible to the researcher only.

Subsequently, amendments were made to ambiguous and unclear questions in items 10.4 and 19.1, where some complex words used in phrasing the questions were replaced with simpler ones. The corrections made to the questionnaire were incorporated in the final version used for the main study.

3.6 DATA COLLECTION

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of the study (Burns & Grove 2011:52). The data for this study was collected using structured self-developed questionnaires structured that were administered to the selected respondents to complete on appointment dates.

Data collection was done after receiving ethical approval from the Research and Ethics Committee of the Department of Health Studies at the University of South Africa (Unisa) (refer to Annexure 1). Permission to conduct the study was also granted by the Permanent Secretary of the Ministry of Health and Social Services in Windhoek (refer to Annexure 3) and the medical superintendent of the specific hospital (refer to Annexure 4).

In order to build rapport with the respondents, the researcher identified himself and clarified his intentions when meeting them at the gate of the specific health care facility. The purpose of the study and its significance were explained to them. Appointments for data collection were done after pre-testing the data collection instrument. These appointments were made when the respondents were knocking off from work at the gate of the health care facility. Appointments made were for a period of three weeks being from the 15th May 2017 to the 2nd June 2017. Data was collected at two points as per the respondent's preferences, at the gate of the health care facility and at the respondent's homes. Appointment with the respondents at the health care facility was done during the first two weeks while the third week was used to collect data at the respondents' home. The respondents were informed that the questionnaire would take 20 to 30 minutes to complete.

Sixty-four (64) respondents agreed to the appointments for the distribution and completion of the questionnaires. The respondents who agreed to participate in the study were requested to sign an informed consent form (refer to Annexure 5) and were further informed of their rights to withdraw from the study at any time without penalty if they wish to do so. The researcher was personally present during data collection in order to give guidance to the respondents on how to complete the questionnaires and for any possible clarification. There was no need for an interpreter as the respondents were conversant with the English language which was the language used in the questionnaires.

In order to maintain privacy and confidentiality, the respondents either completed the questionnaire at the gate of the specific health care facility where a room was allocated by the researcher after verbal permission was granted by the medical superintendent or at their homes where they allocated rooms for themselves.

A total of 64 questionnaires were distributed to the respondents for completion and were collected after two days. The questionnaires distributed on the 15th May 2017 were expected to be returned on the 18th May 2017. The time set for completing the questionnaires was 20 to 30 minutes.

All the questionnaires distributed were completed and returned to the researcher. Twenty-five (25) questionnaires were completed by the registered nurses while 39 were completed by the enrolled nurses, thus a total of 64 completed questionnaires were returned. However, some of the respondents could not keep to the two days given for completion and returned the questionnaire four days later.

Respondents who were slow in completing and returning the questionnaires indicated that they had busy schedules at work.

All questionnaires were identified with a unique code instead of the respondent's name to maintain confidentiality and anonymity. They were stored in a lockable cabinet which was accessible to the researcher only for data analysis purposes.

3.7 DATA ANALYSIS

Data analysis is regarded as the techniques used by researchers to convert data to numerical form and subject it to statistical analysis (De Vos et al 2011:114). It is aimed at reducing, organising and giving meaning to the collected data (Burns & Grove 2011:52).

The results of the study were analysed using SPSS version 23.0 under the supervision of a statistician. The results were converted by means of descriptive statistics into frequency tables and measures of central tendencies such as the mean, mode, median, variance and were ranged in accordance with the objectives and research questions. The results were finally converted into numbers and percentages.

3.8 VALIDITY AND RELIABILITY

3.8.1 Validity

Burns and Grove (2011:334) define validity as a determination of how well the instrument reflects the abstract concepts being examined. Validity seeks to ascertain whether an instrument accurately measures what it is supposed to measure, given the context in which it is applied (Brink et al 2012:165). The data collection instrument was presented to the statistician who approved it for the study on factors contributing to nurses' negative behaviours after examining its internal validity and external validity discussed below.

3.8.1.1 Internal validity

Internal validity refers to the degree to which changes in the dependent variable are indeed due to the independent variable rather than to something else (De Vos et al 2011:153). Polit & Beck (2012:236) defined internal validity as the validity of inferences that, given that an empirical relationship exists, it is the independent variable, rather than something else that caused the outcome.

The data collection instrument that gathered information with regard to factors contributing to negative nurse behaviours in a public health care facility in a specific region of Namibia incorporated both face and content validity, thus ensuring a true reflection of reality. In addition, respondents received a similar questionnaire to ensure that every respondent answered the same questions.

3.8.1.1.1 Face validity

Face validity refers to whether the instrument looks like it is measuring the targeted construct Polit & Beck (2012:336). Brink et al (2012:160) Defined face validity as the effectiveness of the data collection instrument in measuring what it supposed to measure. Face validity was ensured by submitting a questionnaire that was developed after the review of literature and further approved by the statistician. The data collection instrument was found fit to measure factors contributing to negative nurses' behaviours.

3.8.1.1.2 Content validity

Content validity refers to how well the instrument represents all the components of variable to be measured (Brink et al 2012:160). Polit & Beck (2012:336) defined content validity as the degree to which an instrument has an appropriate sample of items for the construct being measured and adequately covers the construct domain.

In this study, content validity was ensured by the researcher developing a data collection instrument with the involvement of the supervisor but with the final approval from the statistician.

3.8.1.2 External validity

External validity refers to the degree or the extent to which results can be generalised to the whole population (De Vos et al 2011:153). Polit & Beck defined (2012:237) concern whether inferences about observed relationship will hold over variations in persons, setting, time or measures of the outcome.

The results of the study were generalised to all nurses working in the specific public health care facility in which the study was conducted. To ensure the generalisability of the results of the study, all respondents were selected using stratified random sampling in each of the categories of nurses in order to ensure that all respondents have equal chance to be sampled.

3.8.2 Reliability

Brink et al (2012:126) define reliability as the degree to which the instrument can be depended upon to yield consistent results if used repeatedly over time. To ensure the reliability of the data collection instrument, the researcher conducted a pilot study on 15 nurses (8 enrolled nurses and 7 registered nurses) to ensure consistent results. In this process, the accuracy and consistency of the data collection instrument was measured by having each nurse complete the questionnaire. After pre-testing the data collection instrument, ambiguous and unclear questions were changed so that misinterpretations by the respondents were avoided in the major study.

The supervisor and the statistician also looked at the questionnaire regarding its stability, internal consistency, and equivalence before the study was conducted.

3.9 ETHICAL CONSIDERATIONS

Ethical considerations imply preferences that influence behaviour in human relations, conforming to a code of principles, rules of conduct, the responsibility of the researcher and the standards of conduct of a given profession (De Vos et al 2011:114).

3.9.1 Permission to conduct the study

The study was approved by the Research and Ethics Committee of the Department of Health studies at the University of South Africa (Unisa) (refer to Annexure 1). Permission to conduct the study was also obtained from the Permanent Secretary of the Ministry of Health and Social Services in Windhoek (refer to Annexure 3) and from the medical superintendent of the specific public health care facility (refer to Annexure 4).

3.9.2 Avoidance of harm

The researcher was responsible for weighing the risk involved and protecting respondents from any harm. The study did not expose the respondents to any form of harm and allowed respondents to withdraw from the study at any time they wished.

3.9.3 Informed consent

Burns and Grove (2011:122) indicate that informed consent includes four elements: disclosure of essential study information to subjects; comprehension of the information by subjects; the competence of the subjects to give consent; and voluntary consent of the subjects to participate in the study. Consent was obtained from the respondents who were deemed psychologically and legally fit. After explaining the study, the researcher obtained written consent from the respondents (refer to Annexure 5). The respondents were assured that taking part in the study was a voluntary decision and they could withdraw from the study at any time without penalty.

3.9.4 Deception of the respondents

Deliberately misinforming respondents for research purposes was not done. The researcher did not withhold any information in order to create a false impression and to influence respondents to take part in the study.

3.9.5 Right to privacy

The privacy of respondents was respected by avoiding the use of hidden cameras, videos and microphones during the study. The researcher allocated a room to the respondents at the gate of the specific health care facility during the appointments and the completion of questionnaires in order to maintain privacy. Some respondents took the questionnaire home to complete.

Respondents were informed that their private information would be shared with the supervisor, UNISA, the Permanent Secretary of Health and Social Services and the medical superintendent of the specific public health care facility.

3.9.6 Anonymity

Anonymity was enhanced by identifying the questionnaires with unique codes instead of the respondents' names.

3.9.7 Confidentiality

The researcher ensured confidentiality by sharing the information obtained from the respondents only with the supervisor, UNISA, the medical superintendent and the Permanent Secretary of the MoHSS, Namibia. The hard copies of information from the respondents were stored in a lockable cabinet. All the questionnaires were given unique codes in order to keep the respondents' information confidential.

3.9.8 Compensation

The study offered neither financial nor material benefits to the respondents who took part in the study. An explanation of the study was given to the respondents before it was conducted while emphasising the need for honest responses that could contribute to improved quality patient care.

3.9.9 Scientific honesty

The researcher maintained the scientific honesty by ensuring that referencing was done according to the Harvard referencing style and listing all relevant literature which was consulted.

3.10 CONCLUSION

This chapter discussed the research design and methodology, including the population, principal assumptions of the study, population, sampling technique, pre-testing of the instrument, the data collection instrument, analysis of the data, permission to conduct the study and ethical considerations. Chapter 5 to follow will discuss the data analysis, presentation and description of the research results.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH RESULTS

4.1 INTRODUCTION

Chapter 3 addressed the research design and methodology of the study. This chapter discusses the data analysis and presents the results based on the study objectives. The specific objectives of this study were to

- explore and describe the factors that contribute to nurses' negative behaviours when rendering patient care
- explore and describe the effects of nurses' behaviours on patient outcomes.

4.2 DATA MANAGEMENT AND ANALYSIS

With the assistance of a statistician, data were analysed using the SPSS version 23.0 computer program. The results were summarised and presented by using pie charts, bar charts and tables. The cumulative percentages indicated in the tables and figures added up to 100%. Therefore, only percentages are indicated on the pie chart and bar charts, whereas the tables contain both frequencies and percentages. Open-ended questions were grouped together in each section and the most common answers were further grouped and analysed. Quotes were then used for some common answers, in order to substantiate responses to the open-ended questions.

In cases where respondents did not answer all the questions, the frequencies in the tables and figures were less than the total number of respondents. The numbers of respondents are indicated in the heading by an "*n*" value in table and figures. On staffing and work schedule (n = 64 an asterisk (*) at the bottom of table 4.5 indicates the missing values. The extent of the analysis performed on the data was further guided by the research questions that were addressed.

4.3 RESEARCH RESULTS

The results of the study were presented based on the five predetermined themes:

- Biographic information
- Staffing and work schedule
- Remuneration, reward, benefits and recognition
- Leadership and management styles
- Working environment
- Patient behaviours and cultural beliefs

4.3.1 Sample characteristics

A total of 64 questionnaires were distributed and collected from 15 May 2017 to 9 June 2017 by the researcher. All the questionnaires distributed were returned and a 100% response rate was recorded. The number of questionnaires distributed, returned and the response rate is indicated in table 4.1.

Table 4.1 Number of questionnaires distributed and returned (N = 64)

QUESTIONNAIRES	**NUMBER DISTRIBUTED**		**NUMBER RETURNED**	
	N	Response rate (%)	N	Response rate (%)
Registered nurses (R/N)	25	39	25	39
Enrolled nurses (E/N)	39	61	39	61
Total	**64**	**100**	**64**	**100**

4.4 SECTION A: BIOGRAPHIC INFORMATION

Section A of the questionnaire focused on the job categories, gender, age and highest qualifications obtained.

4.4.1 Job categories (N = 64)

The respondents at the specific health care facility who took part in the study fell into two categories of nurse (registered nurses and enrolled nurses) (refer to Figure 4.1).

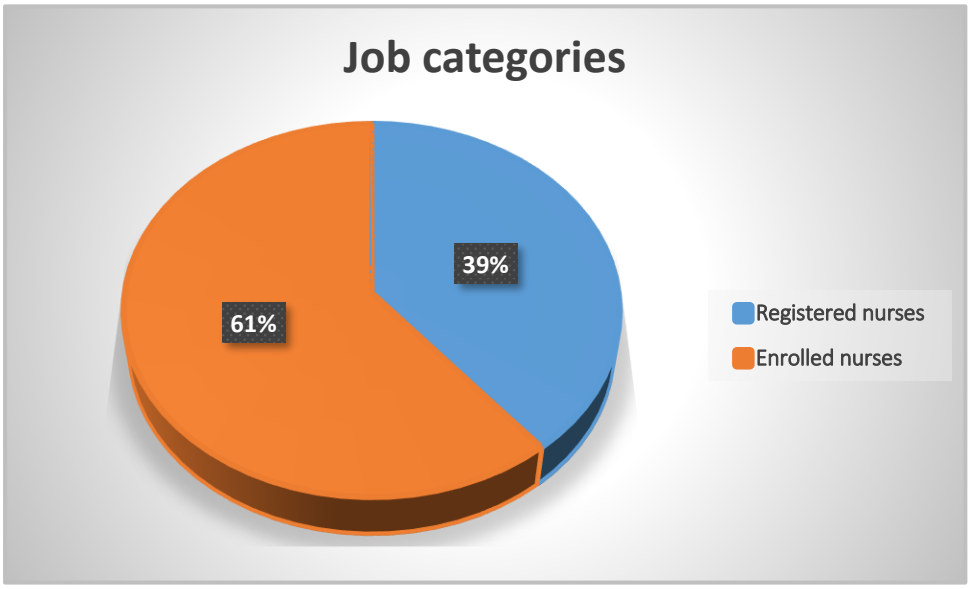

Figure 4.1: Job categories (N = 64)

The majority of the respondents 61% (n = 39) were enrolled nurses, while registered nurses represented 39% (n = 25). The two categories of nurses were in line with the sample of the study.

4.4.2 Gender (N = 64)

Respondents were requested to choose from two options (male and female) to indicate their gender (refer to Figure 4.2).

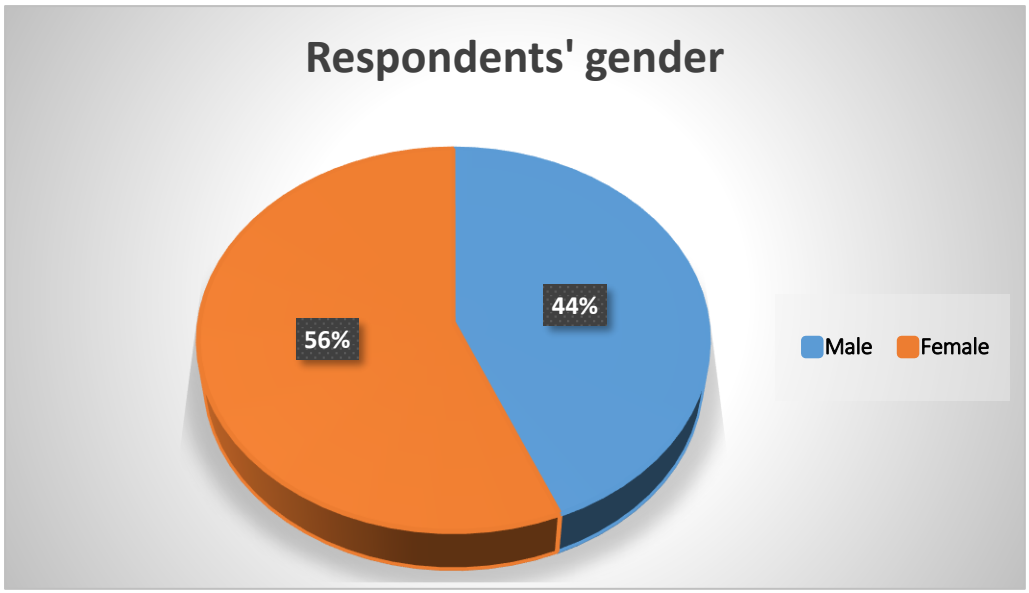

Figure 4.2: Gender (N = 64)

It was clear that the female nurses dominated the number of males who took part in this study. Of the respondents, the majority were female 56% (n = 36), while males were in the minority with 44% (n = 28). Figure 4.2 is not really a representative of the larger nursing population in Namibia, whereby a contrast 97% of nurses are females. This was confirmed by the literature on analytical summary-health workforce in Namibia indicated that 97% of the nursing workforce in Namibia is made up of females (WHO 2014:56).

4.4.3 Age of the respondents (N = 64)

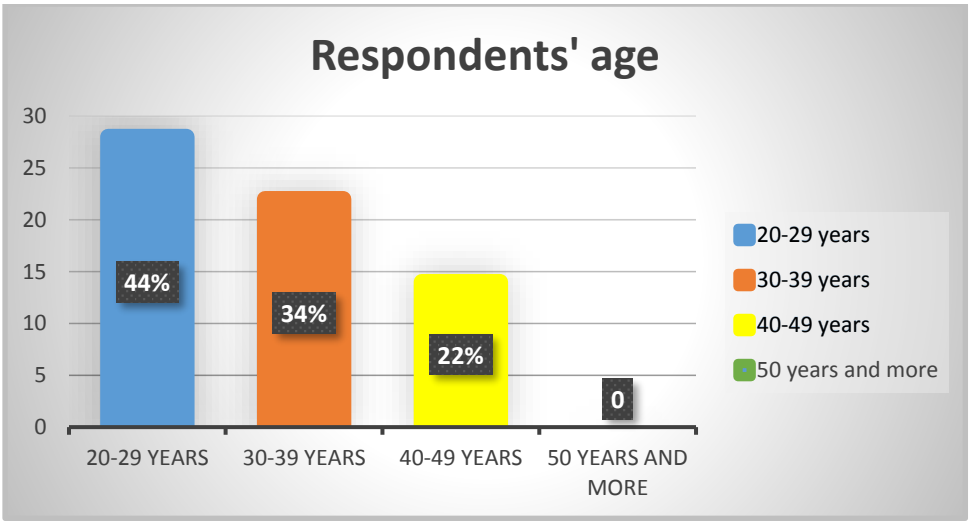

Figure 4.3: Age of respondents (N = 64)

The age distribution indicates that the majority 44% (n = 28) of the respondents were between the ages of 20 and 29 years, 34% (n = 22) were between 30 and 39 years, while 22% (n = 14) were between 40 and 49 years. Figure 4.3 reveals that more than three-quarters 78% (n = 64) of the respondents working at the specific health care facility were younger nurses (from 20–39 years) as compared to the age group 40 to 50 years which comprised only 22% (n = 64) of the sample. This could imply that experienced nurses are leaving the service thus leading to a shortage of staff and the experience of burnout by the remaining staff.

Further, the literature reviewed indicated that some of the factors that made it difficult to for the nurses to advocate for the patients were age, gender and conflict regarding professional role Smith & Mee (2017:15).

4.4.4 Qualifications (N = 64)

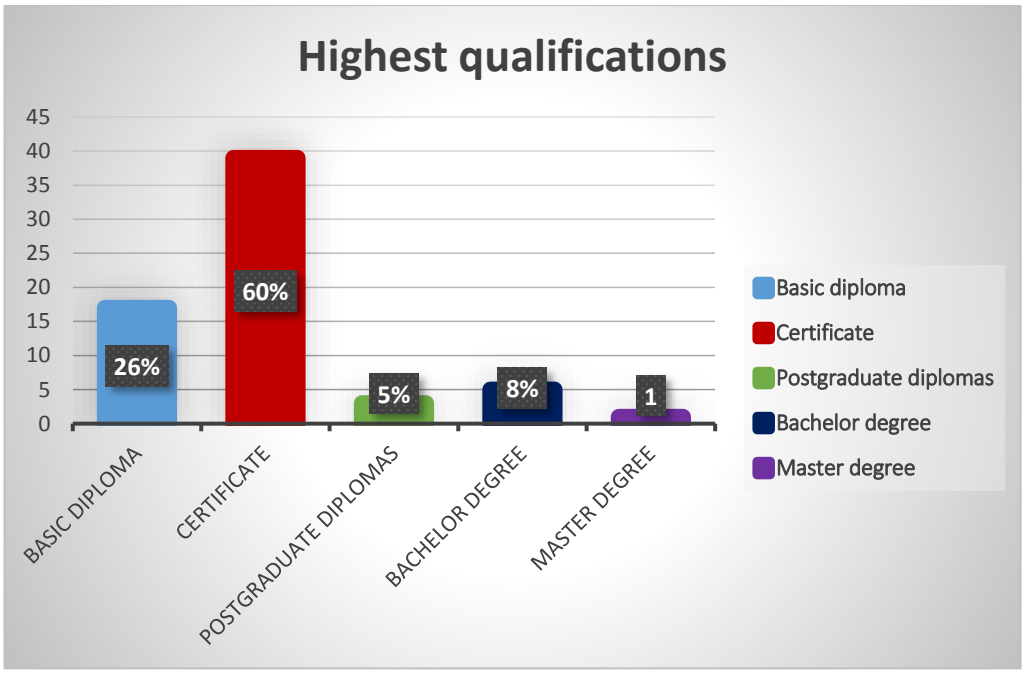

Figure 4.4: Qualifications (N = 64)

In order to determine the skill base of the respondents, they were requested to indicate the highest academic qualification obtained. The results relating to this question are indicated in figure 4.4. Accordingly, more than half 60% (n = 39) of the respondents were enrolled nurses with a two-year certificate, while less than 26% (n = 17) of the respondents were registered nurses with a basic diploma.

In addition, 5% (n = 3) had a postgraduate diploma, 8% (n = 5) had a bachelor's degree and less than 2% had a master's degree. As figure 4.4 shows, the vast majority of nurses at the specific health care facility have basic qualifications (certificates, diplomas and degrees) as compared to one with a postgraduate qualification, for example a postgraduate diploma and master's degree. The low number of holders of a degree or a postgraduate qualification could be associated with the lack of motivation and recognition at work place. This can contribute to the shortage of nurses as those with postgraduate qualifications would leave for better paying jobs, thus contributing to work related stress and burn outs (Amakali 2013:61).

4.4.5 Years of experience (N = 64)

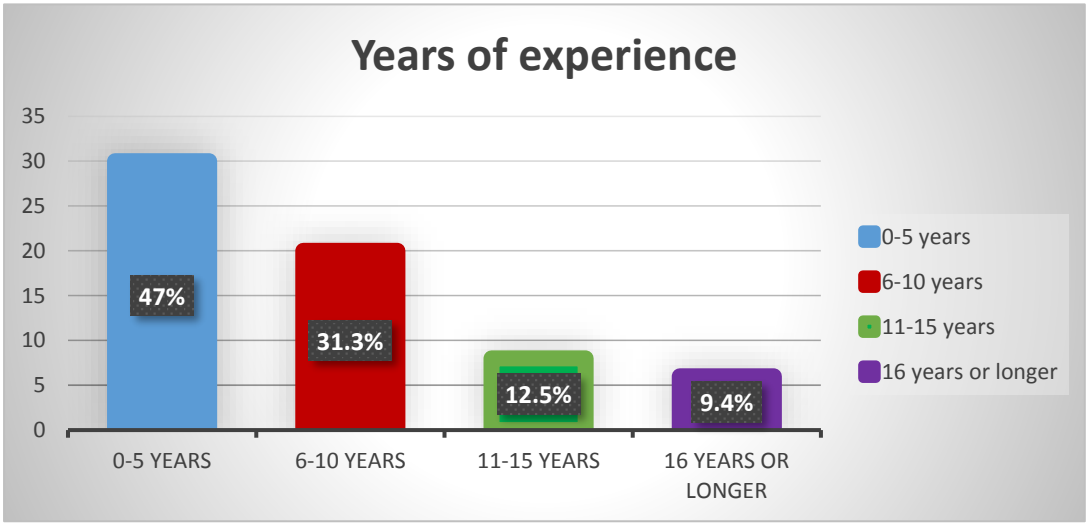

Figure 4.5: Years of experience (N = 64)

Of the 64 respondents, close to half 47% (n = 30) had worked in the profession for less than five years; 31.3% (n = 20) had worked between six and ten years; 12.5% (n = 8) had worked between 11 and 15 years, while those who worked for more than 16 years amounted to 9.4% (n = 6). Figure 4.5 clearly indicates that about 78% (n = 64) had worked in the nursing profession for a period of five to ten years, which is a good sign that young people are choosing nursing as a career. The number of years spent in an organisation can be used to estimate the general staff turnover, as frustrations and work-related stress may be linked to resignation, while motivation and a pleasant working climate are linked to the retention of staff (Booyens & Bezuidenhout 2014:319).

4.5 SECTION B: STAFFING AND WORK SCHEDULE

In this section of the questionnaire, the focus was mainly on aspects related to the staffing and work schedule, for example staff allocation, appropriate skills of staff members and existing work schedules that may affects the behaviour of nurses (refer to Table 4.2).

Table 4.2: Staffing and work schedule (N = 64)

STAFFING AND WORK SCHEDULE	**RATING ON A SCALE OF 1 TO 5**						**Total**
		Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**	
Staff allocation is enough for the unit workload**.**	n	35	13	5	6	5	64
	%	54.7	20.3	7.8	9.4	7.8	100
Your department is staffed with nurses with appropriate skills.	n	3	4	8	28	21	64
	%	4.7	6.3	12.5	43.8	32.8	100
Flexible work schedules exist in your unit**.**	n	4	5	5	33	17	64
	%	6.3	7.8	7.8	51.6	26.6	100
Staff inputs on staffing are considered by management**.**	n	11	28	8	10	7	64
	%	17.2	43.8	12.5	15.6	10.9	100

The respondents were requested to indicate their opinions on aspects related to staffing and work schedule (refer to Table 4.2). More than half of the respondents strongly disagreed that staff allocation is sufficient to meet the unit workload 54.7% (n =35), whereas 20.3% (n = 13) disagreed.

With regard to staff inputs, 43.8% (n = 28) disagreed with the statement that staff inputs on staffing were considered by management, while 17.2% (n = 11) strongly disagreed.

Moreover, close to half of the respondents 43.8% (n = 28) agreed that their departments are staffed with nurses with appropriate skills, with an additional 32.8% (n = 21) strongly agreeing. In response to whether a flexible work schedule exists in the unit, more than half 51.6% (n = 33) of the respondents and an additional 26.6% (n = 17) strongly agreed. The consulted literature revealed that one of the management function is to ensure coordination of activities that promote and enhance group participation in the running of the organisation (Jooste 2017:34).

The above responses were substantiated by the responses to the open-ended questions that were grouped and then analysed. The common answers were *"Nurse-patient ratio is not implemented"* which supported by about 50% (N=32) who suggested patient ration to be implemented while the majority, 40.6% (N=26) of the respondents felt that *"The departments have no enough manpower which in return leave more work for nurses on duty".*

The responses displayed in table 4.2 were confirmed by the literature, which states that the shortage of nurses and poor working conditions have led to many nurses leaving public health care facilities, further exerting pressure on the remaining overburdened staff and leading to the development of work-related stress and frustration (MoHSS 2014c:60). Some of the common suggestions by the respondents included proper planning of human resource development and the need to hire more staff members in order to minimise work related stress caused by work overload. This was confirmed by the literature which indicates that staff norms need to be in place in order to determine the workload and the number of staff to be allocated to each health care facility (Amakali 2013:57).

The results suggest that respondents were not happy with the allocation of staff members to the unit or the fact that the management of the specific health care facility did not consider staff input on staffing which was understood to contribute to staff shortage and consequently lead to work related stress.

4.6 SECTION C: ASPECTS RELATED TO REMUNERATION, REWARDS, BENEFITS AND RECOGNITION

Section C explored the respondent's views regarding remuneration, rewards, benefits and recognition. Respondents were asked to answer closed-ended questions on a five-point Likert-type scale (refer to Table 4.3). Responses to open-ended questions are also provided here to clarify the results. Suggestions made by the respondents are also included.

Table 4.3: Aspects related to remuneration, reward, benefits and recognition (N = 64)

ASPECTS RELATED TO REMUNERATION, REWARD, BENEFITS AND RECOGNITION	**RATING ON A SCALE OF 1 TO 5**						**Total**
		Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly Agree**	
Your remuneration is market related.	n	19	21	10	9	5	64
	%	29.7	32.8	15.6	14.1	7.8	100
Remuneration is based on years of experience and responsibility	n	23	27	0	9	5	64
	%	35.9	42.2	0	14.1	7.8	100
The organisation recognises hard working nurses/best performers with awards.	n	32	28	0	3	1	64
	%	50	43.8	0	4.7	1.6	100
There are opportunities available for professional growth.	n	20	17	9	10	8	64
	%	31.3	26.6	14.1	15.6	12.5	100

ASPECTS RELATED TO REMUNERATION, REWARD, BENEFITS AND RECOGNITION	RATING ON A SCALE OF 1 TO 5						Total
		Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	
Incentives for retaining staff are available.	n	24	20	9	7	4	64
	%	37.5	31.3	14.1	10.9	6.3	100
You are motivated to work hard by your current salary, benefits, reward and recognition.	n	27	19	8	6	4	64
	%	42.2	29.7	12.5	9.4	6.3	100
Performance appraisal is available and is implemented.	n	22	30	4	5	3	64
	%	34.4	46.9	6.3	7.8	4.7	100
The reasons for performance appraisal are known by the staff.	n	23	15	12	8	6	64
	%	35.9	23.4	18.8	12.5	9.4	100
Opportunity to attend workshops and relevant courses exist.	n	3	3	4	30	24	64
	%	4.7	4.7	6.4	46.8	37.5	100
Identified nurses with negative behaviours are supported and retrained.	n	31	24	5	3	1	64
	%	48.4	37.5	7.8	4.7	1.6	100
In-service training provides the needed support.	n	2	5	5	24	28	64
	%	3.1	7.8	7.8	37.5	43.8	100
You are given prompt acknowledgement and recognition for job well done.	n	20	28	6	5	5	64
	%	31.3	43.8	9.4	7.8	7.8	100

Table 4.3 contains the responses regarding aspects related to remuneration, reward, benefits and recognition that may have an influence on nurses' behaviours. In response to the question of whether remuneration is market related, the majority of the respondents 32.8% (n = 21) disagreed, while an additional 29.7% (n = 19) strongly disagreed that remuneration is market related. In response to whether remuneration is based on the years of experience and responsibility, 42.2% (n = 27) disagreed and 35.9% (n = 23) strongly disagreed. With regard to awards, half 50% (n = 32) of the respondents strongly disagreed while about 43.8% (n = 28) disagreed that the organisation recognises hard working nurses or best performers with awards.

In addition, about 31.3% (n = 20) of the respondents strongly disagreed that there are available opportunities for professional growth, while another 26.6% (n = 17) disagreed. Furthermore, 37.5% (n = 24) of the respondents strongly disagreed that incentives for retaining staff are available with 31.3% (n = 20) disagreeing.

It is important to note that the majority 48.4% (n = 31) of the respondents strongly disagreed that nurses who are identified as having negative behaviours are supported and retrained, while 37.5% (n = 24) disagreed with the statement. This implies that nurses with negative behaviours are not identified and thus not be given the opportunity to attend relevant courses or to be retrained and this may continue to affect the delivery of quality nursing care. The literature reviewed has indicated that Health Professional Council regulated the practice of nurses in many countries and is responsible for the registration of nurses on their roll. Complaints against nurses must be forwarded to the health professional council to conduct investigate and if possible take disciplinary actions (Searle, Human & Mogotlane 2013:236).

It was evident that respondents are not aware of the availability or the implementation of performance appraisal, as 34.4% (n = 22) strongly disagreed and 46.9% (n = 30) disagreed that performance appraisal is available and has been implemented. With regard to the reasons for performing performance appraisal, about 35.9% (n = 23) of the respondents strong disagreed and 23.4% (n = 15) disagreed that they knew the reasons for performance appraisal. However, 18.8% (n = 12) were uncertain whether the reasons for performance appraisal are known by the staff members.

This was confirmed by the literature which indicated that the implementation of the appraisal process would motivate employees to maintain positive behaviours in return of awards. The supervisor's engagement one on one with the subordinates to discuss issues that affects productivity (Yonder-Wise 2014:305). Robinns & Judge (2012:61) stated that giving people performance feedback whether real or fake may have a positive change on the mood which influence motivation.

Common responses from open-ended questions were coded into possible answers and analysed using SPSS version 23.0. The responses were then analysed and the common responses were presented in descriptive statistics. The above responses to close-ended questions were confirmed by the responses obtained to the open-ended questions namely *"Intensive Care Unit (ICU) incentive not introduced" which was a common answer to about 45% (n=29) while more than half 75% (n=48) indicated that "rewards and recognition can have a positive impact on the behaviours of nurses if introduced".*

As the responses to the open-ended questions showed that the majority of nurses were not happy with aspects related to remuneration, rewards, benefits and recognition.

The following common responses were obtained: that nurses perform work often falling outside their scope of practice in the absence of the doctors 54.7% (n=35), therefore they deserve to be remunerated more; that hard-working nurses need to be recognised and rewarded for a job well done and that incentives to attract specialised nurses should be considered 62.5% (n=40). The literature confirms that improved salary benefits, incentives and other conditions of service are among the strategies available to improve performance and retain health professionals (Booyens & Bezuidenhout 2014:319).

Other related literature consulted on the aspects of reward and recognition has revealed that recognising employees' hardworking either through a simple "Thank you" or other forms of recognition can motivate employees to achieve more at work place. Where there are procedures for attaining recognition for which performance factors are relatively objective recognition programs are likely to be perceived by employees as fair. Financial rewards were noted to have a short term effects on motivation (Robbins & Judge 2012:127).

On the other hand, nearly half of the respondents were in agreement with regard to opportunities for attending relevant courses, with 46.8% (n = 30) of the respondents agreeing and 37.5% (n=24) strongly agreeing that opportunities to attend workshops and relevant courses exist. On the other hand, 43.8% (n = 28) strongly agreed that in-service training provides the support they require as compared to 3.1% (n = 2) that strongly disagreed.

4.7 SECTION D: ASPECTS RELATED TO LEADERSHIP AND MANAGEMENT STYLES

Section D of the questionnaire focused on the issues relating to leadership and management. Respondents were asked to indicate their opinions and make suggestions regarding leadership and management (refer to Table 4.4).

Table 4.4: Leadership and management styles (N = 64)

ASPECTS RELATED TO LEADERSHIP AND MANAGEMENT STYLES	**RATING ON A SCALE OF 1 TO 5**						**Total**
		Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**	
Mission and vision are known to the employees.	n	4	7	8	32	13	64
	%	6.3	10.9	12.5	50	20.3	100
You work towards achieving the organisation's mission and vision.	n	6	10	6	30	12	64
	%	9.4	15.6	9.4	46.9	18.7	100
The supervisor motivates you to perform to your highest potential.	n	3	5	4	29	23	64
	%	4.7	7.8	6.3	45.3	35.9	100

ASPECTS RELATED TO LEADERSHIP AND MANAGEMENT STYLES	RATING ON A SCALE OF 1 TO 5						Total
		Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	
Your supervisor is a role model.	n	12	18	4	20	10	64
	%	18.8	28.1	6.3	31.3	15.6	100
Your organisation promotes staff involvement in planning and decision-making.	n	11	33	9	8	3	64
	%	17.2	51.6	14.1	12.5	4.7	100
The supervisor gives immediate feedback concerning your performance.	n	16	30	8	8	2	64
	%	25	46.9	12.5	12.5	3.1	100
Induction and orientation programmes are conducted with all new employees.	n	3	9	2	26	24	64
	%	4.7	14.1	3.1	40.6	37.5	100
Copies of job descriptions are available to employees.	n	6	5	5	34	14	64
	%	9.4	7.8	7.8	53.1	21.9	100
Management involves members of the public to contribute to the achievement of organisational goals.	n	9.4	7.8	7.8	53.1	21.9	100
	%	15.6	43.8	9.4	23.4	7.8	100
The managers of this organisation welcome new ideas and suggestions.	n	7	6	9	24	18	64
	%	10.9	9.4	14.1	37.5	28.1	100

Leadership and management are regarded as important aspects when attempting to bring about changes in behaviours. Respondents agreed on some issues related to leadership management. Close to 45.3% (n = 29) of the respondents agreed and 35.9% (n = 23) strongly agreed that the supervisor motivates them to perform to their highest potential. With regard to items related to job descriptions, 53.1% (n = 34) agreed and 21.9% (n = 14) strongly agreed that copies of the job descriptions are available to employees. About 37.5% (n = 24) of respondents agreed that the managers of their organisation welcome new ideas and suggestions, while 28.1% (n = 18) strongly agreed to the statement. In addition, 50% (n = 32) agreed and 20.3% (n = 13) strongly agreed that the mission and vision are known to the employee. Furthermore, 46.9% (n = 30) indicated that they agreed with working towards achieving the organisation's mission and vision and 18.7% (n = 12) strongly agreed.

Additionally, 40.6% (n = 26) agreed and 37.5% (n = 24) strongly agreed that induction and orientation programmes are conducted with all new employees. In response to the question regarding role modelling, about 31.3% of the respondents (n = 20) agreed and 15.6% (n=10) strongly agreed that their supervisors are role models.

However, 25% (n =16) of the respondents strongly disagreed and 46.9% (n = 30) disagreed that the supervisor gives immediate feedback concerning performance. With regard to the involvement of staff in planning and decision-making, 17.2% (n = 11) strongly disagreed and more than half 51.6% (n = 33) disagreed that the organisation promotes staff involvement in planning and decision-making. In response to the question regarding public involvement in planning, close to half 43.8% (n = 28) of the respondents disagreed that management involves members of the public to contribute to the achievement of organisational goals. This was confirmed by the literature that poor communication leads to relationship break down, misunderstandings, high level of emotion and judgement (Yoder-Wise 2014:349).

Some common responses to open-ended questions that confirmed the above statements were grouped together and analysed using SPSS version 23.0 indicated that majority of respondents 53.1% (n=34) indicated that *"The management should involve staff members in planning and give directions to those who need help", about 48.8% (n=28) indicated that "Bureaucratic leadership style at management level frustrate staff members" while 40.6% (n=26) felt that "Supervisors at the unit level lack capacity to deal with negative behaviours."*

Further, the majority 79.7% (n=51) of the respondents suggested that in order to improve aspects related to leadership and management, "*the supervisor should give immediate feedback",* It can thus be deduced from the respondents' responses that there are aspects that need the attention of management in order to avoid the development of negative feelings among nurses. This is supported by the literature which indicates that supervisors need to be empowered in order to do proper supervision (Amakali 2013:57).

4.8 SECTION E: WORKING ENVIRONMENT

This section attempted to elicit information on issues related to the working environment.

All responses regarding the working environment were recorded in the form of a table. Table 4.5 below displays the responses to the Likert scale questions regarding the working environment.

Table 4.5: Working environment (N = 64)

ASPECTS RELATED TO WORKING ENVIRONMENT	**RATING ON A SCALE OF 1 TO 5**						**Total**
		Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**	
More writing time, less time for patient.	n	4	5	1	30	24	64
	%	6.3	7.8	1.6	46.9	37.5	100
ASPECTS RELATED TO WORKING ENVIRONMENT	**RATING ON A SCALE OF 1 TO 5**						Total
		Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**	
You have the needed equipment and materials in the unit.	n	2	4	2	38	18	64
	%	3.1	6.3	3.1	59.4	28.1	100
Occupational support is available for staff at the workplace.	n	8	10	4	25	16	63
	%	12.7	15.9	6.3	39.7	25.4	100
Your safety at the workplace is guaranteed.	n	6	12	2	24	19	63
	%	9.5	19	3.2	38.1	30.2	100
The unit has infection control guidelines.	n	1	2	8	20	33	64
	%	1.6	3.1	12.5	31.3	51.5	100

* Missing values = 2

Table 4.5 displays the variables pertaining to the working environment. The majority of the respondents agreed 46.9% (n = 30) and strongly agreed 37.5% (n = 24) with the statement that nurses spend more time on writing and have less time for the patients. In response to the question on whether the required equipment and materials were available, more than half 59.4% (n = 38) agreed and 28.1% (n = 18) strongly agreed that they were available in the unit. It was clear from the responses given that safety in the workplace is guaranteed, as more than 38.1% (n = 24) agreed and 30.2% (n = 19) strongly agreed with this statement. This was confirmed by (Robbins & Judge 2012:63) who indicated that the lack of equipment make people to be pessimistic about the effectiveness of safety precautions while patient's complaints and blame shifting with lead to negative mood which distract nurse's concentration and lead to careless behaviours.

As indicated on table 4.5, many of the respondents 46.9% (n = 30) agreed that there was too much paperwork which left less time for patients. This may imply that the provision of quality nursing care may be compromised as nurses spend more time on writing rather than carrying out nursing interventions. This also may imply that nurses may develop work stress and negative attitudes, which consequently affects the nurse–patient therapeutic relationship.

4.9 SECTION F: ASPECTS RELATED TO PATIENTS' BEHAVIOURS AND CULTURAL BELIEFS

Section F of the questionnaire focused on aspects related to patients' behaviours and cultural beliefs. These were examined to determine whether patients' beliefs and cultural practices contribute to negative nurse behaviours (refer to Table 4.6).

Table 4.6: Patient behaviours and cultural beliefs (N = 64)

STATEMENT	RATING ON A SCALE OF 1 TO 5						Total
ASPECTS RELATED TO PATIENT BEHAVIOURS AND CULTURAL BELIEFS		**Strongly disagree**	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**	
Some cultural beliefs are in conflict with the vision of the organisation.	n	3	7	7	20	27	64
	%	4.7	10.9	10.9	31.2	42.2	100
Patients appreciate the role played by nurses.	n	7	5	11	20	21	64
	%	10.9	7.8	17.2	31.3	32.8	100
ASPECTS RELATED TO PATIENT BEHAVIOURS AND CULTURAL BELIEFS	**YES OR NO QUESTIONS**						**Total**
Do you regard language and communication barriers as a problem for many of the staff members in this organisation?		Yes	No				
	n	50	14				64
	%	78.1	21.9				100
Do you think that patients or their families' behaviours can influence the behaviour of nurses at workplace?		Yes	No				
	n	40	24				64
	%	62.5	37.7				100

Of the 64 respondents, 31.2% (n = 20) agreed and 42.2% (n = 27) strongly agreed that some cultural beliefs are in conflict with the vision of the organisation.

In response to the question regarding the role of nurses, 31.3% (n = 20) agreed and 32.8% (n = 21) strongly agreed that patients appreciate the role played by nurses.

Close to 42.2% (n = 27) of the respondents were in agreement that some cultural beliefs were in conflict with the vision of the organisation. This implies that if nothing is done, local cultural practices in the area surrounding the specific health care facility will continue to affect the provision of quality nursing care.

Responses from open-ended question on how to improve patients' behaviours and beliefs were grouped together and analysed using SPSS version 23. The majority 71.9% (n=46) of the respondents indicated "health education to be strengthened in order to minimise patients or families calling traditional healers in the hospital or absconding from hospital for traditional healing" as this often leads to confrontations and arguments. To confirm that culture is linked to negative behaviours the literature indicted that stereotyping, cultural prejudice, ethnocentrism and cultural conflict were among factors hindering cultural competence among nurses. Nurses who are not cultural competent often disregard people's individuality of a particular group, have beliefs that a particular group have substandard qualities or present with misunderstandings and inappropriate expectations when a patient do not respond appropriately to their cultural cues (Van Wyk & Leech 2011:63).

In responding to yes or no questions, more than half 78.1% (n=50) have indicated that communication barriers were some of the factors seen to affects proper communication between nurses and patients. The results implied that poor communication between nurses and patients compromise quality nursing care. In addition, about 62.5% (n=40) felt that patients or their families can influence nurses behaviours. From the responses given this implies that the patients or families behaviours may have positive or negative influence on nurses' behaviours. Literature found that poor communication leads to relationship break down, misunderstandings, high level of emotion, judgement and dramas (Yoder-Wise 2014:349).

4.10 CONCLUSION

This chapter discussed the data analysis and presented aspects related to the biographical information, staffing and work schedule, remuneration, rewards, benefits and recognition, leadership and management styles, working environment and patient behaviours and cultural beliefs.

This analysis of the data has revealed the opinions and views of the registered nurses and enrolled nurses at the specific health facility regarding the factors that positively or negatively affect nurses' behaviours. In chapter 5, the conclusions, limitations and the recommendations of the study will be presented.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter the data were analysed and the results were presented and discussed. This chapter presents the conclusions and limitations and makes a number of recommendations. The objectives of this study were to explore and describe the factors that contribute to nurses' negative behaviour when rendering patient care and to describe the effects of such behaviour on patient outcomes.

The conclusions and recommendations made are based on the afore-mentioned objectives and focus mainly on the predetermined themes: the biographical data; staffing and work schedule; aspects related to remuneration, reward, benefits and recognition; aspects related to leadership and management styles; working environment; and aspects related to patient behaviours and cultural beliefs. These are summarised as follows:

5.2 SUMMARY OF THE RESEARCH RESULTS

5.2.1 Biographic information

In this study, of the 64 respondents who took part, the majority 61% (n = 39) were the enrolled nurses. This suggests that more registered nurses are needed in the profession in order to contribute to the provision of quality nursing care in the specific health care facility. With regard to gender, the majority 56% (n = 35) of the respondents were female. This supports the statement that the nursing profession is still dominated by women.

In addition, it was found that 44% (n = 28) of the respondents were in their early twenties (20–29 years) and had fewer than five years of working experience.

The study did not attempt to ascertain what made them to join the profession at such a young age but this may be attributed to the call made by the Minister of Health and Social Services for more nurses in the country to replace the aging nursing professionals (Nembwaya 2013:1). While this is a positive wake up in the call to replace the aging nursing professionals (Smith & Mee 2017:15) has indicated that younger nurses may find it difficult to advocate for their patients as society expect younger people to respect elders even if when they were wrong. In addition the younger nurses are not encouraged to be assertive and stand their ground in protecting the vulnerable.

The respondents had various nursing qualifications but the majority 60% (n = 39) were in possession of the certificate in nursing.

It was concluded from the responses given that many experienced nurses are leaving the health profession, making it difficult for young nurses to be properly guided during their first few years in the profession. This has a negative effect on the quality of nursing care and the general attitudes and behaviours needed to carry out nursing interventions. This was confirmed by the American Association of College of Nursing (2014:2) which indicated that an increased health care demand particularly in nursing is linked to resignation, ageing and low salaries paid to nurses.

5.2.2 Staffing and work schedule

It was evident that the staff shortage was regarded as a problem by many of the respondents, as the majority 54.7% (n = 35) indicated that the number of staff allocated to their units was not sufficient to deal with the workload. One of the factors believed to have caused this increased workload was the fact that staff were not involved in aspects related to staffing.

The results of the study were supported by the study conducted by Amakali (2013:72), on human resources capacity in Namibia which found that a shortage of staff can compromise the delivery of quality nursing care.

5.2.3 Aspects related to remuneration, rewards, benefits and recognition

As indicated by Booyens and Bezuidenhout (2014:319), remuneration, rewards, benefits and recognition are referred to as hygiene factors. Hygiene factors include aspects such as an adequate salary, job promotions, good working conditions and job security and, if applied, individuals will be satisfied with their jobs, have positive attitudes and increase their productivity.

It was evident that the majority of the respondents were not happy with their current salaries as 32.8 % (n = 21) disagreed that their remuneration was market related in contrast to 7.8% (n = 5) who strongly agreed that their remuneration was market related.

On the other hand, 42.2% (n = 27) of the respondents felt that they were not being remunerated based on their years of experience as compared to 7.8% (n = 5) who strongly agreed, thus indicating that they were being remunerated accordingly. It was assumed that many experienced nurses had left the specific public health care facility as a result of frustrations related to remuneration.

Of the respondents, 48.4% (n = 31) were in agreement that nurses who had been identified as displaying negative behaviour were not supported or retrained, although one staff member indicated that something was being done to support and retrain nurses identified with negative behaviours. This is a concern regarding the provision of quality nursing care, as the lack of hygienic factors can lead to negative behaviours.

5.2.4 Aspects related to leadership and management styles

Leadership and management play an important role in promoting a good working environment and maintaining the behaviours required to achieve organisational goals. The study pointed to the fact that supervisors need to give immediate feedback, as 46.9% (n = 30) of the respondents indicated that supervisors do not give immediate feedback. In addition, 51.6% (n = 33) felt that the organisation does not promote staff members who are involved in planning and decision-making. Moreover, 43.8% (n = 28) felt that it is of concern that the management does not involve members of the public in an attempt to achieve the organisational goals.

It is therefore clear that the lack of immediate feedback and the lack of public and staff involvement in planning and decision-making may result in critical issues affecting both the nurses and the public being overlooked. Providing sufficient feedback to employees is an important means of improving productivity and performance. Immediate feedback influences behaviour because it help individuals to set specific targets for improvement, set measurable targets and describe methods for attaining them (Booyens & Bezuidenhout 2014:199).

5.2.5 Working environment

The working environment can positively or negatively influence staff attitudes. Of the respondents, 46.9% (n = 30) were unhappy with the fact that nurses spend more time writing than with being with the patients. The increase in administrative tasks has been shown to be associated with increasing time pressure and low job satisfaction, leading to the quality of nursing care being compromised and consequently causing work-related stress and negative behaviours (Wilson 2017:1).

It is, however, encouraging to hear that the needed equipment were available in the unit, as indicated by the majority 59.4% (n = 38) of the respondents, and that safety at work is guaranteed. This was supported by 38.1% (n = 24) of the respondents who agreed and by the 30.2% (n =19) who strongly agreed that they feel safe in their working environment.

5.2.6 Aspects related to patients' behaviours and cultural beliefs

It was noted that aspects of patients' behaviours and cultural beliefs compromise the quality of nursing care, as 42.2% (n = 27) strongly agreed and 31.2% (n = 20) agreed that some cultural beliefs are in conflict with the provision of quality nursing care. The diverse cultural beliefs and practices made it difficult for the provision of quality nursing care as some families with strong beliefs in traditional healers may not trust or comply with the advice given by nurses and may have little respect for them. In turn, nurses may develop negative attitudes towards those who do not listen to their advice.

It was, however, encouraging to note that 32.8% (n = 21) strongly agreed and 31.3% (n = 20) agreed that patients appreciate the role played by the nurses. The nurses felt that patients understand their important role in society.

The study found that more than half 78.1% (n=50) felt that communication barriers were some of the factors seen to affects proper. Although the study did not determine the exact barriers to effective communication in the specific health care facility, the results showed that poor communication between nurses and patients need to be addressed.

The various factors identified that contribute to negative nurse behaviours have negative implications for patient care and have damaged the reputation of the nursing profession. This needs to be addressed.

5.3 RECOMMENDATIONS

The study makes the following recommendations pertaining to the specific health care facility and the MoHSS:

- There is a need to train and recruit more nurses in order to address the shortage of nursing staff.
- Nurses should be remunerated, awarded and recognised for the important work they do.
- Training courses with a focus on customer care should be developed and introduced.
- Nurses identified with negative behaviours should be supported and retrained to address negative nurse behaviours.
- National and regional awards should be introduced to recognise nurses who perform well and behave as expected.
- Patients should be involved at both national and regional level in planning and decision-making regarding their care.
- Public health education on patients' rights and obligations should be reinforced in order to avoid frustrations.
- Ways in which to minimise writing time (administrative work) should be sought in order for nurses to have more time to spend on rendering patient care.

- Further research is needed to validate these results in other public health care facilities in Namibia.
- The results of this study highlight certain factors identified as being associated with negative nurses' behaviours such as the need to train more nurses, improve aspects related to remuneration, recognition and rewards, the support and of retraining nurses, as well as the need for further research to validate these results so that they may be generalised to other public health care facilities in Namibia.

5.4 LIMITATIONS OF THE STUDY

The results of this study can only be generalised to the specific health care facility in the region where this study was conducted and not to other health care facilities.

All aspects related to the factors contributing to negative nurse behaviours may not have been addressed owing to a lack of resources and limited time for carrying out this study.

5.5 CONCLUDING REMARKS

This chapter presented the conclusions, limitations and recommendations and discussed them in regard to the study objectives and predetermined themes.

The study established that negative nurse's behaviours in the specific health care facility was a result of various factors, namely, the shortage of staff and work overload that seem to continue to hinder the provision of quality nursing care. Other factors identified to contribute to negative nurse's behaviours in a specific health care facility were poor management leadership style, which resulted in inability to identify and address nurses presenting with negative behaviours. Negative behaviours of nurses continues to be unabated and thus inhibiting the provision of quality nursing care. Patient's behaviour and cultural beliefs were also found to contribute to negative nurses' behaviours due to cultural conflict and lack of cultural competence among nurses which hinder the provision of quality nursing care.

Furthermore the working environment, as well as poor remuneration packages were indicated to cause low morale among nurses and further causing frustration and burnout among nurses and which can later develop into work related stress. The inability to deal with nurses identified with negative behaviours may in turn have a negative effect on the provision of quality nursing care, as even new graduates may be influenced and start to think that it is normal to behave in a negative way when rendering nursing care to the patients.

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ANNEXURE 1: ETHICAL CLEARANCE CERTIFICATE FROM ETHICS COMMITTEE DEPARTMENT OF HEALTH STUDIES (UNISA).

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

5 October 2016

HSHDC/545/2016
Mr NPN Tomas
Student: 5185-637-9

Supervisor: Dr KA Maboe
Qualification: D Litt et Phil
Joint Supervisor: -

Dear Mr NPN Tomas

Decision: Ethics Approval

Name: Mr NPN Tomas

Proposal: Factors contributing to the negative behaviours of nurses in a specific public health care facility in Namibia.

Qualification: MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 5 October 2016.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

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ANNEXURE 2: QUESTIONNAIRE FOR REGISTERED NURSES AND ENROLLED NURSES

SECTION A: BIOGRAPHIC INFORMATION

Please put a cross (X) in the relevant box and fill in where doted lines are given.

1. Gender/Sex: Male ☐ Female ☐

2. Age: ---------- (in years)

3. Highest qualification: ----------

4. Professional rank: Registered nurse ☐ Enrolled nurse ☐

5. Years of experience:

Please insert an X in the appropriate box

0-5 years	
6-10 years	
11-15 years	
16 years or longer	

SECTION B: STAFFING AND WORK SCHEDULE

6. Please rate the following statements regarding your staffing and work schedule and mark with an X in the appropriate box using the following definition codes:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	1	2	3	4	5
6.1	Staff allocation is enough for the unit workload.					
6.2	Your department is staffed with nurses with appropriate skills.					
6.3	Flexible work schedule exists in your unit.					
6.4	Staff inputs on staffing are considered by management.					
6.5	Counselling is available for staff at the workplace.					

6.6	Nurses perform tasks not in their scope.					
6.7	The needed equipment and consumable items are available in your unit.					
6.8	Staff allocation in your unit is fair.					

Please answer the following questions in the space provided.

7. What are your comments on any of your responses regarding staffing and work schedule?

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8. What do you suggest for improving staffing and work schedule?

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SECTION C: REMUNERATION, REWARD, BENEFITS AND RECOGNITION

9. Please read the following statements regarding your remuneration and reward.

Mark with an X in the appropriate box using the following definition codes:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	1	2	3	4	5
9.1	Your remuneration is market related.					
9.2	Remuneration is based on years of experience and responsibility.					
9.3	The organisation recognises hard working nurses/best performers with awards.					
9.4	There are opportunities available for professional growth.					
9.5	Incentives for retaining staff are available.					
9.6	You are motivated to work hard by your current salary, benefits, rewards and recognition.					

10. Please read the following statements regarding your staff development.

Mark with an X in the appropriate box using the following definition codes:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	1	2	3	4	5
10.1	Performance appraisal is available and is implemented.					
10.2	The reasons for performance appraisal are known by the staff.					
10.3	Opportunity to attend workshops and relevant courses on customer care exist.					
10.4	Identified nurses with negative behaviours are supported and retrained.					
10.5	In-service training provides the needed support.					
10.6	You are given prompt acknowledgement and recognition for a job well done.					

Please answer the following questions in the space provided.

11. What are your comments regarding remuneration, reward, benefit and recognition?

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12. What would you suggest be improved with regard to remuneration, reward, benefit and recognition?

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SECTION D: LEADERSHIP AND MANAGEMENT STYLES

13. Please rate the following statements regarding the leadership and management of your organisation and mark with an X in the appropriate box using the following definition codes:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	1	2	3	4	5
13.1	Mission and vision are known to the employees.					
13.2	You work towards achieving organisation's mission and vision.					
13.3	The supervisor motivates you to perform to your highest potential.					
13.4	Your supervisor is a role model.					
13.5	Your organisation promotes staff involvement in planning and decision making.					
13.6	The supervisor gives immediate feedback concerning your performance.					
13.7	Induction and orientation programmes are conducted with all new employees.					
13.8	Copies of job descriptions are available to employees.					
13.9	Management involves members of the public in contributing to the achievement of organisational goals.					
13.10	The management of this organisation welcomes new ideas and suggestions.					

Please answer the following questions in the space provided.

14. What are your comments regarding the leadership and management style?

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15. What do you suggest for improving the leadership and management style?

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SECTION E: WORKING ENVIRONMENT

16. Please rate the following statements regarding working environment and mark with an X in the appropriate box using the following definition codes:

1. Strongly disagree
2. Disagree
3. Uncertain
4. Agree
5. Strongly agree

	Statement	1	2	3	4	5
16.1	More writing time, less time for patient.					
16.2	You have the needed equipment and materials in the unit.					
16.3	Occupational support is available for staff at the workplace.					
16.4	Your safety at the workplace is guaranteed.					
16.5	The unit has infection control guidelines.					

Please answer the following questions in the space provided.

17. What are your comments regarding your working environment?

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18. What do you suggest for improving the working environment?

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SECTION F: PATIENT BEHAVIOURS AND CULTURAL BELIEFS

19. Please rate the following statements regarding patients' behaviours and cultural beliefs and mark with an X in the appropriate box using the following definition codes:

    1. Strongly disagree
    2. Disagree
    3. Uncertain
    4. Agree
    5. Strongly agree

	Statement	1	2	3	4	5
19.1	Some cultural beliefs are responsible for negative nurse behaviours.					
19.2	Patients appreciate the role played by nurses.					

Please mark with an X in the appropriate box

20. Do you regard language and communication barriers as a problem for many of the staff members in this organisation? ☐ Yes ☐ No

21. Do you think that patients or their families influence the behaviour of nurses at the workplace? ☐ Yes ☐ No

Please answer the following questions in the space provided.

22. If either of your answers to questions 20 and 21 is yes, in what ways does the patient or family contribute to negative behaviours of nurses at the workplace?

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23. What do you suggest for improving patients' behaviours and beliefs?

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ANNEXURE 3: PERMISSION LETTER TO THE PERMANENT SECRETARY OF THE MINISTRY OF HEALTH AND SOCIAL SERVICES (MoHSS)

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2562
Fax: 061 – 222558
E-mail: hnangombe@gmail.com

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3
Enquiries: Ms. H. Nangombe

Date: 19 April 2017

Mr. Nestor PN Tomas
PO Box 352
Swakopmund
Namibia

Dear Mr. Tomas

Re: Factors contributing to the negative behaviours of nurses in a specific health care facility in Namibia

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purpose;

3.2 No other data should be collected other than the data stated in the proposal;

3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

3.4 A quarterly report to be submitted to the Ministry's Research Unit;

3.5 Preliminary findings to be submitted upon completion of the study;

3.6 Final report to be submitted upon completion of the study;

3.7 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

Andreas Mwoombola (Dr)
Permanent Secretary

"Health for All"

ANNEXURE 4: PERMISSION LETTER TO THE MEDICAL SUPERINTENDENT OF THE SPECIFIC HEALTH CARE FACILITY

9 - 0 / 0001

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Rundu Intermediate Hospital
Kavango East Region
Rundu

Private Bag 2094
Rundu
Namibia

Tel: +264 66 265500
Fax: +264 66 255260
Email: hospru@iway.na

INTERMEDIATE HOSPITAL RUNDU
OFFICE OF THE CHIEF MEDICAL OFFICER

Date: 13 Apri 2017
Ref:
Enq:

To: Mr. NPN Tomas
P.O. Box 352
Swakopmund
Namibia

RE: REQUEST TO CONDUCT RESEARCH ON THE PREMISES OF INTERMEDIATE HOSPITAL RUNDU (INPATIENT AND OUTPATIENT DEPARTMENTS)

Your letter on the above issue refers.

Intermediate Hospital Rundu grants permission to Mr. Tomas to conduct research titled: **Factors contributing to the negative behaviours of nurses in a specific public health care facility in Namibia.**

You are kindly requested to adhere to the conditions as stipulated in the approval letter from the Permanent Secretary's Office (Ref:17/03/3).

Wishing you the best in your studies.

Kind Regards

DR. MEDSON CHIBWE
CHIEF MEDICAL OFFICER

MINISTRY OF HEALTH AND SOCIAL SERVICES
P BAG 2094, RUNDU
Tel 066 - 265500
CHIEF MEDICAL OFFICER
RUNDU INTERMEDIATE HOSPITAL
13 APR 2017
KAVANGO EAST REGION
REPUBLIC OF NAMIBIA

"Your Health Our Concern"

ANNEXURE 5: INFORMED CONSENT FORM

Mr Nestor PN Tomas
P.O. Box 352
Swakopmund, Namibia
Email. tomas.npn@gmail.com
Cell: +264 81 234 0425
14 July 2016

Dear respondents

My name is Tomas Nestor, doing Master in Public Health with the University of South Africa, I am conducting a study among nurses in Rundu district, Kavango east region, Namibia.

You are hereby invited to take part in this study on the factors contributing to the negative nurses' behaviours in public health care facility in Namibia. The purpose of this study is to explore and describe the factors contributing to the negative behaviours of nurses in rendering patients' care in a specific public health care facility in Namibia. Your participation is vital in providing valuable information needed to transform negative nurses' behaviours into acceptable behaviours and contribute to the quality of care for all patients receiving treatment at this public health care facility.

You are kindly requested to complete a questionnaire which will take you about 40 minutes to complete and there are no correct or wrong answers when answering the questions. Information provided and the results will be reported in a dissertation and be published in an accredited journal and presented at the conference.

Kindly note that confidentiality and anonymity will be maintained. You are not required to write your name on the questionnaire. Your participation to this study is on a voluntary basis and you have the right to with draw at any time without any penalty.

Should you require any further information kindly contact my supervisor Dr K A Maboe at Department of Health Studies, University of South Africa, tel: 012 429 2393 or email: maboeka@unisa.ac.za.

You are requested to sign this consent form if you are willing to participate in this study.

Your participation in this study is highly appreciated.

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Researcher' signature	Date
----------	----------
Respondent' signature	Date

ANNEXURE 6: LETTER FROM THE STATISTICIAN

20 September 2017

Dear Mr NPN Tomas

RE: ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH RESULTS

It has been a pleasure to be part of your study (where you consulted) on how to analyze data using SPSS version 23.0. I am convinced that your analysis of this study has reflected the content of your data collection tool and one can only hope of an informative report out of this analysis.

Kind regards

Olavi Kapapero

Regional Statistician
Namibia Statistics Agency (NSA)
FGI House,44 Post Street Mall,Windhoek, Namibia
P.O.Box 2133,Windhoek, Namibia

Cell:+264(81)-4256080

Namibia Statistics Agency

ANNEXURE 7: PROFESSIONAL LANGUAGE EDITOR'S LETTER

Alexa Barnby

Language Specialist

Editing, copywriting, indexing, formatting, translation

BA Hons Translation Studies; APEd (SATI) Accredited Professional Text Editor, SATI

Mobile: 071 872 1334

Tel: 012 361 6347

alexabarnby@gmail.com

7 October 2017

To whom it may concern

This is to certify that I, Alexa Kirsten Barnby, ID no. 5106090097080, a language practitioner accredited by the South African Translators' Institute, have edited the dissertation, submitted in accordance with the requirements for the degree of Master of Public Health, titled "Factors contributing to the negative behaviours of nurses in a specific public health care facility in Namibia" by Nestor Petrus Namulo Tomas.

The onus is, however, on the author to make the changes and address the comments made.