

**AN EXPLORATION OF THE PERCEPTIONS OF NURSES OF THEIR ROLES AND
RESPONSIBILITIES IN REALISATION OF THE QUALITY IMPROVEMENT
INITIATIVE “BACK TO BASICS” NURSING CARE**

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DECLARATION

I declare that **AN EXPLORATION OF THE PERCEPTIONS OF NURSES OF THEIR ROLES AND RESPONSIBILITIES IN REALISATION OF THE QUALITY IMPROVEMENT INITIATIVE “BACK TO BASICS” NURSING CARE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



.....
SIGNATURE

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30 November 2017

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AN EXPLORATION OF THE PERCEPTIONS OF NURSES OF THEIR ROLES AND RESPONSIBILITIES IN REALISATION OF THE QUALITY IMPROVEMENT INITIATIVE “BACK TO BASICS” NURSING CARE

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ABSTRACT

Patient outcomes are influenced by the quality of care that the workforce renders. The registered nurse, as designated process-owner of the “Back to basics” quality improvement (QI) initiative, plays a vital role, being responsible for providing compassionate patient-centred care to alleviate suffering and restore health. The aim of the study was to gain an in-depth understanding of how nurses perceive their roles, responsibilities and challenges in delivering basic nursing care, linked to the organisational “Back to basics” QI initiative. A qualitative study with an explorative descriptive contextual design was utilised. Registered nurses with a direct patient care involvement in the general nursing discipline of a private hospital group participated in focus-group interviews. Data were analysed using Creswell’s data-analysis cycle. Findings were that patient care coordination involves an assessment-delegation-supervision triad. However, meeting stakeholder expectations, management and administrative responsibilities, remove the registered nurse from direct patient care. Time constraints affect physical bedside availability to model the exemplary knowledge, skills and attitudes underlying quality basic nursing care delivery. Reduced opportunities to model quality basic nursing care at the bedside affect patients’ care expectations, resulting in complaints related to basic nursing care omissions. Participants felt that they needed more clarification on the “Back to basics” QI initiative, and more in-service training. The many broad-ranging recommendations include in-service training that empowers registered nurses with the competencies to deal with role and task balance in the face of the diverse and complex demands of the modern healthcare arena.

Key concepts

“Back to basics”; basic nursing care delivery; quality improvement (QI).

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Dedication

*I dedicate this dissertation to every human being
who performs their day task with diligence and pride
to optimise the quality of life for mankind.*

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Nurses are the largest component of the health workforce and are instrumental in providing quality nursing care to patients, aimed at the maintenance and restoration of health and alleviation of pain and suffering (Hinkle & Cheever 2014:5; ICN 2015:1; Pipe, Connolly, Sphar, Lendzion, Buchda, Jury & Cisar 2012:231). The South African healthcare system is predominantly nurse based, and competence is essential to meet the healthcare needs of patients (Ministerial Task Team 2012:23). Nurses have multiple roles; diverse decisions are made in everyday practice which influences the efficiency and effectiveness of patient care delivery (ICN 2015:1).

The International Council of Nurses (ICN 2015:4) has stated that the global economic crisis has had a devastating impact on the nursing workforce since 2008, at a time when the nursing profession faced an increased demand for healthcare services. Technological advances in healthcare and expensive treatment for complex care needs, with consequent increases in healthcare costs, place progressive emphasis on the consumers' expectations of quality in nursing care delivery (De Freitas, De Camargo Silva, Minamisava, Bezerra & De Sousa 2014:455; Hinkle & Cheever 2014:8). The demand for skilled nurses amidst critical healthcare workforce shortages increases the challenges to providing sustainable quality care in the clinical practice environment. Despite global and national service delivery challenges, Irfan, Ijaz and Farooq (2012:870) maintain that *quality* remains the key parameter for measuring service delivery. De Freitas et al (2014:455) state that the nursing profession is globally confronted with the need to improve work processes to ensure quality nursing care to patients.

The global quest to sustain quality in nursing care delivery, as embedded in nursing values, gives rise to the development of initiatives to improve quality (Shahriari, Mohammadi, Abbaszadeh & Bahrami 2013:1). Armstrong, Rispel and Penn-Kekana (2015:1) confirm that such initiatives are implemented as an operational strategy to ensure patient safety and improve clinical competence. "Back to basics" nursing care is

a familiar and ongoing quality improvement (QI) initiative, abroad and in South Africa, to re-affirm hands-on patient-centred basic nursing care delivery at the bedside of the patient. Eygelaar and Stellenberg (2012:1) and Jardien-Baboo, Van Rooyen, Ricks and Jordan (2016:1) indicate that in South Africa the quality of healthcare is directly related to patient-centred care.

The registered nurse as process-owner of the “Back to basics” QI initiative hold vital roles and responsibilities to direct safe, efficient, patient-centred basic nursing care.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

In the globalised context, each country faces unique challenges concerning the quality and safety of hospital care (De Freitas et al 2014:455). Over the past few years global reports have uncovered high-profile cases of poor nursing care related to flaws in the quality and safety of nursing care, with consequent adverse patient outcomes (De Freitas et al 2014:455; Sawbridge & Hewison 2011:3). The Mid Staffordshire Report (Francis 2013:45) indicates that poor leadership, staffing policies, dire shortages of skilled nursing personnel, inadequate staff recruitment and training deficits contributed to the failure in professionalism and passive acceptance of poor standards in nursing care delivery. Workplace culture affects workforce empowerment, multidisciplinary relationships and the innovative deployment of evidence-based practices such as QI initiatives (Moss, Mitchell & Casey 2017:116). Moss et al (2017:116) indicate that several scholars acknowledge the relationship between a poor workforce culture and lowered employee satisfaction, the development of nurse burnout and high personnel turnover rates. The causal relationship between workforce culture and patient outcomes is receiving increased attention by healthcare leaders because it ultimately affects the quality and safety of patient care (Moss et al 2017:116).

Global trends correspond to the service delivery challenges in the South African healthcare arena. Eygelaar and Stellenberg (2012:1) and Rispel and Bruce (2015:118) point out that South Africa faces a nursing crisis, characterised by staff shortages, skills deficits – with limitations in continuous development programmes – and a lack of caring ethos, coupled with a declining interest in the profession. South Africa deploys 39.3 nurses per 10 000 population, with a high workforce percentage designated by the private sector (ICN 2015:5). Mayeng and Wolvaardt (2015:1) explain that the combination of

increasing patient numbers and personnel shortages poses ominous concerns for the nursing profession, because the nurse practitioner retains legal responsibility and accountability for all acts and omissions related to nursing care provision. As the nature and extent of the nurse's work has become increasingly more complex, with elaborate documentation requirements expected by professional regulatory bodies, nurses tend to leave essential basic nursing care behind (Pipe et al 2012:225). Mayeng and Wolvaardt (2015:2) indicate that unsafe patient care is associated with significant morbidity and mortality rates throughout the world, with up to 20 times higher incidence of harm being incurred by patients in developing countries. Suliman, Aljezawi, AlBashtawy, Fitzpatrick, Aloush and Al-Awamreh (2017:E1) concur that the workforce's safety culture impacts on patient satisfaction and ultimately predicts patient outcomes.

Statistics of the South African Nursing Council (SANC) indicate that the majority of professional conduct cases per annum are related to poor basic nursing care (Ministerial Task Team 2012:23). Studies conducted on the broad causes of nursing errors in a hospital setting portray an array of probabilities to account for the factors that affect quality in nursing care delivery. Jardien-Baboo et al (2016:2-3) reflect on specific factors that enable patient-centred care, such as a positive work environment, professional leadership, continuous in-service education and collaborative teamwork. On the contrary, Jardien-Baboo et al (2016:3-4) indicate that staff shortages, resulting in an increased workload with limited equipment, administrative work, documentation, record-keeping and unprofessional behaviour with a lack of caring nursing ethos cause barriers to the promotion of patient-centred care.

A study by Pipe et al (2012) sets out various challenges with regard to nurses' conceptual understanding (mental model) and acceptance of their role and responsibility to sustain delivery of quality basic nursing care. It was found that nurses' ability to provide basic nursing care (with the emphasis on *care*) was compromised by a lack of standardised definitions about care essentials, coupled with challenges to managing patient expectations about care and care practices (Pipe et al 2012:226). Several studies conducted on the reasons for poor basic nursing care execution (Ball, Murrells, Rafferty, Morrow & Griffiths 2014; Bradshaw 2010; Kalisch 2006; Pipe et al 2012) address causal similarities for poor quality nursing care. In these studies the corresponding reasons for omitting nursing care point to an absence of agreed nursing role definitions (Bradshaw 2010:3555), which results in role and responsibility ambiguity among nurses. Kalisch,

Labelle and Boqin (2013:248) and Kalisch (2006:309) refer to an “it is not my job” syndrome, when nursing staff do not respond to a patient’s needs if a nursing task is not assigned to them. Kalisch et al (2013:248) suggest a correlation between nurses’ conceptual understanding of the roles and responsibilities of each team member and the response time when reacting to patients’ healthcare related needs.

This perception that basic nursing care is not considered the duty and responsibility of the registered nurse is echoed by public opinion, with the allegation that nurses regard basic nursing care delivery as a task beneath them, to the detriment of patients’ healthcare needs (Smith 2012). The “it is not my job” perception and reluctance to take accountability for basic nursing care (Kalisch et al 2013:248; Kalisch 2006:309; Smith 2012) point toward an alarming work ethic that causes disrepute to the nursing profession. The global stance of basic nursing care delivery justifies the importance of international and national QI initiatives to re-affirm the importance of basic nursing care delivery at the bedside of the patient. Ball et al (2014:116) and the South African Strategic Plan for Nursing Education, Training and Practice (Ministerial Task Team 2012:23) indicate that nurse negligence when omitting basic nursing care responsibilities towards patients has the potential to cause serious adverse health outcomes or even loss of life, and continues to carry tremendous financial implications for the healthcare industry.

Regardless of the complex interface between workforce, work skill and work-environmental attributes, the National Patients’ Rights Charter (HPCSA 2008) and the Batho Pele Principles (Department of Public Service and Administration 1997) emphasise the responsibility of every nurse to provide quality nursing care in response to the right of every patient to receive quality nursing care (Eygelaaar & Stellenberg 2012:1; Jardien-Baboo et al 2016:1)

1.3 STATEMENT OF THE RESEARCH PROBLEM

A research problem in the nursing discipline implies an area of concern where a gap exists in the knowledge base within nursing practice (Grove, Gray & Burns 2015:131). Research enables the founding of knowledge needed to address practice concerns, to contribute ultimately to clinical evidence-based nursing care (Grove et al 2015:131).

The SANC's published statistics implicate poor basic nursing care delivery as the major culprit in professional misconduct cases (Ministerial Task Team 2012:23). Eygelaar and Stellenberg (2012:1) and Jardien-Baboo et al (2016:1) propose that quality in healthcare is directly related to the concept of patient-centred care. Various studies (Ball et al 2014; Bradshaw 2010; Kalisch 2006; Pipe et al 2012; Sayers, Salamonson, DiGiacomo & Davidson 2015) suggest ambiguity in that the role definition of nursing care delivery and performance expectations among nurses are unclear. Ball et al (2014:120) and Kalisch (2006:308-309) argue that nurses' perceptions with regard to basic nursing care provision and the amount of (nursing) care left undone, correspond to the overall perception of quality and safety of care. Public opinion corroborates this, with the allegation that registered nurses regard basic nursing care delivery as a task beneath them, to the detriment of patients' healthcare needs.

Patient outcomes in any hospital are mainly influenced by the quality of care that the workforce is able to provide (Maharaj 2015:2). Despite strong professional regulation and ongoing QI initiatives, the quality of basic nursing care delivery remains an enduring challenge.

The researcher has identified a need to explore nurses' perceptions of their roles and responsibilities in the "Back to basics" QI initiative aimed at the enhancement of basic nursing care delivery at the bedside of the patient.

The question that arose was: **How do nurses perceive their roles and responsibilities in the realisation of the QI initiative "Back to basics" to improve basic nursing care at the bedside of the patient?**

1.4 RESEARCH PURPOSE

The purpose of the study was to gain an in-depth understanding of how nurses perceive their roles and responsibilities to deliver the "Back to basics" QI initiative at the bedside within the general nursing care context.

1.4.1 Research objectives

The study aimed to address the following objectives:

- Explore nurses' perceptions of their roles and responsibilities in supporting the healthcare organisations' "Back to basics" QI initiative.
- Describe challenges that nurses face in the realisation of "Back to basics" nursing care delivery within the organisational QI initiative.
- Recommend practical ways to enhance QI initiatives at the bedside of the patient.

1.5 SIGNIFICANCE OF THE STUDY

The study could provide an in-depth understanding of how nurses perceive their roles, responsibilities and challenges in delivering basic nursing care linked to the organisational QI initiative "Back to basics" nursing care at the bedside in a real-life general nursing care clinical context.

Recommendations would be made on how the nurses' role as process owners of basic nursing care could be strengthened to enhance "Back to basics" nursing care in support of the QI initiative. This study could contribute to the scientific body of knowledge in providing a better understanding of nurses' perceived ideas when reflecting on the functional position of nurses' authority and accountability (as recommended by Bradshaw (2010:3555-3556) to strengthen the nurse's role in the clinical practice environment.

1.6 DEFINITION OF KEY CONCEPTS

1.6.1 Nurse

A *nurse* in this study is a person licensed with the SANC on completion of an education programme to nurture, assist and treat clients (patients) in activities that contribute to the attainment or maintenance of health, recovery, rehabilitation or assistance towards a dignified death (SANC 2001).

For the purpose of this study the term *nurse* will refer to a registered nurse who is qualified and competent to independently practise comprehensive nursing in a manner and to the

level prescribed, and who is capable of assuming nursing care responsibilities and accountability for such practice. In this study, the term registered nurse will be used synonymously with the term professional nurse as defined in the Nursing Act (Act 33 of 2005) (henceforth the Nursing Act) (South Africa 2005) in terms of assuming professional roles and responsibilities in basic nursing care delivery.

1.6.2 Nursing

The term *nursing* will refer to an action of protecting, promoting and optimising the health and abilities of a patient by means of preventing illness and injury, and alleviating pain and suffering through diagnosis and treatment of human needs and response to disease (Hinkle & Cheever 2014:5). For the purpose of this study, promotion of safety and quality of care by means of role and responsibility performance will form focal points in nursing care delivery (Hinkle & Cheever 2014:5).

1.6.3 Basic nursing care

Basic nursing care refers to the acts and procedures as stipulated in the Regulations relating to the Nursing Act (South Africa 2005). For the purpose of the study, *basic nursing care* encompasses the comprehensive execution of clinical responsibilities in providing direct care to the patient when diagnosing a patient's healthcare related needs. *Basic nursing care* aims to meet the patient's unique needs with regard to hygiene, nutrition, elimination and medication administration, and includes communication in an environment in which the physical and mental health of the patient is promoted (South Africa 2005).

1.6.4 Roles and responsibilities

For the purpose of the study, *roles and responsibilities* (of the nurse) must be interpreted within the ethical-legal framework of nursing as stipulated in the Nursing Act (South Africa 2005).

Responsibilities refer to being answerable for the way in which basic nursing are carried out towards health promotion and restoration, alleviating of suffering and illness prevention (Maharaj 2015:10). *Roles and responsibilities* entail the obligations of the

nurse in patient care when employing the scientific nursing process to diagnose the physical, psychological and social signs and symptoms of patients which require individual interaction between the nurse and the patient (South Africa 2005). *Roles and responsibilities* encompass the obligation of the registered nurse to take charge of the patient's healthcare needs, be it in terms of a written direction to delegate patient treatment, direct nursing care delivery, or in the capacity to advocate for a patient when collaborating with the multi-disciplinary team towards quality health outcomes (adapted from the Nursing Act (South Africa 2005)).

1.6.5 Quality

Quality is a multifaceted concept whose dimensions encompass technical competence, access to service, care efficiency, interpersonal relationships, and safety and continuity in nursing care provision (Mayeng & Wolvaardt 2015:1-2). For the purpose of this study, *quality* in nursing care delivery will be explained as full engagement in meeting the patients' human needs (Burhans & Alligood 2010:1694).

Patients' needs refer to physical, psycho-emotional, social and spiritual needs. For the purpose of this study *quality* refers to a therapeutic patient-nurse relationship that signifies empathetic, caring nursing interactions with intended responsibility and advocacy (Burhans & Alligood 2010:1694). *Quality* nursing care delivery aims to restore health and alleviate pain and suffering, with a significant decline in professional misconduct incidents.

1.6.6 “Back to basics”

The *Back to basics* concept encompasses the nurses' roles and responsibilities as well as the compassionate environment in which the care is provided (Pipe et al 2012:225). “*Back to basics*” nursing care realises through direct care of patients with explicit task descriptions and specified nursing intention (Pipe et al 2012:225). The “*Back to basics*” QI initiative is an ongoing organisational expectation to enhance the nursing workforce's presence, availability and patient-centred therapeutic interaction at the physical bedside in the nursing unit.

1.6.7 The “Back to basics” organisational quality improvement (QI) initiative

The “Back to basics” QI initiative forms part of the QI strategies that the healthcare organisation drives to enhance patient-centred care at the physical bedside of the patient. For the purpose of this study, the “Back to basics” QI initiative is regarded as an ongoing initiative which aims to enhance physical involvement and presence of the registered nurse towards the patient as process owner of basic nursing care.

The registered nurse is legally mandated as an active participant in basic nursing care delivery (South Africa 2005) and is held accountable for execution of the nursing regimen to ensure safe and efficient nursing care.

1.6.8 Clinical practice environment

For the purpose of the study, the *clinical practice environment* will refer to the nursing discipline of general nursing care in an acute care hospital context where the majority of patients are considered stable and uncomplicated on the healthcare continuum. Acute care includes promotive, preventative, curative, rehabilitative or palliative nursing interventions with the primary focus of health improvement where effectiveness depends on time-sensitive and often rapid care intervention (WHO 2013:386). This study applied the concept from the stance that the *clinical practice environment* aims at the improvement of health by means of efficient diagnosis, treatment and rehabilitation of sick people (WHO 2013:386).

1.6.9 Assessment-delegation-supervision triad

For the purpose of the study, the term *assessment-delegation-supervision triad* refers to three interrelated responsibilities that the registered nurse has to execute to direct and coordinate nursing care through the efficient utilisation of human resources to enhance quality nursing care.

1.7 OVERVIEW OF RESEARCH DESIGN AND METHODOLOGY

Methodology refers to the methods applied to conduct research (McNiff & Whitehead 2011:34). Table 1.1 provides a summary of the research methods that were applied in

this study. Chapter 2 provides a detailed description of the research design and methodology that were applied in this study.

Table 1.1 Summary of the research methods

Research methodology	A qualitative study
Research design	An explorative and descriptive contextual study design.
Population	The population for the study consisted of nurses with a direct involvement in nursing care delivery at the bedside of patients within the general nursing care context of a private hospital. The accessible population consisted of nurses with work experience in a general nursing discipline.
Sampling method	Purposive sampling.
Data collection	Focus groups.
Data analysis	Creswell's data-analysis cycle.

1.8 RESEARCH SETTING

Research setting refers to the site or location used to conduct a study (Grove et al 2015:276). The research setting was private hospitals within a particular hospital group in Gauteng; participants were recruited from the general nursing care units where their professional operational duties constituted the delivery of general nursing care to patients.

1.9 TRUSTWORTHINESS

Tappen (2011:153) defines trustworthiness as the adherence to high standards when conducting research. The goal of rigour in qualitative research is to represent the experiences of study participants accurately (Streubert & Carpenter 2011:48). Trustworthiness was maintained through consistent employment of the underpinning principles of credibility, dependability, transferability, authenticity and confirmability. Adherence to and maintenance of these principles is described in Chapter 2.

1.10 ETHICAL CONSIDERATIONS

Ethical considerations guide decision-making and direct accountability during the research process (Norwood 2010:69). The Research Ethics Committee of the University of South Africa (Unisa) provided an ethics clearance certificate in confirmation of study

approval. Ethical principles were maintained to safeguard the rights of the institution, including the research sites, as well as to protecting and maintaining the rights of the study participants. The researcher committed fully to the sacredness of research ethics and acquainted herself with Unisa's tutorial letter to guide ethical decision-making during dissertation development.

1.11 SCOPE OF THE STUDY

The scope of the study involved private hospital settings within a private hospital group. The healthcare group is one of three leading private hospitals in South Africa, with an extensive hospital network that includes 63 hospitals, with an overall bed capacity of almost 8 000 beds. The hospital group owns hospitals within a comprehensive geographic spread in seven of the country's nine provinces, with representation in the most popular metropolitan areas, including Johannesburg, Pretoria, Cape Town, Port Elizabeth, East London and Bloemfontein, as well as KwaZulu-Natal. Among various specialised units, the hospital group's division currently operates 56 acute care facilities. The three hospitals utilised as research sites during data collection fall within the Gauteng province.

1.12 STUDY LIMITATIONS

Possible limitations of the study could be that nurses working in the clinical environment might have perceived the researcher, as an educator, as not being part of the clinical workforce, with limited understanding of the clinical practice environment. The researcher reduced the potential limitation during the introductory phase of the focus groups by explaining that as a nurse educator she is involved in the practice environment when doing clinical accompaniment and when engaging with patients and students during experiential learning sessions in the practice environment to enhance theory-practice correlation.

Conducting research on a topic that could affect the nurses' professional work integrity might evoke in participants a fear of being judged when disclosing their experiences and perceptions regarding the clinical practice environment. The researcher reduced the potential limitation by maintaining open, transparent communication with the participants. The researcher established an open, honest, trust-based relationship with the participants

to obtain an in-depth understanding of the registered nurses' views and challenges. The participants shared their experiences spontaneously and freely in cognisance of the ultimate aim that their real-world experiences would assist the researcher to make recommendations to improve the clinical practice environment.

1.13 STRUCTURE OF THE DISSERTATION

Chapter 1 presents the introduction and overview of the study.

Chapter 2 outlines the research design and methodology.

Chapter 3 presents the data.

Chapter 4 provides a discussion of the findings and the integrated literature.

Chapter 5 concludes with findings of the study, discusses its limitations, and makes recommendations. Practical recommendations are provided to the healthcare institution to institute QI initiatives at the bedside of the patient. Study recommendations are provided for nursing practice, the healthcare institution and nursing education and suggestions made to augment existing plans for continuing professional development to address the dynamic developmental needs of the registered nurse in managing the nursing unit. Recommendations for further research are provided.

1.14 SUMMARY

Chapter 1 presented an overview of the study. The background, research problem, purpose, objectives and a brief summary of the research methodology have been addressed. The methodology of the study is described in Chapter 2.

CHAPTER 2

RESEARCH DESIGN AND METHOD

*“Give me six hours to chop down a tree
and I will spend the first four hours sharpening the axe”.*

Abraham Lincoln

2.1 INTRODUCTION

New knowledge about the world must constantly be generated for society to progress (Bless, Higson-Smith & Sithole 2013:1). Knowledge of nursing research enhances professional practice for the research consumer as well as for the research producer (Polit & Beck 2012:22). Chapter 2 presents an in-depth discussion of the research design and methodology, and application of criteria to enhance trustworthiness and adherence to the ethical principles of the study.

2.2 RESEARCH SETTING

Grove, Burns and Gray (2013:709) suggest that research ‘setting’ refers to the location for conducting the study. According to Tracy (2013:8), the field of study is the collection of spaces and places in which the phenomenon may be found and explored. Grove et al (2015:277) state that descriptive qualitative studies are often conducted in a natural setting that represents the real-life situation of the environment. The research site for this study was a private healthcare hospital group in one of the nine provinces in South Africa. Three private hospitals within a private healthcare group located in Gauteng were utilised as the research setting to conduct the focus groups.

2.3 RESEARCH DESIGN

Creswell (2013:49) states that a ‘research design’ is the plan for conducting a study. Grove et al (2015:511) explain that a research design is a blueprint for conducting a study to guide its planning and implementation towards the intended goal. The researcher developed a diagram (Figure 2.1) to depict the blueprint that guided this study towards the attainment of accurate and valid findings.

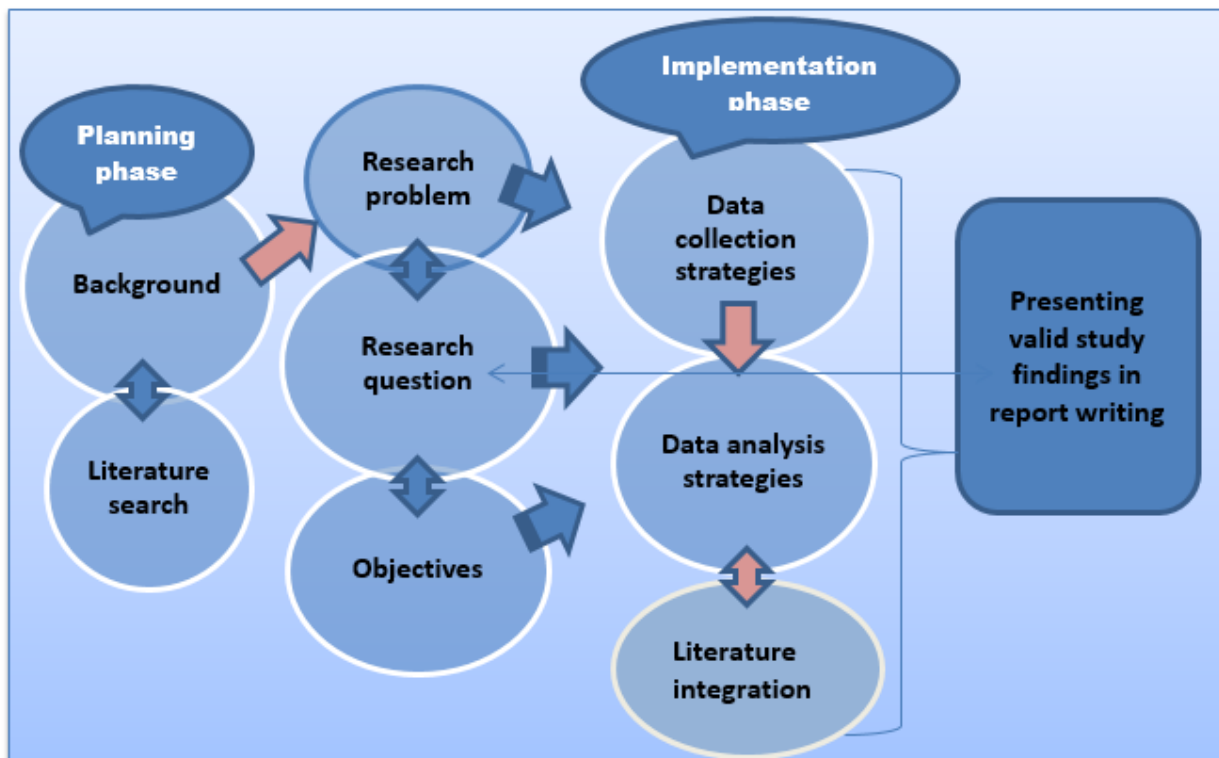


Figure 2.1 Research design blueprint

(Adapted from Yin 2011:76)

2.3.1 Qualitative design

Polit and Beck (2012:17) suggest that the general purpose of nursing research is to answer questions or solve problems relevant to the nursing profession. Qualitative research is a systematic, subjective approach to describe inner life experiences and situations from the perspective of the participant and to explore how meanings are formed and transformed, towards comprehensive, holistic discovery of the phenomenon under study (Corbin & Strauss 2015:4-5; Grove et al 2015:20; 67). Sutton and Austin (2015:226) argue that qualitative research enables access to the thoughts and feelings of research participants, which enables the development of understanding of the meaning that people ascribe to their experiences. Holloway and Wheeler (2010:11) suggest that the qualitative research design adopts a person-centred and holistic perspective to generate data on real-life human experiences. The qualitative research design enabled the researcher access to the participants' thoughts and feelings towards comprehensive understanding of their experiences pertaining to the phenomenon under study.

Grove et al (2015:20) indicate that qualitative research is conducted to promote understanding of human experiences portrayed as emotional responses with the aim of understanding behaviour and developing theories that describe these experiences and situations. The qualitative study approach was useful in this study to enable deep understanding of human experience when facing the challenges underlying the roles and responsibilities for providing basic nursing care delivery at the bedside of the patient, within the social realities of workforce and work quality demands.

The interactive, subjective holistic qualities of the qualitative research design are outlined in Table 2.1 to describe the application of the qualitative research characteristics to this study.

2.3.2 Exploratory-descriptive qualitative research

Exploratory research is undertaken to contribute to the larger body of knowledge by generating new ideas about the phenomenon under study (Grove et al 2013:370). Grove et al (2015:277) indicate that descriptive qualitative studies are often conducted in a natural setting that represents the real-life situation of the environment. The exploratory-descriptive design of this study enabled the researcher to generate new ideas through the exploration of nurses' perceptions pertinent to their real-lived roles and responsibilities in the natural setting of the clinical practice environment. The focus-group technique enabled exploration and descriptions of real-life first-hand experiences based on the participants' subjective understanding of the clinical practice environment. These dense descriptions of experiences that emerged during data analysis enabled the researcher to develop insight and construct an in-depth understanding regarding the registered nurses' challenges that materialise from their daily roles and responsibilities to sustain patient-centred basic nursing care delivery.

2.3.3 Characteristics of qualitative research

Creswell (2013:45-47) provides a collective outline of qualitative research characteristics. The researcher combined Creswell's outline with the work of three other researchers in support of the versatility underlying the qualitative research methodology. The following collated characteristics illustrate the application of the qualitative research design to justify the choice of methodology used in this study.

Table 2.1 highlights important characteristics of qualitative research and explains the application and relevance of each characteristic to the research design in this study.

Table 2.1 Outline of qualitative characteristics as applied in the study

Characteristic of the qualitative research design	Application to the study
<ul style="list-style-type: none"> • Subjectively valued • Multiple realities • The participants' meanings suggest multiple perspectives on a topic with diverse views • Human behaviour is influenced by past and present experiences, as well as by physical, psychological and social context of behaviour or experience 	<ul style="list-style-type: none"> • Participants provided accounts of their individual subjective perceptions of the phenomenon of inquiry. • The grand tour question utilised as data collection strategy enabled each of the participants to share their own perspectives and diverse views based on individual experiences. • The focus of the enquiry was the nurses' perceptions and understanding of their real-world experiences (ranging from their earliest impressions to their current experiences) as nurses being involved in basic nursing care delivery at the bedside of the patient.
<ul style="list-style-type: none"> • Meaning is subjectively created by individuals and intersubjective (created by groups) • Knowledge is co-constructed by the persons involved in an interaction 	<ul style="list-style-type: none"> • The researcher valued the notion that participants as individuals derive their own understanding of the work situation based on their unique framework of experiences, individual value systems and mental models. • The focus group technique utilised to collect data collection enabled self-reflection within the group. One participant's thoughts stimulated the thinking process of other participants. • Subjective perceptions of individual experiences elicited the construction of shared realities. • The data analysis process enabled the researcher to develop subcategories from the participants' collective realities.
<ul style="list-style-type: none"> • Aimed at discovery, description and understanding of subjective realities • Interpretative • Commitment to participants' viewpoints 	<ul style="list-style-type: none"> • The individual participants perceive their external environment uniquely. • The focus group technique enabled the discovery of data and the description thereof during the data analysis process was based on the construction of subjective realities underlying individual mental processes and personal experiences.

Characteristic of the qualitative research design	Application to the study
	<ul style="list-style-type: none"> Multiple realities of participants' experiences were discovered through a process of understanding the contextual and universal ranges of perceptions pertaining to the participants' operational duties in the work environment. Communication, expression (non-verbal communication) and language (textural descriptions) with participants facilitated dense descriptions of nurses' real-lived experiences in the clinical work environment. As the researcher engaged with and became submerged into the data during data analysis, understanding led to progressive insight into the registered nurses' roles, responsibilities and perceived challenges in the realisation of "Back to basics" nursing care.
<ul style="list-style-type: none"> The researcher becomes part of the research process Researcher as key instrument The researcher becomes intensely involved Researchers become the research instrument 	<ul style="list-style-type: none"> The researcher became instrumental in the discovery of the participants' real-world experiences through the process of data collection and simultaneous data analysis. The researcher submerged herself in the data through vigorous listening and note-taking of the audio-recordings, data transcription, repetitive reading of the collected data while engaging in self-reflexivity to discover the real-world experiences and perceptions of the participants, while bracketing her own views and experiences pertaining to the roles and responsibility expectations of the registered nurse. A vigorous review of recent literature and regular discussions with the study supervisor enabled the researcher to become part of the research process towards data discovery and constructing understanding and insight of the phenomena under study. Being the key instrument in this qualitative study enabled in-depth discovery of the participants' perceptions in the real, lived clinical practice environment.
<ul style="list-style-type: none"> The whole is greater than the parts Holistic account Strive for an understanding of the whole 	<ul style="list-style-type: none"> The grand tour question initiated group discussion and focus groups commenced with the sharing of individual perspectives.

Characteristic of the qualitative research design	Application to the study
	<ul style="list-style-type: none"> • The interaction process of sharing individual views and experiences in context of a shared practice environment facilitated self-reflection amongst the participants. • Multiple realities emerged from the participants' experiences as they developed confidence during the engagement process. • During the data analysis process, single perceptions evolved into multiple shared realities amongst the participants. • The various parts of all participant's experiences and perceptions were collated when data analysis commenced after focus groups. • The process of data de-construction and re-construction enabled the researcher to explore, describe, understand and develop understanding of the bigger picture where complex transactions represent more than the individual perception in the clinical practice environment. • The researcher developed insight during the data analysis process into the fact that the sum of individual reality represents a holistic account of similarities in perceptions and experiences by a diverse population within a similar circumstantial context. • Conclusions and recommendations were derived from the entirety of the participants' accounts of their individual experiences regarding the execution of their roles and responsibilities to support the QI initiative "Back to basics" in the general nursing context.
<ul style="list-style-type: none"> • Context dependent • Natural setting 	<ul style="list-style-type: none"> • The data was obtained in context of the nurses' clinical work environment in the medical and surgical units with a direct involvement in patient-centred nursing care delivery. • Data was collected from participants who were working in the natural setting of the clinical practice environment with real-world contextual role players, where they experience challenges pertaining to the delivery of basic nursing care at the bedside of the patient.
<ul style="list-style-type: none"> • Is flexible and capable of adjusting to new information during the course of data collection 	<ul style="list-style-type: none"> • The participants had freedom of speech to explain their operational roles, responsibilities and challenges without the

Characteristic of the qualitative research design	Application to the study
	<p>restrictions of a narrowed, structured interview guide.</p> <ul style="list-style-type: none"> • The flexibility of the unstructured focus group process enabled the researcher to clarify statements and to gain further information regarding the individual and/or collective responses of the participants. • Open-ended probing questions became more focused as data collection and analysis assisted the researcher to develop insight in towards the eventual construction of new knowledge. • The grand tour sentence construction was slightly rephrased during the course of data collection to ensure that the participants were clear on the question. • Non-verbal language cues prompted the researcher to elicit more in-depth data through open-ended probing.
<ul style="list-style-type: none"> • Complex reasoning through inductive and deductive logic 	<ul style="list-style-type: none"> • The researcher followed a systematic backwards and forwards reciprocal working procedure between the textured descriptions of participants' data. Data was deconstructed into small meaning units of similarities. • The researcher built patterns and identified trends in order to group clusters of information together. Subcategories were developed based on the data that emerged during focus groups. • The subcategories were constructed into categories, representing an authentic and comprehensive account of the database. • Finally, themes were formulated to represent a holistic account of the data that emerged from the focus groups.
<ul style="list-style-type: none"> • Emergent design that evolves as researchers make ongoing decisions • Involves ongoing analysis of data to formulate strategies to determine when saturation of data has been reached 	<ul style="list-style-type: none"> • The researcher applied a systematic process of going back and forth between data and literature to verify multiple realities by trustworthy and scientific deductions. The researcher continuously built knowledge, understanding and insight during the data analysis cycle. • Data analysis started off with the identification of a few core experiences during the first focus group, but as the researcher engaged in data analysis with follow-up focus groups, a pattern of

Characteristic of the qualitative research design	Application to the study
	<p>similarities in participant experiences became evident.</p> <ul style="list-style-type: none"> • The data collection process became more focused as the researcher became sensitised to the core concepts that emerged during the focus groups and probing questions elicited responses that augmented the growing database. • As the researcher engaged with the data by doing ongoing analysis integrated with relevant literature, the realisation was reached that no new responses were evoked by the participants, despite repetitive probing and open-ended questioning. • After data collection from four focus groups, it became evident that data saturation had been achieved.
<ul style="list-style-type: none"> • Reflexivity 	<ul style="list-style-type: none"> • The researcher had to bracket her own background, experiences, and perceptions with regard to the operational roles and responsibilities of the registered nurse in terms of basic nursing care delivery. The researcher kept a personal journal to reflect on her own ideas, the research supervisor's inputs and feedback, challenges and mind mapping to make sense of the complexities underlying the registered nurses' roles, responsibilities and challenges to support the "Back to basics" QI initiative at the bedside of the patient.

(Adapted from Creswell 2013:45-47; Polit & Beck 2012:487-489; Streubert & Carpenter 2011:20-23)

2.4 RESEARCH METHODS

A research method is the application of systematic techniques to structure a study in terms of data gathering and analysis that corresponds to the relevance of the research question (Polit & Beck 2012:12, 741). Thoughtful consideration went into the development of research methods to select the most suitable population with characteristics essential to provide comprehensive answers to the research question. The research methods applied in this study are discussed in terms of the population and its essential characteristics for inclusion in the study, and the sampling process.

2.4.1 Population

A population is defined as the entire aggregation of individuals that share the defining characteristic of interest to the researcher (Polit & Beck 2012:59, 273). Bless et al (2013:164) suggest that a population is sometimes referred to as a target population and explain that a population is a set of elements which the research focuses upon. Grove et al (2015:46, 250) add that a population consists of individuals that meet specific criteria pertaining to the focus of the study. Registered nurses working in acute care hospitals with a direct patient care involvement in medical and surgical nursing units encompass the characteristics of interest in view of the research question.

2.4.1.1 Accessible population

Polit and Beck (2012:274) and Grove et al (2015:250) explain that the accessible population is a portion of the target population, conforming to the distinctive criteria, to which the researcher has reasonable access. The accessible population of this study consisted of registered nurses working in the medical or surgical units in hospitals within a private hospital group in Gauteng.

2.4.1.2 Eligibility criteria

Grove et al (2015:251) explain that eligibility criteria encompass the essential characteristics according to which the sample is selected from the accessible population. Bless et al (2013:164) emphasise the importance of having a well-defined population and adequate sample, because a sample is considered to be adequate if it represents the full range of elements of the phenomenon under study, to enable data saturation.

Eligibility criteria enabled the researcher to obtain in-depth experience from the most suitable participants within the accessible population. Qualitative research focuses on experiences and events within the setting of inquiry (Grove et al 2015:270). Permanently employed nurses who had worked in the medical-surgical nursing discipline for a period of two years and longer were included to ensure that they had a clear understanding of the work-related culture and work processes related to the clinical practice environment. All participants that assumed duty in the general nursing discipline, whether on day-duty or night duty or mixed shifts, were eligible for inclusion in the study, to enhance adequate

representation of real-world contextual experiences of different unit-related work dynamics.

Eligibility criteria for this study included:

- Participants had to be registered under the Nursing Act (Act 33 of 2005) as registered nurses (South Africa 2005).
- Participants had to have been employed as permanent employees within the private hospital for a period of two years or longer.
- Participants had to be directly involved in patient care within the general nursing science discipline.
- Participants had to be working day-, night shifts or mixed shifts

2.5 SAMPLING APPROACH AND TECHNIQUE

Grove et al (2015:511) define sampling as a process of selecting a group of people that are representative of the population under study. Yin (2011:88) indicates that sampling of participants in qualitative research is utilised to ensure that the researcher obtains the most relevant and broadest range of information and perspectives on the subject under study.

The registered nurse category was included in this study in view of such a nurse's legal mandate as process owner of basic nursing care delivery. The study focused on the QI initiative "Back to basics" nursing care; where patient-nurse interaction and direct patient care involvement is imperative in the provision of nursing care.

2.5.1 Non-probability sampling approach

In quantitative studies, it is of the utmost importance that researchers obtain a representative sample in order to generalise the findings from the sample drawn from the accessible population and then, more abstractly, to generalise the findings to the target population (Grove et al 2015:250).

Etikan, Musa and Alkassim (2016:1) explain that non-probability sampling is a sampling technique in which not all participants in the population have an equal chance of inclusion

in the study. Bless et al (2013:175-176) and Etikan et al (2016:1) concur that qualitative research using the non-probability sampling approach does not concentrate on a representative portion of the population at large to draw inferences from the sample to the population. Grove et al (2015:267) propose that qualitative researchers pursue participants with experience of the phenomenon under investigation.

A non-probability sampling approach was used in this study – pursuing participants with extensive knowledge about the roles, responsibilities and challenges of registered nurses to support the “Back to basics” QI initiative in the clinical practice environment.

2.5.2 Purposive sampling technique

Purposive sampling is defined as a sampling strategy whereby participants are recruited consciously by the researcher as sources of data that are able to provide and expand upon the data that is required to achieve the study aims (Grove et al 2013:268; Grove et al 2015:270). Gray (2014:217) indicates that purposive samples are used when particular people, events and settings are chosen because of unique capabilities to provide important information that would have been unachievable through other sampling designs.

Grove et al (2015:270) and Tracy (2013:134) confirm the fact that in purposive sampling the researcher deliberately includes specific participants to fit the parameters of the study’s research question, goals and purposes. For the purpose of this study, the researcher intentionally selected the registered nurse category in view of the initial literature review that cited the registered nurses’ custodianship as process owners of quality nursing care at the bedside of the patient. The establishment of eligibility criteria enhanced the contextual focus aiming to obtain an in-depth account of the roles, responsibilities and challenges as perceived by registered nurses in the realisation of the “Back to basics” QI initiative at the bedside of the patient.

2.5.3 Sample size

The sample size must be considered with the aim of obtaining rich descriptions from participants to enable the researcher to gain insight into and describe an important situation related to the healthcare environment (Grove et al 2015:264).

Grove et al (2013:371) and Yin (2011:89) indicate that there is no fixed formula to determine the desired number of samples for data collection in a qualitative study. Yin (2011:92) argues that larger sample sizes are not the only way to enhance trustworthiness. For the purpose of this study, a sample size of 24 participants produced in-depth data on the specific focus of inquiry. The data collection process continued until it became evident that the participants were repeatedly describing similar perceptions with regard to their roles, responsibilities and challenges to support basic nursing care delivery in the clinical practice environment. Polit and Beck (2012:521) indicate that the guiding principle of sample size is directed by the principle that sampling of participants will continue to the point at which no new information is obtained from focus groups and data saturation is achieved. The information emerged as dense descriptions of the real-life operational experiences in the clinical practice environment. Data saturation was achieved after four focus groups.

2.6 DATA COLLECTION

Creswell (2013:147) explains that data collection is a series of interrelated activities aimed at gathering sound information to answer the research question. Sutton and Austin (2015:227) indicate that the data collection process often involves the generation of huge amounts of data in the form of audio recordings, with large volumes of transcribed dialogue and field notes to complement the audio-recorded interviews. For the purpose of this study, data collection generated large volumes of audio-recorded transcriptions and field notes to enable deep exploration of nurses' perceptions regarding their roles and responsibilities in supporting patient-centred basic nursing care delivery.

2.6.1 Data collection approach

Corbin and Strauss (2015:38) indicate that unstructured interviews provide the richest data, because participants are enabled to talk freely about the issues and challenges pertinent to their situation. Unstructured approaches to data collection enable the formulation of a list of possible answers aimed at the discovery of new aspects of the problem by exploring the detailed explanations of participants (Bless et al 2013:197). For the purpose of this study, a "grand tour" question (Annexure 10) initiated discussions during the data collection process. The participants were encouraged to share their

individual perceptions spontaneously and to share additional ideas in view of other participants' contributions to the topic within the focus range of the grand tour question.

2.6.2 Data collection method

Gray (2014:470) proposes that focus groups as a method of data collection are utilised to understand the experiences within the particular phenomenon under study and explore the feelings, attitudes, beliefs, reactions and experiences of participants, which would not be so accessible through other data collection approaches. Focus groups are a valuable strategy for qualitative researchers because the technique aims at promoting self-disclosure among participants (Streubert & Carpenter 2011:27). The most beneficial feature of focus groups is their "robust versatility to shed light on almost any topic or issue", because they capitalise on the synergistic building of data; the interaction between participants expressing their views is likely to provide the best information (Creswell 2013:164; Gray 2014:469). For the purpose of this study, the focus group method evoked the individual voice and simultaneously facilitated the participants' collective perceptions and experiences pertaining to their roles, responsibilities and challenges to support the "Back to basics" QI initiative. The researcher utilised an experienced co-facilitator to record non-verbal responses and guide probing questions to limit desirability bias, if any would occur.

Gerrish and Lacey (2010:366) and Streubert and Carpenter (2011:39) suggest two distinctive processes that are present in focus groups: group *focus* and group *interaction*. Streubert and Carpenter (2011:39) suggest that a good focus group session provides the opportunity to learn about *the focus* as well as from *the group*. In this case the *focus* of the group was initiated with the grand tour question. The participants elaborated spontaneously on their individual operational experiences in the clinical practice environment.

The dynamics with regard to *group interaction* enabled individual participants to measure their own understanding and insights against the perceptions and opinions of other participants. In this study, the reflection-in-action process stimulated narrowed exploration of the phenomena under study, which enhanced the depth and quality of the participants' descriptions. As group interaction intensified, participants built confidence to share the detail of their individual and collectively constructed multi-faceted operational

realities. Grove et al (2013:274, 278) suggest that focus groups signify more than overt communication in expressing and clarifying personal views, because participants apply non-verbal clues, gestures, facial expressions and other body language as an extension of the overt verbal message. To enhance the dynamics between group *focus* and group *interaction*, an experienced co-facilitator observed and recorded group interaction that emanated from covert communication cues and non-verbal gestures as participants agreed with and supported the perceptions and challenges of each other.

2.6.3 Data collection process

Grove et al (2013:691) explain the data collection process as a systematic process to accumulate information that addresses the study's aim and specific objectives. Bless et al (2013:194) state that a pilot study assists the researcher in the formulation of clear questions while focusing on the sequence of the presentation. Bless et al (2013:194) and Creswell (2013:165) suggest that pilot testing provides a basic indication of how participants respond to the question frame, and facilitates the collection of background information. For the purpose of this study, the data collection process commenced with a pilot study with participants who met the eligibility criteria. The researcher assessed the quality of responses from participants when applying an unstructured approach to data collection and tested the efficiency of verbal and non-verbal communication to elicit maximal responses from the participants. The central question enabled in-depth discussion in respect of the purpose of the study. The participants signed informed written consent and this data was included in the study.

Gray (2014:60) suggests that qualitative researchers provide detailed descriptions of how the data collection instrument was constructed to arrive at trustworthy findings. The researcher utilised the following four phases to enable the systematic collection and accumulation of information by means of focus groups.

Written approval from the healthcare institution (Annexure 3) and permission from the respective research sites to conduct the study (Annexure 5) initiated the preparatory phase of the data collection process.

2.6.3.1 Preparatory phase

Grove et al (2013:274) suggest that the effective use of focus groups requires careful planning. Preparing for the focus groups entailed a systematic coordination of various activities towards the eventual success of data collection. Tracy (2013:169) explains that focus groups require a combination of event planning and organisational skills. The planning tips and guidelines of Tracy (2013:169-171) and Grove et al (2013:274-276) were applied as follow in this study to ensure systematic data gathering:

- *Accessibility to participants*

Prior to the actual logistical preparation for conducting a focus group, the researcher engaged with the various research sites to apply for permission to conduct the study at the respective research sites (Annexure 4). When permission was formally granted by the respective research sites to conduct the study (Annexure 5), the researcher commenced with the recruitment process for appropriate participants.

- *Recruiting appropriate participants*

Grove et al (2013:275) reiterate the importance of recruiting appropriate participants to avoid failure in the data collection process of the study. Rapport was established with participants from the accessible population to establish trust in the researcher-participant relation and to provide information regarding the topic of the study. Information leaflets (Annexure 6) were handed out to prospective participants to take home and consider participation without coercion. To ensure uncompromised continuity in patient care delivery, the duration of focus groups, which were each anticipated to last between 60 and 90 minutes, was included in the information leaflet, to enable participants to organise off-duty time, or alternatively to arrange for a stand-in whilst participating in a focus group. Between five and seven participants participated in each of the various focus groups.

- *Confirmations*

The participants who indicated their willingness to participate in this study were contacted in advance of the scheduled focus group date to confirm attendance, and reminding them

about their rights as participants, the estimated duration of the focus group and venue location.

- *Facility and location requirements*

When selecting the most suitable location for focus groups, the researcher ensured that venues were easily accessible, and were a place where participants could share their perceptions and experiences in a private, comfortable setting. One focus group was held in a classroom and three focus groups were held in meeting rooms of the particular research site. The locations were secured with a scheduled booking in advance and confirmed beforehand with the designated logistic managers.

Chairs and tables were positioned in such a way that every participant could form part of the discussion. A “Do not disturb – focus group in progress” notice was affixed to the door of the venue to reduce the risk of interruptions and ensure privacy and confidentiality of information during focus groups.

- *Payment/compensation*

The researcher provided refreshments to enhance comfortable social interaction amongst the participants as well as with the researcher and co-facilitator. The provision of refreshments facilitated a relaxed inviting atmosphere before commencement of a focus group. The participants were not financially remunerated for their participation in this study.

- *Focus-group responsibilities*

An experienced co-facilitator was utilised to take field notes regarding group dynamics. The co-facilitator was positioned at the side of the room to enable unobstructed observation of non-verbal gestures. The researcher managed her own technological device to audio-record focus groups. The grand-tour question was printed and laminated on an A4 paper to enhance articulation of the central question.

Before commencement of focus groups, the Information leaflet (Annexure 6) that participants had received during the recruitment phase was discussed again, to ensure

that participants were well aware of their rights and responsibilities and that all potential queries of participants had been addressed before commencement of the focus group. Participants signed the following documentation before progressing to the central question that facilitated the focus of the discussion:

- Written informed consent forms, in confirmation that they understood the aim of the study and their ethical rights as participants in this study (Annexure 7).
- A confidentiality binding form, to formalise their personal commitment towards the healthcare institution and the co-participants to maintain confidentiality of information during focus groups, as well as adhering to the ethical principle of privacy of the other participants and the healthcare institution (Annexure 8).
- Demographic questionnaires (Annexure 9), which formed part of the data analysis process.

2.6.3.2 *Focus group introductory phase*

Yin (2011:140) suggests that the entering dialogue sets an interpersonal tone that will carry into the substance of interaction and conversation. The researcher welcomed the participants, introduced herself and the co-facilitator and repeated the purpose of the focus group as set out in the Information leaflet (Annexure 6). As an ice-breaker, the researcher utilised a graphic image of the ripple effect (Annexure 10) to symbolise the effects behind a single ripple that could be caused by individual actions and how it can spread out to affect and influence others. After confirming the anticipated timeframe for the focus group, participants were granted the opportunity to introduce themselves to enhance psychological comfort and confidence during group participation.

Group norms were established with the total of 24 participants that participated in the four focus groups. This was to facilitate mutual respect and allow every participant an equal opportunity to share his or her views. The ethical principle of maintaining confidentiality of information and privacy of co-participants within the healthcare setting was reiterated before commencement of focus groups.

2.6.3.3 *Facilitation of the focus groups*

The facilitation phase of data collection is discussed in terms of the two distinctive processes as mentioned above: ‘the focus’ and ‘the group’ as suggested by Gerrish and Lacey (2010:366) and Streubert and Carpenter (2011:39):

- *The focus*

The study focused pertinently on the QI initiative “Back to basics” nursing care, where the patient-nurse relationship is considered as a fundamental strategy to enhance the quality of patient care by means of the nurse’s direct involvement with the patient through the execution of the nursing regimen.

Yin (2011:137) proposes that grand tour questions be used to start the conversation. After the introductory phase, the researcher continued to the grand tour question to initiate the *focus* of the group. The grand tour question, which was directly linked to the research topic, was provided to participants in tangible typed and laminated format to state and refer back to the main focus of inquiry.

The grand tour question (Annexure 10) was presented as:

“How do you perceive your own roles and responsibilities in the realisation of “Back to basics” to enhance quality nursing care at the bedside of the patient?”

Grove et al (2013:276) suggest that the participants should be provided with opportunities to express their views on the topic of discussion early in the session. After the grand tour question was presented, the researcher encouraged the participants to freely express their views and understanding regarding “Back to basics” nursing care delivery. The discussions were initiated with a single perception that led to another opinion and gradually evolved into full-scale discussions among the participants, describing their perceptions in the context of their operational challenges. The focus group technique enabled the construction of multiple realities from the participants’ viewpoints.

Tracy (2013:172) proposes that the act of listening includes obtaining clarification from participants, paraphrasing comments and using the probing technique to enhance listening, and leading the focus of the discussion. The researcher maintained authentic interest during the focus groups by engaging in listening attentively to the individual experiences of the participants. Throughout the focus groups the researcher maintained interpersonal rapport with eye-contact, receptive body language and inclusion of all participants during the focus groups. The researcher consciously limited non-verbal gestures such as facial expressions to avoid conveying suggestions to participants that could have been perceived as concealed prejudice against the real-life perceptions of registered nurses in the clinical practice environment.

The discussion revolved mainly around the challenges experienced by the participants that compromised their ability to deliver quality nursing care at the bedside of the patient. The researcher reflected on the comments to clarify the exact meaning of their experiences. The technique of prompting was applied by asking the participants to provide examples to explain the magnitude of operational roles and responsibilities that consume their daily work time. The participants provided examples and detailed descriptions, with emphasis on the work-related expectations that challenge their ability to support the “Back to basics” QI initiative.

Bless et al (2013:239) propose that the flexible nature of qualitative research enables the researcher to effect changes after the study has commenced. Steward and Shamdasani (2015:70) indicate that the researcher can modify the line of questioning, which leads to a rephrased question for the focus groups to follow. As the data analysis process evolved, after obtaining data from the second focus group in this study, the analysis of existing data suggested that participants were disengaged from direct patient care for a variety of organisational and functional reasons. Bless et al (2013:239) advise that decisions about changes to the questioning approach must be made in consultation with other researchers. After thoughtful deliberation with the supervisor, the researcher rephrased the central question to enhance participant responses in view of the slight probability that the question might be failing to direct their attention towards the real focus of the question. The flexible nature of the study design assisted the researcher to ensure that the grand tour question would enable clear answering towards the focus of the study. The grand tour question was rephrased (Annexure 11) as follows:

“In terms of basic nursing care delivery at the bedside of the patient, how do you perceive your roles and responsibilities in the QI initiative “Basic to basics” nursing care?”

Data analysis did not provide new data thereafter, as participants directed their focus onto the myriad of managerial-administrative responsibilities and other work-related expectations that compromised their ability to support “Back to basics” nursing care in terms of direct care. Data saturation was achieved after three focus groups, but the researcher continued to include a fourth focus group to enhance confidence in the truthfulness of data.

- *The group*

Tracy (2013:167, 169) refers to the group effect and suggests that participants be strategically combined in focus groups to produce insights that result from group reaction to shared experiences. In this study, the researcher included participants with shared operational role and responsibility expectations in similar work-related circumstances from three different research sites. The majority of participants engaged enthusiastically in the discussion and shared their perceptions openly and honestly. Grove et al (2013:2760) suggest that the pronounced perceptions of fluent participants break the ice for the less forthcoming participants. In this study, the establishment of an unbiased, receptive group climate, coupled with good group cohesion during the focus groups, enabled the less talkative participants to share their perceptions with more ease.

When group members interrupted each other, the researcher maintained eye contact with the interrupted participant and paraphrased the most recent statement. This facilitation technique focused attention back to the participant’s opinion. The researcher then clarified the statement and asked the opinion of the participant who had interrupted the conversation. In this way, participants were provided equal opportunity to express their individual perceptions based on their accumulated clinical experiences.

Tracy (2013:172) indicates that it could be challenging if all the participants do not contribute to the discussion. During one particular focus group, the researcher noticed early into the focus group that one of the participants did not contribute to any discussion. The researcher attempted to include the participant by making eye contact but to no avail.

As the focus group continued, the researcher took a more direct approach and probed the silent participant to provide her opinion with regard to another participant's perception. The silent participant indicated that she was in agreement with what had been conveyed. The verbal and non-verbal approach to include the silent participant was repeated to enhance inclusion of all participants in the focus groups.

Grove et al (2013:276) suggest that clarification, paraphrasing and reflection of the statements made by individual participants tend to express group norms. During this study, the participants spontaneously utilised the symbolic gesture of the ripple effect image (Annexure 10) to emphasise how someone else's ideas, experiences and viewpoints stimulated reflection on one's own perceptions.

The participants identified with each other's experiences and challenges in the practice environment and made use of non-verbal language gestures such as expressing "uhm's" and head nodding to portray their agreement and motion of support. Similarities in operational experiences strengthened individual confidence and enhanced synergistic interaction among the participants. Rich in-depth data was obtained from the focus groups because real-life experiences with rich descriptions were elicited from participants when they shared their individual and collective perceptions related to their roles, responsibilities and operational challenges in actualising the "Back to basics" QI initiative among the nursing workforce towards quality nursing care delivery.

2.6.3.4 Exit mode phase

The duration of the focus groups in this study varied from approximately 45 minutes to 90 minutes before the researcher started to conclude the particular focus group. Yin (2011:140) states that the exit mode of focus groups provides opportunities to ask additional substantive questions, because a participant may have the need to say a "last word". In this study, the researcher concluded each focus group by asking if there were any other comments or 'take-home messages' for the researcher before ending the group. The participants mainly opted for a final conclusive remark, but thematically, these comments reflected repetition of aspects already addressed during the intermingled course of data collection and analysis.

Polit and Beck (2012:164, 725) explain that debriefing entails thoughtful communication, such as creating opportunities for final comments, towards the exit mode of the focus group. Debriefing sessions were included after focus groups and the participants were provided with the opportunity to give feedback on how they had experienced the focus group. The debriefing intervention sensitised the researcher to the potential onset of psychological harm and the need to initiate referral of participants for professional debriefing (Polit & Beck 2012:164). Feedback from participants did not suggest any potential of psychological harm done during the execution of focus groups.

2.7 DATA MANAGEMENT

Data managing involves the creation and organising of files for data (Creswell 2013:190). In this study, the process of data management commenced with chronological organisation of all data obtained during the data collection process. All the data were labelled and catalogued in terms of focus group events (per research site and date thereof). Voice recordings of focus groups were saved electronically with a backed-up version of each voice recording per focus group event. Hard copies of the original signed informed-consent documents, demographic data, co-facilitators' notes and the researcher's reflexive notes were catalogued in terms of research sites and date of conduction and kept in a safe. Creswell (2013:180-181) suggests that data analysis commences with data organising. The process of data organising will be discussed as part of the data analysis cycle (Creswell 2013:180-183).

2.8 DATA ANALYSIS

Creswell (2013:180-183) indicates that data analysis is an ongoing and evolving process of continual reflection and learning by doing, to conclude with interpretative findings when answering the research question. Data analysis is an encompassing process that involves organising of the data, conducting a preliminary read-through of the database, coding, theme arrangement and a representation of the data in discussion format towards the final step where interpretations are derived from data themes (Creswell 2013:180). In this study, the researcher applied Creswell's data analysis cycle (Creswell 2013:180-183) as a systematic approach to enhance the trustworthiness of the findings. Creswell's data analysis cycle is discussed according to the following five steps:

2.8.1 Step 1: Organising the data

Data were organised and prepared throughout the data collection phase as focus groups were conducted. Hard copies of individual focus group events were labelled in terms of participants' signed consent forms, demographic data forms, handwritten reflective notes of the researcher and field notes of simple observations made by the co-facilitator.

All four of the focus groups were recorded on a voice recorder. After each focus group, recordings were copied to the researcher's private laptop where hard-disc drive encryption is enabled. Access control was secured via password to safeguard data content and ensure the healthcare organisations' and participants' confidentiality. Separate files were created electronically for each focus group according to the research site and date of the focus group. Copies of focus group recordings were deleted from the audio-recorder after saving and backing-up of each of the focus group recordings. Electronic back-up databases were established on an external USB device; not only were the files encrypted, but also access to the device was restricted by password authentication. The external USB device is kept in a safe.

After ensuring that the information was secured, the researcher engaged with the data by listening to the voice recordings as soon as possible after the exit mode of each focus group. The researcher transcribed one of the focus group's recordings in person. The remainder of the focus group recordings were transcribed by an experienced qualitative researcher in the nursing discipline. Sutton and Austin (2015:228) suggest that the researcher should talk through the research with the transcriber. The researcher and transcriber engaged in a lengthy discussion which included the background, purpose, aims and objectives of the study. On completion of the transcriptions the researcher did data cleaning by reading while listening to the recordings, jotting down notes on the printed transcriptions and ensuring that all identifying cues were removed from the printed versions. The researcher was confident that the transcriptions reflected a true representation of the actual audio-recordings.

2.8.2 Step 2: Reading and memoing

Creswell (2013:183) and Sutton and Austin (2015:228) suggest that researchers should read the transcripts in their entirety to obtain a feel for the participants' perceptions of the

phenomenon under study. Creswell (2013:183) suggests that the process of breaking down into smaller parts should commence after the holistic view is established, The researcher made hard copies of all transcripts and read through them several times to reinforce the general sense of the participants' perspectives. The researcher immersed in the process of repetitive reading aimed at the identification of meaningful statements and relationships between the verbal accounts of the participants' perceptions.

As the researcher developed a feel for the participants' experiences during data reading, she started to think about issues that could be pursued in subsequent focus groups (Sutton & Austin 2015:228). Sutton and Austin (2015:228) explain that data saturation is reached when one participant's narrative informs the next, as the researcher continues data collection with a sensitisation towards things that participants continue to repeat during interviews.

Field notes of non-verbal impressions were collated with textural and structural verbal descriptions to verify congruence between verbal and non-verbal communication. The focus groups' verbal communication did not suggest any incongruence with non-verbal gestures or cues. The researcher became progressively immersed in the data as they were collected and analysed simultaneously. The researcher constantly sought for relationships in the perceptions, opinions, viewpoints and experiences of the participants as data emerged during the focus groups.

2.8.3 Step 3: Describing the data into codes and themes

Sutton and Austin (2015:228) suggest that once all of the research interviews have been transcribed and checked, it is time to begin coding. Coding refers to the identification of topics of similarities and differences that have been revealed through the participants' narratives (Sutton & Austin 2015:228). Sutton and Austin (2015:228) indicate that the coding process enables the researcher to understand the world from the participant's perspective.

Creswell (2013:184) proclaims that the forming of categories represents the heart of qualitative data analysis. Sutton and Austin (2015:228) suggest that coding could be done by making notes on a copy of the transcript. The researcher used text-highlighter colours to cluster similarities in data together to form subcategories. The researcher looked for

significant statements that portrayed how the participants perceived their experiences and understanding pertaining to their own roles and responsibilities when supporting the “Back to basics” QI initiative. As the researcher immersed in the collected data, it became apparent that specific perceptions and shared experiences were repeated. The collected data evolved progressively to strengthen similarities in the perceptions of the participants’ experiences pertaining to their roles, responsibilities and challenges in “Back to basics” nursing care. The researcher listed non-repetitive, non-overlapping statements on a separate list.

Various subcategories were merged together, based on their parallel congruence, to form categories. Categories were formed out of the descriptive subcategories. These reflected the interrelationships between similarities in the participants’ perceptions and experiences with regard to their roles, responsibilities and challenges in providing basic nursing care at the bedside of the patient.

2.8.4 Step 4: Grouping significant statements into themes

Creswell (2013:193) suggests that the researcher take significant statements and group them into larger units of information, called themes. Themes are broad units of information that consist of several codes, to form collective ideas that describe categories. The researcher continued with the systematic process of joining interrelated categories together to derive overarching statements that encompassed the in-depth data of the participants’ perceptions and experiences and challenges of the topic under discussion. The process of grouping significant statements into themes was done in a colour-coded manner during the coding process (Annexure 12).

2.8.5 Step 5: Interpreting the data

Sutton and Austin (2015:229) propose that the data be drawn together to represent truthful research findings. The synthesis of data is done in the final stage of a qualitative study (Sutton & Austin 2015:229). As the ‘story of the participants’ was distilled and summarised, the findings were formulated (Sutton & Austin 2015:229). Findings are presented in Chapter 3 according to the themes, categories and subcategories that emerged during the data analysis process.

2.9 TRUSTWORTHINESS OF THE STUDY

Trustworthiness refers to the degree of confidence that qualitative researchers have in their data when measured against the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck 2012:768). Standards of trustworthiness are used in qualitative research and are equal to those of validity and reliability in quantitative research (Polit & Beck 2012:537). Trustworthiness in qualitative research is an encompassing and deliberate intent from the onset of question formulation to the presentation of conclusions and recommendations in the formal study report. The application of the criteria, originally developed by Lincoln and Guba (1985), is discussed below:

2.9.1 Credibility

Credibility refers to confidence that the findings provide a credible reflection of the truth of the reality under study (Bless et al 2013:236; Grove et al 2015:394; Polit & Beck 2012:585).

Yin (2011:79) suggests various strategies to enhance the credibility of a study, because rich data from participants enhances confidence in the truthfulness of data. The researcher was intensely involved by conducting interviews, analysing data and engaging in co-facilitator discussions with the supervisor and co-coder consensus meetings.

The researcher repeatedly applied the technique of member checking when asking participants, “Do I understand you correctly when you say...” followed by a repetition or rephrased statement to ensure that participants’ real-world experiences were understood in a truthful and authentic manner. Focus groups continued until the researcher realised that data saturation had been attained and no new information could be added to the scope of the inquiry.

Tracy (2013:40, 63) indicates that triangulation refers to the practice of combining various methods of data collection from multiple data sources and using multiple researchers in qualitative studies. Bless et al (2013:238) propose that triangulation is the most frequently used method to increase the trustworthiness of qualitative research. The following methods of triangulation were applied to enhance the credibility of this study:

- **Methodological triangulation**

Bless et al (2013:238) define methodological triangulation as the use of different methods to collect data. Bless et al (2013:340) suggest that the unstructured nature of the focus group approach with limited restrictions encourages in-depth exploration of participants' perceptions towards dense descriptions of their real lived experiences. Audio-recording and transcriptions of the focus groups enabled repetitive engagement with data to secure the reality as conveyed by the participants. Audio-recording of focus groups served as actual and direct data and reduced the need to triangulate because actual data were captured during focus groups (Yin 2011:82). The audio-recordings were secured and stored and are available for verification as actual and direct data of the participants. Methodological triangulation was further enhanced by comparing data transcriptions with the field notes of the co-facilitator. Transcriptions and field notes reflected no incongruence between verbal and non-verbal communication of the participants during the data collection process.

- **Investigator triangulation**

Bless et al (2013:239) explain that investigator triangulation refers to the utilisation of more than one researcher to enhance diversity in data gathering and data interpretation. The research supervisor acted as the co-facilitator during the focus groups and engaged in observation and field note taking to enhance diversity in data collection. The co-facilitator's direct involvement as co-facilitator and respected senior researcher enhanced the trustworthiness of this study's findings. Using a variety of researchers to enhance diversity in data gathering and data interpretation is referred to as investigator triangulation (Bless et al 2013:239). The co-coder of this study holds a PhD degree and contributed to the diversity of data interpretation to enhance investigator triangulation.

- **Theoretical triangulation**

Theoretical triangulation implies the use of different theoretical perspectives in the interpretation of data (Bless et al 2013:239). The researcher utilised recent and relevant literature as a control strategy to contextualise this study's findings against the global and national clinical practice environment. The initial literature review enhanced specific focus during the proposal development phase. As the process of data collection and

simultaneous data analysis evolved, scholarly literature were integrated to contextualise the findings that emerged from the data as control strategy to enhance theoretical triangulation.

- **Data triangulation**

Data triangulation refers to the use of the same method of data collection and analysis with different research participants (Bless et al 2013:238). The focus group technique of data collection was maintained during the course of four focus groups. Creswell's data analysis cycle was utilised throughout the mingled data collection-data analysis process.

2.9.2 Dependability

Dependability refers to the truth value of data over time and over conditions and implies that findings are consistent and accurate (Holloway & Wheeler 2010:303). Thoughtful selection went into identifying the most suitable participants that would be able to provide the best answers to the phenomenon under inquiry within the clinical setting. The researcher recruited participants who met specific eligibility criteria to ensure contextual homogeneity with regard to their first-hand involvement and lived experiences in basic nursing care provision. This strategy ensured that participants with similar role and responsibility expectations shared their experiences within the narrowed focus of the study. Similar content of participants' lived experiences emerged within the four focus groups across different research sites.

The background of the study narrowed the focus of inquiry and subsequently enabled the formulation of the contextual problem statement to obtain accurate findings. Data cleaning ensured that the transcribed data represented a true reflection of what had been recorded. Creswell's data analysis cycle (2013:180-183) was employed continually as a systematic approach of data analysis to enhance the dependability of this study.

2.9.3 Confirmability

Confirmability refers to the degree of bias in the results (Grove et al 2015:399). Polit and Beck (2012:175) explain that confirmability is the degree to which study results are derived from participants in context of the study. Sutton and Austin (2015:227) suggest

that qualitative work requires reflection on the part of the researcher before and during the research process. Reflexivity enables researchers to articulate their position, own perspectives and biases (Sutton & Austin 2015:226). Holloway and Wheeler (2010:304) suggest that appropriate strategies should be used by the researcher to ensure truthfulness in the reporting of the participants' ideas.

The researcher's awareness of potential bias was contained through the technique of bracketing. The researcher consciously bracketed her own preconceived knowledge and assumptions with the goal of attending to, and progressively immersing herself in, the data that were provided by the participants. This strategy enabled the researcher to maintain an open, unbiased frame of mind in order to gain in-depth understanding of the phenomenon under inquiry from the angle of the participants' unique lens. During the data collection and data analysis processes, the researcher and supervisor engaged in reflective exercises to make sense of the complexities underlying the registered nurses' roles, responsibilities and challenges in supporting the "Back to basics" QI initiative at the bedside of the patient. The researcher kept a personal reflective journal to uphold awareness and sensitivity and to set personal experiences and perceptions aside during the data collection and analysis phases of the study.

The researchers utilised literature to substantiate the participants' perceptions and ideas against global and national trends in the context of the studied phenomenon. In addition, the researcher engaged in reflection sessions with the supervisor, who acted in the dual role of study supervisor and co-facilitator, after each focus group, to ensure authentic reporting of the participants' perceptions. A co-coder was employed as a strategy to eliminate the potential of bias during the data analysis phase of the study.

2.9.4 Transferability

Transferability refers to the degree to which the research findings could be applied to other people, settings and times (Polit & Beck 2012:585). Grove et al (2015:392) indicate that the purpose of qualitative studies is not to generalise the findings, but that they should be applicable to other settings with similar participants. The findings of this study would hold significance for all nurse practitioners in the private or public healthcare sector, with involvement in nursing care delivery, because quality in healthcare is directly related to

the concept of patient-centred care (Eygelaar & Stellenberg 2012:1; Jardien-Baboo et al 2016:1).

Grove et al (2015:392) propose that the strengths of a study are confirmed if the purpose addresses the focus of the study and the qualitative approach produces data that meet the objectives and answer the research question. The purpose of this study was to gain an in-depth understanding of how nurses perceive their roles, responsibilities and challenges in delivering basic nursing care linked to the “Back to basics” QI initiative. The background of the study that led to the formulation of the aim and purpose of the study suggested that the majority of nurse misconduct is directly related to poor basic nursing care delivery (Ministerial Task Team 2012:23). Global literature portrays similar contextual concerns with regard to quality in patient-centred nursing care delivery. The studies of Ball et al (2014:120) and Kalisch (2006:308-309) directly support the relation between nurses’ perception of quality and safety of nursing care provision and the amount of missed care. Against the background of worldwide striving to enhance the quality of nursing care delivery, this study’s findings do have the possibility of transferability to similar contexts of interest.

Grove et al (2015:393) argue that the strength of a study depends on the measures taken by the researcher to enhance trustworthiness in the methodology and data findings. For the purpose of this study, the researcher applied several strategies to enhance methodological, data, investigator and theoretical triangulation to enhance authenticity in study outcomes. Findings were formulated from dense descriptions of 24 participants with regard to their perceptions and understandings in supporting the “Back to basics” QI initiative. This study would enable a comparison with nurses’ perceptions within the contextual scope of inquiry in other private healthcare settings when similar eligibility criteria are implemented. The study could produce applicable data on the roles, responsibilities and challenges that nurses experience in the public healthcare setting. The study might also produce valuable data when exploring the perceptions of registered nurses versus enrolled nurses with regard to their roles, responsibilities and challenges in providing basic nursing care at the bedside of the patient.

2.9.5 Authenticity

Polit and Beck (2012:585) state that authenticity refers to the extent to which the researcher describes a range of different realities in a truthful, authentic manner. The researcher applied the technique of bracketing to minimise the potential of preconceived ideas. Different realities were obtained during focus groups to enable comprehensive descriptions of the true perceptions and lived experiences of nurses with an open mind, motivated by authentic interest.

Holloway and Wheeler (2010:304) and Polit and Beck (2012:174) refer to fairness in participant treatment to gain their acceptance and authentic engagement throughout the study. The researcher maintained fair and respectful interactions with all participants, as agreed upon during the introductory phase of the focus groups, with group norms that facilitated mutual respect and commitment to confidentiality and privacy of information, persons and the healthcare institutions.

Audio-recordings were transcribed and field notes of non-verbal communication cues were collated during the data analysis process to describe the range of realities as perceived from the viewpoint of the participants. Verbatim quotes of the participants' perceptions pertaining to their lived experiences were analysed against recent literature to contextualise different realities in authentic findings.

2.10 ETHICAL CONSIDERATIONS

Creswell (2013:174) suggests that qualitative researchers face many ethical issues that surface during the data collection process, whatever the approach to qualitative inquiry. Ethical considerations guide decision-making and direct accountability during the research process (Norwood 2010:69). The following aspects were taken into consideration to maintain adherence to ethical principles:

2.10.1 Ethical clearance

Based on the research proposal, an ethical clearance certificate was issued to the researcher by Unisa in confirmation of study approval (Annexure 1).

2.10.2 Permission to conduct the study from the private hospital group

The researcher followed the institutional process to apply for approval from the healthcare institution where the study had to be done (Annexure 2). Institutional permission was granted by the healthcare organisation to conduct the study providing that no direct references would be made to the healthcare institution or its facilities in report writing or publication thereafter (Annexure 3).

2.10.3 Permission from hospitals (site facilities)

Written applications were directed to the nurse managers of the relevant research sites to request permission to conduct this study at particular hospitals involving participants that met the eligibility criteria (Annexure 4). In accordance with the non-disclosure agreement, the name and reputation of the institution and its employees as participants of the study were kept confidential throughout the study. Each hospital issued a separate letter of formal approval to the researcher to engage with the participants through focus group engagement (Annexure 5).

2.10.4 Rights of the participants

The following aspects have been addressed by the researcher to uphold the rights of the participants:

2.10.4.1 Informed consent

All participants that met the eligibility criteria provided written informed consent (Annexure 7) to engage in this study. The Information leaflet (Annexure 6) accentuated their freedom of choice to participate, without any act of coercion or retribution should a participant decide to withdraw from the study. The researcher included key information in the information leaflet, describing the criteria for participant selection, explaining the aim and significance of the study, the nature of the research activities and time commitments, and suggesting the potential risk and management of psychological discomfort (Polit & Beck 2012:158, 177). The researcher provided her personal contact details should the need arise for further questions or comments.

2.10.4.2 Confidentiality

Streubert and Carpenter (2011:63) state that providing confidentiality and anonymity to study participants applies the principle of 'doing good and preventing harm' to people. The researcher undertook in writing on the Information leaflet that the identity of individual participants would not be revealed in the findings. The participants pledged their commitment to adhere to the ethical principle of confidentiality of data obtained from the research site. All the participants signed the confidentiality binding form (Annexure 8) to formalise their individual responsibility to maintain confidentiality of participant data that emerged during the focus group.

2.10.4.3 Justice

The researcher executed fairness in ethical conduct when setting and agreeing upon group norms that upheld mutual respect and acknowledgement of all participants' views and perceptions pertaining to the inquiry under study. Confidentiality was maintained throughout the study in terms of scrupulous data management to secure the anonymity of the respective research sites as well as of the individual participants; data were cleaned to avoid reflection of any institutional names or participants' identity on the transcribed data. The researcher adhered to a professional work ethic of providing accurate information to outline general information pertaining to the nature of the study. Focus groups were phased out with a debriefing session where participants gave feedback on sharing their experiences on the focus groups.

2.10.4.4 Scientific integrity of the researcher

The researcher is a nurse educator with a dual role in nursing education and clinical accompaniment of students in clinical practice. The researcher promoted scientific integrity throughout the study by augmenting her knowledge and own understanding of the scientific processes underlying research through a rigorous literature review and by keeping a personal reflective journal. The researcher committed fully to the sacredness of research ethics with steadfast determination to refrain from falsification and fabrication of data. The principles of ethical research were internalised to the best of her knowledge and ability. The supervisor executed a significant role in guiding and facilitating the researcher in the enhancement of scientific integrity.

2.11 SUMMARY

Chapter 2 provided a detailed description of how the research design and methods of qualitative research were applied in this exploratory descriptive qualitative study. The chapter also addressed the measures taken by the researcher to optimise trustworthiness in findings against the framework of Lincoln and Guba (1985). Chapter 2 concluded with the discussion of ethical principles that guided decision-making during the research process. Chapter 3 presents verbatim quotes of participants as part of the data analysis process to strengthen the authenticity and reliability of this study's findings.

CHAPTER 3

RESEARCH FINDINGS

*“Curiosity is the greatest teacher. It evokes questions in human mind
along with a keen interest in finding their answers”.*

Senora Roy

3.1 INTRODUCTION

This chapter first provides a biographical overview to indicate the general characteristics of the participants. The data analysis cycle (Creswell 2013) produced four themes with corresponding categories and subcategories. Findings are presented according to the themes that emerged during the data analysis process. Verbatim quotes from participants as they emerged during the focus groups will illuminate the findings.

3.2 BIOGRAPHICAL DETAIL

Data were collected from 24 participants during the course of four focus groups. Participants were between the ages of 25 and 60 years. The focus groups comprised three male and 21 female participants. Thirteen participants possessed a diploma as a General Nurse, and five participants possessed a Diploma in General Nursing and Midwifery. Three participants possessed a four-year comprehensive Nursing Diploma and two participants possessed a BA Cur degree. One participant did not complete the professional qualification section on the demographic questionnaire.

3.3 DATA INTERPRETATION

Four themes with categories and subcategories emerged from the data. Themes one and two reflect the participants' roles and responsibilities with regard to managerial and administrative duties. Theme three provides an overview of what the participants perceive to be the expectations of the registered nurse, which contribute to the nature and extent of their workload. Theme four addresses the participants' perceptions and experiences pertaining to their direct patient care responsibility in terms of legislation and concludes

with the participants' understanding and perceived ideas of past nursing practices in relation to the realities of current nursing care practice. Table 3.1 reflects the collated representation of themes, categories and subcategories pertaining to this study.

Table 3.1 Collated representations of themes, categories and subcategories

Theme	Category	Subcategory
Managerial responsibilities	Patient care management	Patient assessment
		Delegation and supervision
		Multi-disciplinary team coordination
		Complaints management
	Human resource management	Workforce management
		Work quality management
Administrative responsibilities	Hospital service administration	Unit-related organisation and documentation
		QI involvement
	Patient-related administration	Documentation of patient management processes
		Patient care coordination
Expectation management	Organisational requirements	Control measures to ensure efficient unit management
		Disciplinary consequences
	Doctor satisfaction	Negative relationships
		Effect of doctor-nurse relationship on patient care
	Patient-family-relative satisfaction	Change in patient profile
		Care expectations
Patient care responsibilities	Ethical-legal framework – scope of practice	Role and responsibility perceptions
	Direct patient care provision	Perceptions of idealistic nature
		Realistic experiences
	Reflection on past nursing practices	

3.3.1 Theme 1: Managerial responsibilities

Theme 1 was established in view of the participants' perception that a large component of their functional workday entailed managerial responsibilities. The participants' viewpoints and experiences pertaining to managerial responsibilities emerged as two

categories: patient care management and human resource management, which are discussed within the context of the participants' perceptions.

3.3.1.1 Category 1.1: Patient care management

The participants concurred that the registered nurse holds a lot of responsibility for managing patient care and that the accountability for nursing care delivery always reflects back on the inputs of the registered nurse.

“You have a lot of responsibility you are holding, or that you need to be holding, as a registered nurse.”

The participants indicated that patient care is delivered as a team and that the nursing staff assist the registered nurse to fulfil his or her work-related duties.

“... the staff around in the ward ... they must also deliver ... to help me ... it is a teamwork there.”

Healthcare institutions are among the most complex and interdependent entities when facilitating integrated patient care management, because this necessitates cooperation and collaboration among and between various role players within the organisation (Kodner & Spreeuwenberg 2002:1). The following subcategories are illustrative of the participants' opinions regarding their roles and responsibilities in facilitating patient care management:

3.3.1.1.1 Subcategory 1.1.1: Patient assessment

Participants reflected on their responsibility to do patient assessment because it serves as a point of departure for prioritising and planning nursing care.

“Yes, it goes back to assessment ... because assessment is giving us time to plan so that you can implement. We know what to do. You know which one to start with.”

Participants acknowledged that they start to conduct patient assessment to prioritise nursing care before delegating it, to ensure nursing care delivery at the bedside of the patients.

“... you need to do a daily analysis about the patients to see what are the needs and then you can fulfil your responsibility as a RN to ... ensure that the care is delegated ...” [for execution thereof at the bedside].

Muller and Bester (2016:204) confirm that the first step that a supervisor undertakes before initiating the delegation process is an assessment of the nature of the work, to divide the work among the nursing team members.

3.3.1.1.2 Subcategory 1.1.2: Delegation and supervision

According to the participants, the registered nurses' responsibility for care of patients is realised through coordinating of nursing care activities by means of task delegation. The participants perceived their delegation role as crucial to get the work done.

“... the biggest, biggest responsibility is delegating, because otherwise you are not going to get the work done, my dear.”

The participants concurred that supervision is central to their role and responsibilities, because the registered nurse is responsible for supervising and monitoring the delivery of basic nursing care to patients.

“... you, as a RN, you need also to go and see that those things [basic nursing care tasks] are done and check it yourself ...”

“... it is also their [the registered nurses'] responsibility to monitor basic nursing care.”

Responses of participants suggested underlying frustration pertaining to their supervisory role and their responsibility towards lower nurse categories to ensure that 'routine' basic nursing care is performed at the bedside of patients.

“I feel as if the RNs is the police officers in the ward. You are looking, watching your EN, if she did the medication; or if the patient’s complaining, then you go to the patient and find out what’s going on. If they didn’t report a blood pressure to you, you find out what’s going on ...”

The participants revealed the challenges of supervising nursing care delivery when delegating basic nursing care tasks to lower nurse categories.

“You do delegate, but the person does not have the insight why you have to do this. Because the person does not have insight, not thinking. ... because you are a registered nurse you feel more responsible for all of this 40 patients in the ward.”

Feedback from participants addressed the perception that various nursing categories cause fragmentation in comprehensive patient care execution, because delegation of basic nursing care delivery is affected by a long chain of command.

“I have to tell the shift leader, please go and speak to the EN and do it. Then I had to make sure with the EN that she did do it because the RN got busy with two other things and she didn’t have the time to tell the EN so now it’s still not done. And it’s two, three hours later. So I physically have to go back, even though I physically gave the order: Please follow up on it, it’s not been done yet. And we all know the game we used to play at school about the telephone – the message starts and the final message is totally distorted.”

“... there are so many levels and people actually just pass the buck.”

3.3.1.1.3 Subcategory 1.1.3: Multi-disciplinary team coordination

The participants suggested that patient care coordination involves inter-departmental activities and responsibilities.

“... Yes, we’ve got ... theatre cases all day...they want the patient to walk in, getting ready for theatre.”

Patient care coordination encompasses professional collaboration with the doctor and other multi-disciplinary team members to meet the patient’s health needs holistically.

“You must have knowledge and skills...also with the members of the multi-disciplinary team; and you are dealing with fifty doctors ...”

Meyer, Naude, Shangase and Van Niekerk (2009:188) confirm that organising plays an important role in the management process because it facilitates coordinated functioning of the nursing unit. The descriptions from participants portray the integration of inter-departmental activities and multi-disciplinary collaboration to deliver outputs towards the service delivery expectations of other healthcare workers.

3.3.1.1.4 Subcategory 1.1.4: Complaints management

Participants explained that the complaint management process aims to manage patient complaints promptly and efficiently to prevent further escalation. Prompt complaint management facilitates acceptable complaint resolutions and aims to enhance customer satisfaction.

“Originally they said it [incident management] is to reduce the complaints and to catch a complaint before it becomes an incident, to please the patients and to make them happy.”

Participants suggested that patient complaints are often related to acts and omissions that are directly related to basic nursing care delivery.

“I have four incidents now of four patient complaints that I have to do. One was hair not washed, mouth care not done, patient not assisted with feeding. So it's small basic nursing care that is not being done.”

“... we would find that we got a lot of incidents and they would think we don't do “Back to basics” nursing. So something like pressure care, it's back to basic nursing ...”

A complaint is defined as an expression of dissatisfaction, made to or about an organisation, related to its products, services or staff, where a response or resolution is expected or legally required (Ombudsman Western Australia 2017:1). The participants indicated that patients complain about the quality of nursing care delivery and that it is expected of them to resolve the complaints.

Personal experiences of participants suggested that complaints management comprises a large component of their daily responsibilities; much work time is dedicated to the complaint management process, to the detriment of direct patient care involvement.

“... all you do is, you are investigating; you are not attending to a patient, not at all, you are only investigating a problem ...”

The participants suggested that the resultant adverse effect of reduced availability adds to the risk of further incidents occurring in the absence of adequate supervision.

“... while you sit in your office you are trying to resolve this problem, another incident occurs in your ward because you are not at the bedside with the patient – mmm – observing and monitoring what is going on at that stage.”

The participants maintained the view that the registered nurse’s responsibility for preventing incidents from occurring is at the core of efficient task delegation to lower category nursing staff.

“So for as a shift leader, you got your ENs working on the floor ... I cannot expect my 4 staff members that give medication to do hourly rounds and then, just as an example, to do the hourly rounds and still not expect them to make medication incidents.”

3.3.1.2 *Category 1.2: Human resource management*

Participants perceived their duty as a broad responsibility to align coordination of the human resource component (nursing personnel) to deliver work outputs that reflect safe and efficient nursing care and patient satisfaction. In addition to the unit-related managerial responsibilities, the participants elaborated on other interrelated roles and responsibilities of the registered nurse in managing the work and the people in the nursing unit. In view of the participants’ experiences, they discussed the following human resource related roles, responsibilities and challenges to providing nursing care in the clinical practice environment:

3.3.1.2.1 Subcategory 1.2.1: Workforce management

The participants indicated that they are responsible for the overall functioning of the nursing unit by means of staff management.

“So ... at the end of the day the role ... is to make sure that you fulfil your responsibility towards your patient, to ensure that in the general sentence, having enough staff to fulfil the basic needs of the patient.”

The participants elaborated on the challenge of delivering work-related outputs amidst a low ratio of registered nurses to busy, full nursing units. Participants suggested that it is challenging to ensure adequate staffing levels to deliver nursing care to patients in such busy nursing units.

“... because usually we are two RNs in a 33 bed ward. You have to ensure that you got enough staff ... It's not as easy said as done but it is one of your responsibilities to ensure that the amount of staff is correct for the care that you need for your patients.”

A general concern was raised during the focus groups that nursing units are often staffed by agency personnel. The competence levels of agency staff contribute to the challenge of additional supervision, guidance and remediation of erroneous work conduct.

“We work most with agency staff. Some of them they're so incompetent ...”

“You take the amount of agency staff that we work with, the agency staff maybe they don't have all the training they need.”

One particular focus group added to the challenges of managing the nursing workforce a specific mention of communication and language barriers that add to the registered nurses' workload. The other participants concurred with the statement of these participants and voiced their agreement after the statement that some of the nurses are not proficient in the English language.

“But what irritates me is, they come in, they are from the agency, the agency sent them to be orientated, but they hardly understand English ... So where did this person train: it was one of the local nursing colleges. Where did she do her practical: at an old age home. Because I try to find out all those things and the poor girl doesn’t understand English when you speak to her, how is she going to communicate with the patients?”

One focus group suggested that the high staffing levels of agency staff in the nursing unit amidst a constant turnover of personnel add to the burden of in-service training.

“You cannot run a company on agency staff ... How do you train them if you get every day new people? Because the quality that came from the street is people who train in nursing colleges that is sub-standard.”

The participants suggested that the high personnel turnover results in a situation where the unit’s personnel are working overtime to supplement the work complement, because the permanently employed nurses are preferred above agency personnel.

“... you give your permanent staff the opportunity to book extra; instead of the five shifts, the company allow them to work overtime. You give them extra. So at the end of the day we are allowed to work fifteen shifts a month. ... you give them an extra ten shifts overtime, because you don’t want the agency people.”

The experience was conveyed that personnel are over-utilised in an attempt to meet the patient-nurse ratios and thus nursing personnel suffer burnout.

“... you prefer using your own staff that knows the work, with the result these people are burnt out.”

3.3.1.2.2 Subcategory 1.2.2: Work quality management

A frequent theme that emerged from participants’ experiences was the challenges that registered nurses endure because they remain accountable for quality work performance amidst dire shortages of competent registered nurses. Participants supported the following statement by a motion of verbal agreement by the other participants.

“I also experience that because we are really struggling to get competent RNs and staff nurses. And it’s really sitting on you as a RN or as a UM in the unit ...”

Participants indicated their responsibility for managing the staff’s work quality and addressing negligent nursing conduct when having review sessions with staff.

“At the moment in our unit, it’s a specific ... I have to review with the staff to do basic hygiene with the patients because it’s lacking.”

Participants maintained that they have a crucial training role to ensure that quality nursing care is delivered at the bedside of patients.

“... most of the time you want a quality nursing care to be given to the patient so you are always teaching that same nurse or RN to do the correct things ...”

“And again as a ... RN, my role is to continue ... educating my subordinates.”

The feedback received from participants suggested that training and education to sustain basic nursing care delivery should be especially directed at lower categories of nursing personnel.

“In terms of basic, basic nursing care the juniors does not know how to turn a patient. The hands-on nursing of patients also needs a lot of attention.”

The participants shared their experience that agency personnel do not uphold the organisational values underlying the caring ethos of patient care. Experience revealed that a poor attitude to nursing by personnel concerns the registered nurse, because the registered nurse is obliged to trust the nurse for task execution while remaining responsible for the quality of work that is delivered at the bedside of the patient.

“I was very disappointed in some of the agency workers because they don’t have the same roles and values as our own staff, I mean they pitch up at work, they’re not wearing uniform, they wear a T-shirt, and they are not proud of themselves. How can you work with somebody like that? You have to trust them to look after your patients and you are really stressed because, you know, you are taking responsibility of this ward ...”

“The agency’s level of training is not up to standard.”

“They don’t focus like us on medication and knowledge is lacking ...”

Focus groups portrayed a general perception that teaching and remediation of agency personnel removes the registered nurse from the bedside of the patient.

“... that is the end product that this fly-by-night colleges are producing and they become RNs and you must actually start teaching them what Panado is from scratch and that is taking a lot of time from the RN and from the bedside.”

Participants elaborated on the nature of basic nursing care that registered nurses have to teach personnel, and reflected on the lack of time available to teach basic nursing care tasks to lower categories of nurses.

“If you can take the ENA to the bed and show her and teach her all the basic little things; mouth care of a patient, the assessment of the mouth, urine test, all the little things that add to the outcome that patient ... there is no time to get to all those things.”

“The time that the RN has to train the ones that’s working with her is impossible. There is just no time ...”

The participants proposed that the lack of time to teach lower nursing categories to deliver efficient basic nursing care causes incidents with a negative reflection on the competence of the registered nurse. Other participants in the particular focus group agreed with this concern verbally, as well as by giving non-verbal cues such as nodding their heads in agreement with the following statement of a particular participant:

“There is just no time and I think that is making you feel also less competent at the end of the day.”

“... there is no time to get to all those things [teaching basic nursing care delivery skills to nurses]. That causes incidents that cause a negative approach with the pressure on the RN to take care of the patient.”

3.3.2 Theme 2: Administrative responsibilities

Participants' accounts of administrative responsibilities emerged as a theme that describes participants' lived experiences inclusive of hospital service- and patient-related administration. The participants used the term "admin" recurrently during focus groups, reflecting the administrative responsibilities in the nursing unit.

The holistic overview of perceptions and experiences of participants suggested that recordkeeping is perceived as a time-consuming activity that takes the registered nurse away from the bedside.

"Everything that you do, you must record and recording, statistics and paperwork, really taking a lot of time and taking the RN away from the bedside away from the patient."

The concern that the administrative responsibilities take the registered nurse away from the bedside recurrently reflected participants' apprehension during the focus groups.

"But due to admin and other duties that are keeping you, we are not getting there [at the bedside of the patient]. It is totally gone."

The high proportion of administrative activities was perceived as an imbalance in the distribution between administrative responsibilities and direct patient care.

"It is said, it is a 40:60 nursing, 40% on admin, 60% on bedside nursing. I'm afraid it is the opposite; it is like a 20% nursing and 80% admin."

Focus groups revealed that the number of administrative activities cause stress for them.

"You are stressed out more than anything else to get the paperwork done."

Jooste (2010:87) explains that proper records provide the foundation of quality nursing care and therefore documentation must be done to communicate specific information to another person or to the nursing team. Standards for nursing care are based on accurate and complete recordkeeping (Jooste 2010:88).

3.3.2.1 Category 2.1: Hospital service administration

Participants suggested that attending meetings forms part of their general administrative function. Participants indicated that a proportionate amount of time is spent daily on agenda preparation to enable input delivery during review meetings.

“I try to spend time with my staff and my patients up until about 11h00. So for me that’s a good time and then I just prepare for the afternoon meeting and then as I am back I have a meeting with my nurses.”

The business initiated review meetings as a quality assurance initiative. A registered nurse from each unit is obligated to attend the daily review meeting. The purpose of daily review meetings as a medium of direct communication between unit personnel and management is to provide an administrative overview of the daily operation of each unit in the hospital with regard to patient acuities and bed availability, as well as to provide feedback about personnel numbers and staff categories on duty to deliver the required healthcare service. Following the daily review, the professional nurse practitioner acts as the spokesperson between management and unit personnel to communicate business expectations and review care management activities with the personnel.

From the participants’ point of view, responsibilities related to their day-to-day administrative function were mentioned in all the focus groups. The Charter of Nursing Practice framework (SANC 2004) proposes that record and information management are integral to care management.

3.3.2.1.1 Subcategory 2.1.1: Unit-related organisation and documentation

Registered nurses perceived the general administration underlying patient care management to be a time-consuming activity.

The participants conveyed their frustration at duplication of administrative processes when doing recordkeeping; this represents a large portion of the time spent in the execution of their daily job responsibility in the nursing unit.

“Actually our problem is documentation, the documentation is a lot, we are doing a lot of documentation and we are duplicating ourselves.”

“So we are checking and auditing and auditing the check and checking the check after that. Why? Because we want to make sure that on paper it is done.”

The recurrent and consistent theme regarding the documentation and recordkeeping responsibility of the registered nurse is representative of the experiences of all participants:

“We nurse more paper than nursing the patient itself.”

3.3.2.1.2 Subcategory 2.1.2: QI involvement

The participants shared their perceptions that QI initiatives are driven from an organisational perspective, without acknowledgement of the grass-root circumstances that point to a lack of resource capacity to implement the “Back to basics” nursing care initiative successfully.

“... they do try to implement this [“Back to basics” QI initiative] and it still falls through, because you do not have the capacity to go through with it.”

“So I think there is space for things to be by the bed. The beds is what they [the Organisation] want to do and I will debate it in that way if it comes to represent this and you want to implement this, then I say well, I do not agree with this because this is not possible.”

The participants indicated that they want to support QI initiatives because the registered nurse wants to deliver excellent nursing care, but that the methods that the organisation apply do not speak to the nursing care needs of the patient in the bed.

“... we want to deliver excellent nursing care but the method we are using to get it done doesn’t speak to the patient in the bed.”

The opinion was maintained that QI initiatives in nursing care should involve nurse input.

“... quality improvement in nursing care should come from the nurses.”

3.3.2.2 Category 2.2: Patient-related administration

Participants shared their lived experiences in terms of multiple interrelated tasks that the registered nurse is responsible for, to provide evidence that patient care is delivered at the expected quality standard.

3.3.2.2.1 Subcategory 2.2.1: Documentation of patient management processes

Participants maintained the perception that patient management activities imply repetition in the administrative processes.

“There is lots of things that we repeat ourselves. There is a ... let me just give you an example about the admission. We do an admission, there is a question about ... same thing also on the prescription. So ... duplication.”

3.3.2.2.2 Subcategory 2.2.2: Patient care coordination

Participants proposed that registered nurses are responsible for coordinating patient care activities. The participants shared their experiences and elaborated on their administrative responsibilities for making telephone calls about patients, arranging for transferrals of patients and engaging in numerous telephonic and interdepartmental communications related to patient care. The following accounts from participants illustrate the coordinating nature of patient-related administration:

“Sisters ... they phone here, they phone there, they arrange patients to go to stepdown, they must phone for an ambulance.”

One particular focus group suggested that skilful professional nurse practitioners are given the administrative work and that less skilful nurse categories are designated to conduct the hands-on care delivery at the bedside of the patients. Other participants agreed (verbally and non-verbally) with this statement during the focus group:

“I just want to add on to what ... said, it take skilful people and give them administrative work to do and the people in the sub-categories we leave to attend to the patient.”

Coordination of patient care was experienced as challenging, because the participants perceived other stakeholders involved in patient care as target driven, with little understanding or acknowledgement of the registered nurses' challenges in facilitating synchronised coordination of patient care activities.

“It doesn't matter what is done, vitals, what basics you got down for this patient ... that patient must be in theatre.”

Frustrations were conveyed during the focus groups that care coordination, in which patients' condition, needs and nursing care assignment are dealt with among nursing personnel, is often interrupted when doctors turn up to do ward rounds with their patients.

“At the moment the doctor walks in, everybody drops everything and runs for the doctor ...”

“Now you busy with a hand-over and they [the doctor] walk in and they demand immediate attention. So you're really missing out.”

The participants indicated that telephonic calls demand immediate attention because the caller usually does not want to talk to the secretary and requests that the phone call should be directed to the registered nurse. Participants shared their frustration about disruption of the clinical situation if they have to function between interruptions.

“They phone during hand over time ... you, the policy says that the secretary must answer the phone. But they don't want to talk to the secretary, call for a registered nurse to talk to them”

“Then you go back ... then there is another interruption. You feel down about this.”

Perceptions were conveyed that registered nurses feel that they are instrumental in their own disempowerment because they do not take control of a situation and say no when their attention is required for a specific duration of time.

“We disempower ourselves. We forgot how to say no. If you are busy here, talking; say your patient needed emotional support, then whoever walk in: “I want this and this”, you immediately leave and go instead of saying “no you can see I am busy, find someone else.”

“... you immediately drop everything and do with. Then you finish there then you come back, you start again, next person bothers you.”

3.3.3 Theme 3: Expectation management

The nurse practitioner has to apply a range of collaborative and communication skills to balance the patient’s care expectations in alignment with the healthcare organisation’s business objectives and medical physician’s healthcare agenda. The registered nurses’ perceptions of roles and responsibilities in supporting the “Back to basics” QI initiative portrayed in-depth descriptions of indirect patient care activities.

The categories that emerged from the data entailed descriptions of organisational requirements, doctor satisfaction and patient-family-relative satisfaction within the ethical-legal framework established by the professional regulatory body (SANC).

3.3.3.1 Category 3.1: Organisational requirements

Participants suggested that individual work performances are monitored and evaluated to ensure that the set business objectives are met. Recurrent accounts of participant experiences were identified that addressed the challenges that nurses have to overcome to meet stakeholder expectations in the real-world clinical context.

Participants shared their understanding of meeting the organisational requirements as follows:

“Actually at the moment the perception of the role of the RN is to keep the company happy more than keeping the patient happy.”

“... the UM [unit manager] run her ward as a business unit, she must show profit at the end of the month, so they’re cutting down on staff, they’re cutting down on stock ... and I mean everybody check you up and that is, the UM is so focused on ‘I have to run this ward as a business’.”

The participants shared perceptions that the company goals are not in alignment with the registered nurses’ perceptions of basic nursing care delivery. Participants perceived that the registered nurses’ roles and responsibilities for basic nursing care delivery are not embraced in their performance objectives. The concern was raised that the nature of the work-related objectives removes the registered nurse from the bedside of the patient.

“At the moment it is a fine line [between] what we as RN [registered nurse] perceive as basic care delivery compared to the goals that the company expects us to do. For example if you look at the new JPM [joint performance management] that has just come out, basic nursing care delivery is barely touched on in the JPM. They are talking more high level things like debtors’ days, stock days and those sorts of things, which they take the RN away from the bedside.”

Participants maintained that nursing care delivery is determined by the organisational budget and that cutting down on personnel has an adverse effect on quality patient care.

“Now everything is about money, cutting down of personnel and when you cut down on personnel, you are cutting down on our patients’ quality. The quality is down.”

Aiken, Serneus and Van den Heede (2012:2) point out that healthcare organisations are obligated to implement a wide range of cost-containment strategies in the light of increased pressure on health expenditure. Research confirms that the hospital work environment is closely linked to patient outcomes due to the important role that nurses execute in the surveillance system of hospitals (Aiken et al 2012:2).

One particular focus group shared their understanding of paid patient days (PPDs) as follows:

“PPDs is very short-sighted and it is not aware of time because we working on the now. Now there is ten patients, so two people has to go home. But they [management] don’t realise: two hours down you going to admit four [patients] and then those two [nursing personnel members] already went home.”

“We sit with skeleton staff: you have to cope.”

Participants suggested that the registered nurse experiences her roles and responsibilities as unrealistic expectations, because the registered nurse category is utilised as a “stand-in” for everything that needs to be done, whatever the work requirements entail. The nature and extent of the registered nurse’s work expectations are perceived as leading to tremendous pressure, causing stress in trying to keep up with the workload.

“I feel that some of the expectations they put on RNs is unrealistic because a RN, a nurse is a nurse, if there is nobody else to do something, I need to do it.”

“We take a lot of pressure. I feel that RNs are under a tremendous amount of pressure to keep up with her workload. The expectations are too high.”

Participants perceived that the registered nurse is abused by various stakeholders in the service delivery chain. The following quotes from the participants reflect shared experiences of verbal abuse by other members of the multi-disciplinary team.

“The abuse on the nursing staff and on the registered nurses is immensely.”

“This abuse comes from everyone. Let’s not put the doctors, let’s not put the unit managers, it comes from everybody. Everybody, that includes the multidisciplinary team, you can think x-rays, you can think doctors’ rooms, pharmacy. You can think everybody, it comes from there.”

“... the doctor is screaming at you, the unit manager is screaming at you, the relatives is screaming at you, the patients are screaming, everybody is screaming at you.”

Participants concurred during focus groups that the magnitude of organisational requirements and work-related expectations culminate in feelings of frustration and work-related stress.

“At the end of the day you are so stressed, so frustrated ...”

3.3.3.1.1 Subcategory 3.1.1: Control measures to ensure efficient unit management

Participants held the perception that their documentation- and record-keeping related responsibilities are expected by the healthcare organisation. It was acknowledged that record keeping will remain an integral part of their work responsibility.

“... documentation is something that we all have to do and I don’t think we will ever reach the company’s expectation of what they expect us to do with regards to documentation ...”

Armstrong, Bhengu, Kotzé, Nkonzo-Mthembu, Ricks, Stellenberg, Van Rooyen and Vashuthevan (2013:243) suggest that record keeping is an important part of the nurse’s responsibility and part of the obligation to communicate information about the patient to other healthcare professionals.

In addition to the existing legal requirement to record the nursing care that was provided, the participants indicated that additional quality control measures are implemented to enhance the evidence trail of nursing care delivery. The following statement is illustrative of the perceived responsibility of the registered nurse to ensure that checklists are upheld instead of directing the supervision towards the actual execution of the nursing care at the bedside of the patient.

“... you bring a checklist to check...Then we get a checklist for VTE [venous thrombo-embolism], so what happens, let’s not check if the Clexane was given, let’s check the check-list ... and this is exactly where we are in nursing at the moment.”

The implementation of “check-rounds” and “check-lists” is perceived as unrealistic and an added barrier to managing their time efficiently.

“It is not only for the UMs, also for the RNs; I’ve got a checklist ... the RN needs to go to each bed with a checklist and ask five questions and write yes or no and your reasons on these list ... 32 patients twice a day.”

Participants acknowledged that an increased vigilance with regard to record keeping in hospitals is aimed at the prevention of litigation.

“The admin thing is a big thing, but how can one address it? It is important to have records for legal purposes.”

Participants claimed that documentation and record keeping is taking up a large component of their time and that the responsibility to keep proper records takes the registered nurse away from the bedside of the patient.

“Everything that you do, you must record and recording, statistics and paperwork, really taking a lot of time and taking the RN away from the bedside, away from the patient.”

The participants conveyed shared experiences, with voiced agreement by others that the record-keeping expectation is upheld without the actual provision of nursing care at the bedside of the patients.

“... whether the action was physically done is not important, whether it was recorded ... what you actually done or the service you actually provided doesn’t seem to be as important as the proof of providing the service.”

The rationale for this unlawful practice was provided in terms of accommodating unrealistic organisational requirements to consistently validate evidence of nursing care delivery.

“Stepping away, and like they [other participants] said, they [nursing staff] will rather put everything on paper than really giving the patient care; and there’s fraudulent things, there’s a paper of IV checks. I tell you, you won’t believe how they [nursing staff] will write every hour, I mean, it is impossible to do around the clock the IV checks. Because they want to cover themselves ...”

3.3.3.1.2 Subcategory 3.1.2: Disciplinary consequences

Participants shared their viewpoints and experiences of performance management in view of meeting the set standards and policies of the healthcare institution.

Participants indicated perceptions that despite the nursing care that you do for a patient, there is often a negative 'come-back' for which the nurse is held accountable. The perceptions of being disciplined for 'everything' threaten the registered nurse.

"... there is always something that is coming back to us that is negative, that you feel threatened, with regards to everything that you do with your patient."

"... for every blink you are doing, you got to be disciplined ..."

One of the focus groups shared their perceptions that management becomes visible in the nursing unit only when problems are identified within the nursing unit.

"Nowadays when you see management in the unit you know there is a problem. When you see them you know there is a problem."

Participants maintained that self-preservation is a survival strategy to disciplinary action.

"Cause you must understand, self-preservation is key and with the way we are doing things now ..."

A particular focus group indicated that nurses' fear of being disciplined, with the risk of losing their work, leads to the establishment of survival mechanisms where unlawful documentation practices are upheld as counter-strategy to avoid disciplinary action.

"... so they are actually covering up with paper things that they didn't do, because they are afraid of being disciplined. If it is on paper it is done."

Jooste (2010:87) suggests that control in a nursing unit ensures that activities are aligned with set standards to evaluate staff members' performance, as well as deviations in performance where performance did not consistently meet with the set standards.

3.3.3.2 Category 3.2: Doctor satisfaction

The participants maintained that satisfying doctors was perceived as an essential responsibility of the registered nurse. Doctor satisfaction was perceived in terms of the quality of nursing care delivery.

"... and then also the doctor ... must ... must, must be satisfied about the ... the quality nursing you are giving to the patient".

"You must keep the doctors happy, you must keep the visitors happy, as long as they are happy, you are a good nurse."

The experiences of participants suggested that the doctor has the mandate over patient care.

"With us, the doctors have the say ..."

3.3.3.2.1 Subcategory 3.2.1: Negative relationships

Participants experienced the collegial relationships with doctors as challenging. The doctor-nurse relationships appear to be tense when doctors do not adhere to standardised hospital protocols.

"I can just add ... we've got really a problem with the doctors to sign telephonic scripts. ... when I asked him to please sign the script, he throws his pen like that and said, I'm not going to sign it. ... I brought it forward from your script to our script and you have to sign it to make it legal. *Dit is sommer blerrie nonsense*"[The doctor will respond to the registered nurse's request to countersign a medication script that it is absolute nonsense].

Experiences were shared where doctors verbally abuse the registered nurse and that it causes feelings of resentment to work with such doctors.

“... the doctors are there, they are swearing at us ...”

3.3.3.2.2 Subcategory 3.2.2: Effect of doctor-nurse relationship on patient care

Participants suggested that the negative attitude and abusive behaviour from doctors causes feelings of frustration and emotional stress for them.

“At the end of the day you are so stressed, so frustrated, the doctor is screaming at you ...”

The participants suggested that the stress caused by the demeanour of doctors when collaborating with them on patient-related matters has a detrimental psychological effect on them that snowballs to the nurse-patient relationship.

“The attitude that they have influence your attitude against him. So it’s going to make a circle: ... I don’t want to work with that doctor’s patient ... get somebody else to work with that patient.”

“... then the doctor starts to scream and verbal abusing because the patient is not prepared for theatre so it adds up to the tension of the nurses, they turn onto each other and it’s just a ripple effect that carries over to the patient.”

3.3.3.3 Category 3.3: Patient-family-relative satisfaction

Participants reflected on their experiences that a large portion of the registered nurse’s time is dedicated to interaction with the patient’s family and relatives.

“The major time waster are family members hopping in when it is not visiting time and some of them will tell you the doctor said I must come at this time and it’s time to be doing your routine but the family members are there.”

The participants portrayed their experiences of feeling that they have insufficient authority to prescribe nursing care to a patient when visitors are present at the bedside of a patient.

Participants suggested that visitors often want to dictate nursing care provision of patients.

“Visitors will decide how you nurse their family; when to turn them, when to change a nappy. We don’t have the authority any more to say, listen I’m going to let you go out this unit right now because you interfere with our workspace.”

“We have tried that ..., they say, they will remind you we are the ones paying for the patients to be here ...”

Bellou and Gerogianni (2007:1) confirm, however, that the family plays a significant role in hospital treatment of patients because it provides psychological and emotional support to patients when undergoing treatment in hospital.

3.3.3.3.1 Subcategory 3.3.1: Change in patient profile

Participants shared their experiences that patients challenge the nurses with the health-related knowledge and patient-rights expectations that they acquire on websites. Other participants confirmed this phenomenon during the focus groups, with several verbal agreements in support of this statement.

“... most of our patient ... they come well informed ... they Google ... and they will challenge you.”

The emancipation of patients with regard to their rights as healthcare consumers leads to a raised administrative vigilance in documentation practices to avoid lawsuits.

“As people are becoming more and more aware of their rights, the hospitals also to be having more and more paperwork to cover that and to cover that everything is written.”

The participants also indicated that the registered nurse has to teach patients about health-related matters because patients often need explanations to understand the health-related conditions and treatment interventions in addition to the information that the treating physician provides patients with.

“That person needs some explanations, needs somebody to understand what is going through emotionally right now ... Is this still reversible? What is really going on? But the doctor leaves; ‘Sister, tell me what is really going on?’... now you have to sit down again, you have to explain. We are sitting down and you are the only RN on duty.”

3.3.3.3.2 *Subcategory 3.3.2: Care expectations*

Participants perceived their responsibility as keeping the visitors and patients happy. This responsibility contributes to the challenge of efficient time management.

“I am on the floor ... the whole time to keep the visitors and the patients happy and then my work I do in my own time.”

Participants have little authority to control the care expectations of family members and visitors because nursing staff are reminded that nursing care is a paid-for commodity with the entitlement of involvement.

... not like here where it is a Holiday Inn ... ‘I’m paying the money; that’s why I have to come in; it’s my mother, it’s my father’, as if you don’t have nothing.”

Management do not strengthen the authority of the registered nurse, because once complaints are raised at management level, the registered nurse decisions are overridden and visitors are allowed to visit patients at any time.

“... if you refuse them [visitors] to come in, they chase or push the security and it’s been from in front, it’s been said [by management] [to] allow them to go in: ‘Shame, he is here from far’.”

Participants recurrently indicated that the registered nurse must be competent when dealing with the magnitude of care demands in the nursing unit.

“We need to see for wound care, skincare, that type of thing. If we got a younger patient, say for example with diabetes, you will more go to the knowledge part of it. When you start the insulin, you make sure to start at the psychiatric part of it, because it’s a big thing for our patients to have a chronic illness. Then you’ll adjust your role and responsibilities to education with more focus on education, because someone needs to continue with life with the condition that he/she have and then with that information can live like healthy.”

Participants acknowledged their need for knowledge by suggesting that all registered nurses do not have the same level of knowledge because they attended different training institutions.

“Obviously not everyone is educated like as everyone else. We went to different schools, you know. We attend different training schools, so obvious our level of education is totally different.”

Participants maintained that the professional capacity of the registered nurse creates an expectation that the practitioner is competent, regardless of his or her actual level of competence.

“When you come in as a registered nurse no one really considers whether you are more educated or less educated or not. The fact that you are a registered nurse, everything is coming back to you.”

One of the focus groups conveyed the need for in-service training and development as follows:

“So there’s a cry for help even if you want to implement this thing going “Back to basics”. And then at the end of the day I also need to be able to educate the staff members; how am I going to do that if I’m not empowered from the word go? How do I uphold the rights of the patients if I am not educated, if I am not aware of the patients’ rights?”

The participants continued to indicate their need for professional development to equip them with knowledge and skills to deal with the demands of patient care expectations.

“If they can introduce courses like time management. That is one of the things we really need.”

“Courses whereby you learn how to manage families ...”

“For instance, managing a full ward. Not unit management, off duty management blah blah, all that this ... how you can manage your time better.”

3.3.4 Theme 4: Patient care responsibilities

The participants elaborated on their understanding of the nature of basic nursing care provision in direct patient care provision. The following statements are illustrative of the registered nurses’ understanding of basic nursing care delivery:

“You wash your patient, you wash your patient’s hair, you shave your patient, you turn your patient. For me that is important, the basic grooming of a patient, it must be there.”

“... cutting a patient’s nails, keeping the patient comfortable, rubbing a patient’s feet because it’s dry.”

The researcher includes a significant perception of a participant that spoke directly and honestly about his/her own ambiguity in knowing and understanding exactly what “Back to basics” nursing care means.

“I am still young and obviously when they say “Back to basics”, at the back of my head I will ask myself what exactly do they mean with “Back to basics”? If we really have to go back we really need to identify what exactly they mean by basic nursing care ... We need to get a re-definition what does it really mean if they say back to basic nursing care. We are seniors, we know this is the expectation.”

3.3.4.1 Category 4.1: Ethical-legal framework - scope of practice

The registered nurse as process owner of basic nursing care coordinates patient care by means of the assessment-delegation-supervision triad. Direct patient care responsi-

bilities, with specific reference to basic nursing care tasks, are allocated to the lower nurse categories.

3.3.4.1.1 Subcategory 4.1.1: Role and responsibility perceptions

The participants' perceptions reflected acknowledgement that nursing care delivery is prescribed by the scope of practice and policy standards of the healthcare organisation.

“... okay you've got our scope of practice and the policy of this company ...”

The participants maintained a shared understanding that each nurse category has a distinctive role and responsibility with regard to basic nursing care delivery at the bedside of the patient, and that the registered nurse is responsible for supervising the overall execution of patient care activities.

“The EN is responsible for the medication; the ENA is responsible for the vitals together with the care worker. The care worker, the ENA supports the care worker with the bed washing, the mobilisation and the feeding. So you as a RN is a general supervisor on the floor.”

“... the RNs are doing the supervisions and we take the ENs to give medication, they are hands on with the patient – EN, ENA and the care worker. They are hands-on; they are by the bedside ...”

Participants suggested that they do not perceive basic nursing care delivery as the responsibility of the registered nurse because the number of managerial and administrative responsibilities takes the registered nurse away from the bedside of the patient.

“And it stems from the amount of admin and the amount of tasks that is taking the RN away from the bedside, so automatically patient care do not becomes the RN's job.”

“... a lot of administrative function goes into basic nursing care delivery; however, not at the bedside of the patient.”

Participants acknowledged that, in view of the scope of practice, only the registered nurse category is entitled to perform certain nursing responsibilities.

“The RN and the RN only are allowed to administer medication.”

The concern was raised that administration of medication does not fall within the scope of practice of lower nurse categories and that the registered nurse is the only nursing category that is legally responsible for the administration of medication.

“Go back to your scope of practice, go and read the scope of practice of the EN, she’s not allowed to administer medication. The RN and the RN only are allowed to administer medication, but what are we doing, we are creating our own scope of practice, because we allocate the ENs for medication. We teach them, we teach the PEN2s to give medication, we have to teach them and the ENs are working on their own because the RN has to supervise and sort all these nonsense.”

Participants suggested that they need to adhere to company policy despite the prescriptions of the scope of practice.

“RNs on the floor who are aware of their scope of practices, so they know to put their signatures there because they know the risk, but then we as a company say you must do it now.”

Accounts of participants’ experiences suggest that registered nurses might experience feelings of being overwhelmed when assuming responsibility and accountability for patient care in the nursing unit, especially if quality of nursing care is affected by the acts and omissions of lower category nurses.

“I’d say the roles, we are actually supposed to be accountable for everything, but now we are actually supposed to be accountable not for what you are doing but now we are accountable for actually everything that is happening in the ward ... The nurses, when they have not done their work, we have to encounter for that. We have to be in front to give answers to everything they are doing or that they omitted.”

3.3.4.2 Category 4.2: Direct patient care provision

Multiple accounts were provided under the aforementioned themes why basic nursing care delivery at the bedside of the patient is not realised amidst the realities in the clinical practice environment.

Participants' experiences regarding the registered nurses' responsibility for rendering direct care are discussed as an ideal that is not realistic and feasible against the backdrop of time spent on other patient-related care functions.

"... it is impossible for hourly rounds ... we do not have the staff in the wards, it's just too heavy, the activities on a day to day was ... its ... it's just not possible."

"The RN does not really have the time to go to each patient and these days they are more concentrating on the writing. So the time you spend with the patient is not there anymore."

Direct nursing care delivery is no longer considered the responsibility of the registered nurse in view of the multiple other care-related functions that the registered nurse has to fulfil.

"... the RN is more in a supervisory role now. We are not doing nursing care like we used to do in the past."

Participants acknowledged during the focus groups that they are lacking in the ability to provide direct care at the bedside of the patient.

"So the concept of "Back to basics" is very near to my heart because I feel that that is where I lack ..."

The following comments from participants suggest that the administrative responsibilities of the registered nurse are considered to be of more significance in patient care management than direct patient care provision.

“... I don't physically have the time to go and look at 32 or 15 patients every day when they do pressure care, because then I have to sacrifice other administrative functions.”

3.3.4.2.1 Subcategory 4.2.1: Perceptions of idealistic nature

The participants expressed their wishes that the idealistic goal of basic nursing care delivery would bring an end to patient incidents related to a lack of basic nursing care execution.

“... it [“Back to basics”] sound very nice: we will not have pressure sores, we will not have falls ... “

The participants were able to describe scenarios that portray correct nursing care provision.

“Just to be able to sit on the floor next to the mother and to pray with her to give her that little bit of compassion ...”

“... and we can start having that passion for patients to be next to the bed.”

3.3.4.2.2 Subcategory 4.2.2: Realistic experience

The participants provided several examples of ideal care scenarios.

“Making sure that your patient is pain free, things that we used to do, there's compassion. The days of cutting a patient's nails, keeping the patient comfortable, rubbing a patient's feet because it's dry. Small things are now taken out of nursing.”

The participants indicated that their view that their main responsibility in direct patient care encompasses the delegation of direct patient care to lower nurse categories, because staff shortages contribute to the inability to get the registered nurse back to the bedside to provide direct patient care.

“I would basically say to get the RN back to the bed, the staff is one, there is not enough staff on the floor.”

The inherent motivation of the individual nurse was depicted as lacking the passion for nursing to provide patient-centred nursing care at the bedside of the patient.

“People come to nursing without having the passion to be nurses ...”

“This is just a job to her. This is just like any other job.”

3.3.4.3 Category 4.3: Reflection on past nursing practices

The older participants reminisced about “those days” as they recalled their experiences when nursing care practices were better and more efficient in comparison with modern day care models. Focus group discussions showed weighted perceptions with regard to the good nursing practices from the past, as against current business-driven models where technology and changes in patient profile have affected registered nurses’ involvement in supporting “Back to basics” nursing care at the bedside of patients.

Nursing practices from the past had a positive influence on patient care outcomes. Positive perceptions of participants related to “Back to basics” nursing practices are reflected as follows:

“Back to basics”, there some maybe during the day the bedpan routine. We are no longer doing the bedpan routine and then you will find that the patient is lying there...maybe she wants to go to the bathroom, and maybe the bell is there...maybe if every hour we can do bed pan routine, doing back pressure care, bathing and then it will minimise that patient falls.”

The participants in one particular focus group expressed in-depth sentiments regarding the old era of nursing care and unit management. Older participants shared their sentiments, with voices in agreement.

“They didn’t have all this unnecessary papers ... they had one book ... We had one admission book with a diagnosis, you put your patient’s sticker or you write your patient’s name with the diagnosis, the doctor’s name is on there. Most of our stuff was done manually in my time. We didn’t have all this, we had our progress report ... you write your patient’s history, assessment and everything on the

Cardex. But now you have to do an assessment, you have to go to a problem-orientation thing ...”

Participants’ perceived that the practices where nursing care was delivered in a teamwork approach contributed to patient satisfaction.

“... that was a Saturday thing. We had a bedpan round before every visiting, we did a bedpan round ... you take your bedpans and you take your cloths and towels *en alles en dan gaan jy ... nie een patient sal vir jou during a visit ‘n bedpan vra nie* ... [... you take your bedpans and cloths and everything else needed for a bedpan round and off you go ... not a single patient will ask for a bedpan during visiting time].”

In contrast to the positive sentiments recalling basic nursing care delivery at the bedside of the patient in an earlier nursing era, other participants perceived the older methods of nursing care delivery as outdated and impossible to achieve in view of the changes that had happened in the healthcare environment over the past few decades. These perceptions are portrayed in the following statements.

“I think that there is place for it, I just don’t think that everything must go back. It’s the reason why we evolved. And we are “Back to basics”; I am saying there is things that we did in the past, but everything cannot be implemented the way they did it in the past on today’s life schedule ... it’s a different scenario we working in the wards today than forty years back.”

Finally, some of the focus groups suggested that the registered nurse must go back to providing direct patient care when doing basic nursing care delivery at the bedside of the patient.

“RNs are seeing themselves today as standing there with a pen and a paper and is giving orders. We must go back to our roots and be physically next to the patient’s bed.”

3.5 SUMMARY

Chapter 3 presented the findings in themes and categories with their corresponding subcategories that emerged from the participants' verbatim quotes. In-depth discussions on lived experiences reflected authentic descriptions of the participants' roles, responsibilities and challenges in supporting basic nursing care delivery at the bedside of the patient. Chapter 4 presents the literature control and relates findings from the focus groups to scientific explanations pertaining to the phenomenon under study.

CHAPTER 4

DISCUSSION OF THE FINDINGS AND LITERATURE INTEGRATION

“An investment in knowledge pays the best interest”.

Benjamin Franklin

4.1 INTRODUCTION

Chapter 4 proposes an integration of the findings in the context of relevant scholarly literature. This control strategy contextualises this study's findings pertaining to the roles, responsibilities and challenges that registered nurses' perceive in supporting the “Back to basics” QI initiative. The discussion reflects integration of the themes and categories to consolidate the roles, responsibilities and challenges of the registered nurse in the clinical practice environment.

To strengthen the trustworthiness of this qualitative study, the researcher utilised key electronic databases to locate applicable literature towards the final synthesis of the research findings. The most frequently utilised databases were CINAHL (Cumulative Index to Nursing and Allied Health Literature) and MEDLINE (Medical Literature On-Line via Pubmed). The CINAHL database was accessed through Unisa's library. The OVID commercial vendor was also used to access articles. The researcher commenced with a basic search by entering keywords and phrases such as ‘roles and responsibilities in nursing’, ‘quality in nursing care’, ‘factors affecting quality in nursing delivery’, ‘basic nursing care’, “Back to basics” and ‘QI initiatives in nursing’. Records were then limited to those with publication dates within the last five years. The advanced search mode enabled refined searches to produce specific articles. References were screened to determine their accessibility and availability of full copies of the original articles. Articles were then filed according to topic headings to enable easy retrieval of specific information.

4.2 DISCUSSION OF THE FINDINGS

Four themes with corresponding categories and subcategories emerged from the participants' perceptions in reflecting on their real-world lived experiences in the natural setting of the medical-surgical clinical practice environment. The perceptions obtained during the course of data collection from 24 participants provided dense descriptions of the operational challenges that registered nurses encounter in the clinical practice environment in attempting to support the "Back to basics" QI initiative.

4.3 MANAGERIAL AND ADMINISTRATIVE RESPONSIBILITIES

The findings indicate that registered nurses perceive their managerial and administrative roles and responsibilities as interconnected work-related duties that underpin patient care management. The literature acknowledges the registered nurse's professional responsibility with regard to managerial and administrative duties in the practice environment. The International Council of Nurses (ICN 2008:4) indicates that managerial responsibilities are a core competency of registered nurses in order to enhance continuity in patient care (Armstrong et al 2013:123; Jooste 2010:52). Galganski (2006:87) argues that the traditional purpose of nursing administration has been to manage and facilitate patient care delivery. The Charter of Nursing Practice framework (SANC 2004) indicates that record and information management are integral to patient care management. The participants regularly used the term "admin" and elaborated on the nature and extent of their administrative responsibilities in supporting patient care management.

The Charter of Nursing Practice (SANC 2004) divides the registered nurses' clinical responsibilities into *care management* responsibilities and *care provision* functions. Doherty, Gatenby and Hales (2010:35) indicate that the registered nurse is operationally positioned in terms of managerial as well as clinical care responsibilities. The care management responsibilities of the registered nurse in this study reflect a myriad of managerial and administrative roles and responsibilities that keep the registered nurse occupied in the nursing unit. For the purpose of this study, managerial and administrative responsibilities are considered the care management responsibilities of the registered nurse.

The clinical care responsibilities reflect on the direct care provision responsibilities of the registered nurse and will be addressed later in this chapter.

Care management encompasses assessment, delegation, supervision and care coordination responsibilities, which are outlined as follows.

4.3.1 Care management responsibilities

For the purpose of this study, the researcher utilises the concept ‘assessment-delegation-supervision triad’ to indicate the interrelated managerial responsibilities that enable the registered nurse to manage patient care in the clinical practice environment.

4.3.1.1 Assessment-delegation-supervision triad

Okaisu, Kalikwani, Wanyana and Coetzee (2014:1) agree that adequate assessment is essential to guide nursing interventions because assessment influences the continuity of nursing care delivery. The Charter of Nursing Practice (SANC 2004) indicates that the scientific nursing process is central to the responsibilities of the nurse practitioner in nursing care delivery. The findings support the application of the scientific nursing process in the duty to take care of patients, particularly in view of patient assessment and planning of nursing care priorities.

Muller and Bester (2016:204) explain that delegation refers to the devolution of duties and responsibilities by a supervisor because the personnel work as a team and therefore some of the work is delegated to ensure continuity in patient care. The findings correspond with the general definition of delegation, because patient care is delivered in a team approach and the supervisory role of the registered nurse serves as a direct linkage between the registered nurse and the patient. The findings indicate that delegation is crucial to get the work done, because the implementation phase of the nursing process is delegated to lower nurse categories for execution of basic nursing care delivery at the bedside of the patient.

Muller and Bester (2016:208) acknowledge that the competencies and abilities of the available personnel influence the success of delegation in the healthcare service. Booyens (2014:216) confirms that managers may lack confidence in the abilities of

subordinates. The findings portray a lack of confidence in the nursing workforce, which is not perceived to be competent to maintain quality in basic nursing care delivery. Various challenges emerged in the current study underlying the registered nurses' supervisory role when delegating basic nursing care tasks to lower nurse categories. The findings portray the fact that organising patient care by means of task delegation and supervision often results in additional responsibilities, because the registered nurse has to closely supervise and re-train nurses that assume duty in the nursing unit. Workforce-related challenges to sustain quality in basic nursing care delivery will be addressed later in the review.

Doherty et al (2010:36) suggest that in the United Kingdom (UK) since the 1980s the supervisory role of the ward sister has gradually increased to include broader budgetary and human resource responsibilities. As practitioner-managers, the registered nurses have become professionally accountable for maintaining nursing care standards as well as coordinating care delivery (Doherty et al 2010:36). Filling these two roles has necessitated an expansion of the registered nurses' supervisory role, in cognisance of the fact that the registered nurse's direct patient care role will be proportionally compromised. The findings of the current study confirm that the nature and extent of the managerial-delegation-supervision-triad add to an array of operational challenges that exacerbate the managerial responsibilities of the registered nurse with regard to workforce and work quality management within a nursing unit.

4.3.1.2 *Care coordination*

Coordination is defined as a synchronised process of organising and integrating activities and responsibilities to ensure that the resources are functioning harmoniously towards the specified objectives (*Business Dictionary* 2017, *Merriam-Webster* 2017). Meyer et al (2009:188) confirm that organising plays an important role in the management process because it facilitates coordinated functioning of the nursing unit.

The participants' experiences reflected similarities with the findings of Armstrong et al (2015:9-10, 12) in describing the nurses' responsibilities as covering patient administration and communicating with multi-disciplinary team members such as doctors, nurses, students and other healthcare professionals, and patients and their relatives, in person and telephonically. The study by Armstrong et al (2015:17) indicated that there

was no set norm for the proportion of time that unit managers should spend on patient care. The findings of the current study confirm an imbalance in the distribution between administrative responsibilities and direct patient care. A particular participant suggested that despite the organisational prescribed norm of 40% time expenditure on administrative tasks and 60% on bedside nursing, the operational realities came down to about 20% time on direct patient care and 80% time spent on administration. The participants perceived the magnitude of their managerial-clinician roles and responsibility as stressful, and concurred with the notion of Doherty et al (2010:35) that the responsibilities and expectations of the managerial-clinician role are an “almost impossible job to fulfil”. The findings addressed the following roles and responsibilities that challenge the registered nurse attempting to support and sustain quality in basic nursing care provision.

- **Workflow interruptions in the continuity of care coordination**

Doherty et al (2010:38) suggest that the ward sisters “dip in and out” of clinical practice, which causes fragmentation in complete care episodes with the individual patient at the bedside. The findings of the current study indicated that registered nurses find it difficult to sustain continuity in care management because they experience constant interruptions in workflow. Interruptions are related to the duty to attend to doctors, family members and relatives, telephone calls, patients and several other members of the multi-disciplinary team. The service delivery expectations of clinical visibility and availability in the practice environment cause workflow interruptions, because the registered nurse is expected to uncompromisingly attend to doctors, family members and relatives, telephone calls, patients and any other ancillary who claims attention.

Roth, Wieck, Fountain and Haas (2015:264) indicate that distraction and interruption have been studied as human factors contributing to nursing errors because interruptions in patient care undermine care continuity. Ultimately, the holistic picture of patient information is lost, the lack of contact with the patient and knowledge of his or her information reflects as incompetence on the part of the registered nurses, and patients lose trust in them.

Roth et al (2015:264) refer to another study that associates mental workload issues, such as interruptions, divided attention and being rushed, with increases in procedural failures

and an overall increase in clinical errors. Probst, Carter, Cadigan, Dalcour, Cassity, Quinn, Williams, Montgomery, Wilder and Xiao (2017:94) argue that frequent interruptions in workflow are indicative of a sub-optimal nursing work system. Roth et al (2015:268) suggest that nurses may lose work focus due to emergent events in the nursing unit. The following events that emerge in the nursing unit on a daily basis are outlined to relate the care coordination roles and responsibilities of the registered nurse in the clinical practice environment to the challenges of sustaining quality in basic nursing care delivery.

- **Clerical responsibilities**

The findings of the current study suggest that patient care coordination roles and responsibilities of the registered nurse include general office tasks such as telephone calls, transferral arrangements and interdepartmental communications related to patient care. The findings reflected frustration among registered nurses because skilful registered nurses are obligated to attend to such administrative chores, whereas less skilful nurse categories are designated to conduct the hands-on care delivery at the bedside of the patients.

Roth et al (2015:264) acknowledge that distractions are difficult to control in a busy hospital environment, but the study done by Probst et al (2017:97) reflects on the value of doing some in-service training in ancillary departments to enhance awareness and understanding with regard to the connection between interruptions and error. Probst et al (2017:97) propose that certain work-related requests could be successfully relayed to non-nursing staff.

- **Doctor-nurse collaboration**

Several experiences were shared implying that many doctors demand immediate attention when they enter a nursing unit, without regard for other operational responsibilities that require the registered nurse's attention in the unit. Lancaster, Kolakowsky-Hayner, Kovacich and Greer-Williams (2015:275) indicate that physicians and nurses share portions of patient care in terms of treatment and interventions; they recommend that optimal collaboration between physician and nurse is critical to the prevention of errors and fragmentation in patient care. The findings of the current study

agree that doctors' satisfaction is an essential responsibility of the registered nurse, but that it is challenging to manage negative attitudes and abusive behaviour from doctors. Armstrong et al (2013:284) confirm the existence of doctor-driven care models where the maintenance of doctor's satisfaction is important because doctors create the revenue stream.

Lancaster et al (2015:275) suggest that physicians regard themselves as the primary patient care decision makers; these authors acknowledge that other studies reflect a hierarchical/subservient relationship between healthcare professionals in the clinical practice environment. The findings of the current study suggest that the registered nurses perceive the professional relationship with the treating physicians as volatile and stressful, because they perceive themselves as subservient to the doctors' demands, despite their own professional obligations towards the scope of nursing practice and organisational demands. In this study, the stressful doctor-nurse relationships were estimated to have an adverse effect on the development of therapeutic relationships with patients. Abdollahzadeh, Asghari and Maryam (2017:1) indicate that workplace incivility is a significant problem in healthcare organisations and explain that incivility is characterised by rude and disrespectful behaviour towards others. The findings of Abdollahzadeh et al (2017:1) and Sarafis, Rousaki, Tsounis, Malliarou, Lahana, Bamidis, Niakas and Papastavrou (2016:6) acknowledge that workplace incivility causes high degrees of psychological stress and somatic effects that may add to suboptimal care and higher frequency in errors in everyday clinical practice reduced patient satisfaction and increased cost of care. Lancaster et al (2015:275) acknowledge that tension, misunderstandings and conflict between multi-professional team members interfere with effective communication and collaboration (Lancaster et al 2015:275). Behaviours that integrate respect for patients are reduced when conflict exists between nurses and doctors and peers (Sarafis et al 2016:6). Sanders, Krugman and Schloffman (2013:352) reflect on previously generated evidence which links ineffective inter-professional communication with unsafe practices and errors in patient care delivery. Lancaster et al (2015:275) elaborate on the successes related to the implementation of a hospital patient care model based on the 'conductorless orchestra model', where traditional hierarchy is replaced by mutual recognition between physician and nurse, and where improved interdisciplinary communication and collaboration enhances patient safety. Sarafis et al (2016:13) and Abdollahzadeh et al (2017:1) suggest a positive correlation between patient satisfaction and quality nursing evident by a decrease in medical errors and care

costs when workplace incivility is changed to cooperative relationships between doctors and nurses.

- **Inter-departmental care coordination**

The findings of the current study indicate that the registered nurse is responsible for coordinating patient care through multi-disciplinary team collaboration to ensure continuity in patient care delivery. According to Elhauge (2010:1), the narrowest dimension of fragmentation occurs when there is a lack of coordination among the role players involved with providing care to a patient during a single hospital stay.

The current study suggests that the registered nurse perceives some inter-departmental relationships as tense because other hospital departments have little understanding of administrative nursing processes. Sarafis et al (2016:13) confirm that problems with peers and doctors cause nurses to expend a lot of energy on dealing with this challenge. Conflict with peers and doctors compromises the registered nurse's focus on patient needs (Sarafis et al 2016:13). Abdollahzadeh et al (2017:7-8) suggest that nurses are of the main healthcare professional categories involved in the prevention of workplace incivility by having good interpersonal communication skills. Sarafis et al (2016:13) hold that good interpersonal relationships in the workplace reinforce positive caring behaviour towards patients.

4.3.2 Human resource management

Human resource management is defined by Boxall and Purcell (2011:1) as multiple activities related to the management of the *work* and of the *people* in organisations. Muller and Bester (2016:427) indicate that human resource management forms part of the professional healthcare provider's responsibilities. In addition to 'the work' (care management responsibilities), the participants elaborated on their roles and responsibilities for managing 'the people' in the nursing unit. The term 'human resource management' was not verbalised by participants during the focus groups, but in view of the participants' experiences, the following human-resource related challenges are discussed from the registered nurse's viewpoint, when managing the workforce towards quality work outputs.

4.3.2.1 Workforce related challenges to support bedside care delivery

In the current study, the participants maintained that they were held accountable for patient outcomes, without the ability to control the quality of nursing care delivery in terms of workforce competence. Fields and Brett (2015:7) argue that professional practitioners should be competent to manage and organise the staff complement to enable the workforce to deliver the highest possible level of nursing care. Booyens (2014:138-139), Jooste (2010:56-57) and Muller and Bester (2016:208) concur that the registered nurse should be competent enough to delegate activities to others according to their ability, level of preparation and proficiency, in accordance with the legal scope of practice. The ICN (2008:34) recommends that the registered nurse apply support strategies to supervise and monitor delegated care within the legal parameters of accountability. The findings suggest that registered nurses perceive themselves to be inadequately equipped for this, with limited support strategies to deal with the workforce challenges to sustainable quality care delivery. The participants elaborated on their organisational accountability for patient outcomes, yet inability to control the quality of the competence of their workforce.

The following workforce-related challenges are outlined to reflect on the factors that influence the registered nurse's ability to support basic nursing care at the bedside of the patient.

- **Effects of employing a diverse nursing workforce**

The current study suggests that the employment of a diverse nursing workforce is contributing to fragmentation in comprehensive patient care. Nursing personnel with different educational backgrounds and levels of experience are utilised to provide direct patient care. Bender, Connelly and Brown (2013:166) point out that a patient within the hospital setting is treated by different nurses and ancillary staff, who are responsible for different care aspects during a hospital stay. Bender et al (2013:165) acknowledge the existence of an empirical link between fragmented care and adverse healthcare outcomes. Elhauge (2010:1) proposes that fragmentation occurs along multiple dimensions in the healthcare arena.

Mosadeghrad (2014:78) concurs that the heterogeneity of multiple healthcare professionals interacting and working with patients, with miscellaneous competency and

experience levels, individual abilities and personalities, influences the quality of healthcare delivery. The IOM's report, *Crossing the quality chasm*, urged healthcare organisations to ensure that information was not lost or forgotten during transitions in care (Hedges, Nichols & Filoteo 2012:29). The phenomenon of fragmented care delivery among healthcare professionals, specifically in relation to various nursing categories with heterogeneous competence and experience levels, with a workforce distribution of both permanently employed personnel and temporary agency personnel, could be drawn in parallel with the operational circumstances in the current study. The findings of the current study portray a work environment that accommodates various multi-disciplinary team members and nurses with differing qualifications, competence levels, knowledge, skills and personal caring attitudes.

- **Diverse clinical competence levels**

Muller and Bester (2016:208) acknowledge that the competencies and abilities of the available personnel influence healthcare service delivery. The findings indicate that nurses, especially non-permanent agency nursing personnel, do not provide a quality of basic nursing care that accord with the value expectations of the healthcare organisation. Clinical competence is affected by educational background and the degree of individual professional socialisation. Abdollahzadeh et al (2017:7) suggest that nurses require good skills, knowledge and skills to prevent incivility toward them.

The current study indicates that the lack of confidence in the ability of the lower nurse categories results in more vigilant supervision in an attempt to reduce patient complaints and incidents in the clinical practice environment. The registered nurse is responsible for remediating improper work conduct and repeatedly re-training nurses who assume duty in the nursing unit. Remediation and retraining of agency personnel, especially lower nurse categories, consumes a large portion of the registered nurses' time.

- **Communication and language barriers**

Roth et al (2015:266) suggest that communication and language barrier problems are some of the most important factors that may contribute to nursing errors in hospital. Registered nurses have difficulty in managing some nurses' language barriers, despite English being the official language in the healthcare setting. The findings in this study

imply that poor language proficiency compromises the efficient execution of nursing delivery at the bedside of the patient and hinders the development of therapeutic relationships with the patient and his or her relatives at the bedside of the patient.

4.3.2.2 *Workforce related effects on the quality of basic nursing care delivery*

- **Patient complaints**

The Ombudsman Western Australia (2017:1) defines a complaint as an expression of dissatisfaction made to or about an organisation, related to its products, services or staff, to which a response or resolution is expected or legally required. Mathibe-Neke (2015:31) suggests that nurse practitioners are expected to provide quality care to patients because patients rely on the nurse practitioners' expertise, knowledge and professional skills. When malpractice occurs in a nursing unit or when the patient or the family members are not satisfied with the nursing care, the patient or families often seek answers from nurses (Mathibe-Neke 2015:31). Mathibe-Neke (2015:31) indicates that the SANC may institute disciplinary action against the nurse practitioner in order to protect the public against misconduct and nursing negligence.

The findings of the current study indicate that when the quality expectation related to basic nursing care provision is contravened in the nursing unit, the registered nurse engages in the complaint management processes to resolve patient dissatisfaction. The registered nurse remediates workforce competencies through the disciplinary process and provides in-service training to enhance quality nursing care delivery.

This study suggests that patient complaints are often directly related to acts and omissions of basic nursing care provision. Scholarly articles convey a continuous quest to determine the nature of nursing negligence in the global arena of patient-centred bedside nursing care. Dabney and Kalisch (2015:306) indicate that basic nursing care omissions, such as inadequate nutritional intake and insufficient patient mobility, may pose serious risks to patients. The findings in this study revealed that patient complaints are very often related to basic nursing care tasks. Dabney and Kalisch (2015:306) indicate that omissions of nursing care also include unrecognised errors that affect patient safety. Errors of *omission* have been described as failure to do the right thing, whereas errors of *commission* are described as doing something wrong (Dabney & Kalisch 2015:306).

Both errors of omission and commission have the potential to result in adverse patient outcomes (Dabney & Kalisch 2015:306). The term *missed nursing care* refers to the omission or delay of any care aspect required in nursing care provision (Dabney & Kalisch 2015:305). Ball et al (2014:117) comment on evidence that unfinished nursing care ('missed nursing care') is an important indicator of the overall quality in nursing care delivery. The concept of missed care addresses nursing care omissions, and several studies have been conducted by using the MISSCARE Survey-Patient instrument to measure omission of basic nursing care tasks. The findings of Ball et al (2014) reveal that the most common instances of missed care point to comfort talking with patients, patient education and developing/updating nursing care plans. The findings of Ball et al (2014) correspond significantly with a study by Ausserhofer, Zander, Busse, Schubert, De Geest, Raffery, Ball, Scott, Kinnunen, Heinen, Stromseng Sjetne, Moreno-Casbas, Kozka, Lindqvist, Diomidous, Bruyneel, Sermeus, Aiken and Schwendimann (2017:131), conducted across 12 European countries. Their study rated comfort talks with patients, nursing care plan development, patient and family education, oral hygiene, adequate documentation of nursing care, position changing and skin care among the top nine nursing care tasks that are left undone in nursing care delivery. The findings of a study by De Freitas et al (2014) reveal that none of the nursing care that was assessed (including hygiene, physical comfort, physical exercise, sleep and rest, physical safety, nutrition and hydration and elimination needs) reached the desirable level, and that nurses experience challenges in broadening the range of care-related aspects to include emotional and psycho-spiritual needs of patients. Al-Kandari, Vidal and Thomas (2009) concur with many of the aforementioned findings in pointing out that the most common nursing activities that nurses omit are related to comfort talk with the patient and family, adequate documentation of nursing care, oral hygiene, routine catheter care and intravenous fluid management.

In the current study, basic nursing care provision was described in terms of task execution done by the lower nurse categories. Generalised statements of participants revealed several inadequacies of basic nursing care delivery, such as administration of medication by enrolled nurses beyond their scope of practice, failure to report a blood pressure reading, lack of basic hygiene, hair washing and shaving of patients, and neglect of pressure care and patient turning. Enrolled nursing assistants had to have remediation training in basic nursing tasks such as mouth care, assessment of patient's mouth, urine testing and bedpan rounds.

- **Inaccurate recordkeeping practices**

The healthcare organisation demands rigorous documentation trails to counter litigation. The findings of the current study imply that unrealistic organisational demands to maintain scrupulous record trails result in adverse self-preserving practices of inaccurate documentation to avoid disciplinary action. Wang, Hailey and Yu (2011:2) indicate that documentation should hold valid and reliable information and comply with quality standards because it is utilised for quality and legal purposes, as well as being a resource for nursing development.

Okaisu et al (2014:2) suggest that documentation accounts for up to 50% of nurses' time per shift. Documentation enhances continuity of care because it entails communication between healthcare professionals (Okaisu et al 2014:2). Poor communication contributes to the occurrence of adverse events in healthcare delivery (Okaisu et al 2014:2). These authors suggest that nursing documentation is a significant indicator of quality nursing practice and could be used to predict mortality. They reflect on several studies done by various authors that articulate reasons for poor recordkeeping, including incongruence between what is documented and actual physical patient status. The study of Wang et al (2011:12) also reflects poor congruence between the recorded content and the actual results from patient assessments, observations and patient interviews. Wang et al (2011:12) confirm that documented data in the nursing records sometimes do not reflect the clinical bedside realities.

Nurses' perceptions and attitudes towards documentation affect the quality of recordkeeping (Okaisu et al 2014:2). Okaisu et al (2014:2) confirm that studies done in various settings indicate that nurses perceive documentation as a burdensome secondary task that takes nurses away from direct patient care. These suggestions pertaining to nurses' perceptions of documentation (Okaisu et al 2014:2) reflect congruence with findings of the current study, in view of the perceptions that recordkeeping and duplication of documentation are taking up a large component of the registered nurses' time and hinder them from direct patient care involvement.

Okaisu et al (2014:2) suggest that the hospital culture and workplace environment can contribute to poor documentation because heavy workloads with extensive documentation requirements, language burdens and inadequate resources impact on the

quality of documentation. Sustainable improvement in the quality of documentation requires modifications to existing systems, in-service training, and mentorship with strong innovative leadership in order to influence and change the culture of nursing (Okaisu et al 2014:6).

- **The inherently caring attitude of nurses**

Roth et al (2015:266) suggest that poor inherently caring attitudes of nurses contribute to nursing errors and negligence in nursing care delivery. The findings of the study suggest that agency personnel do not uphold the organisational values underlying the caring ethos of patient care. Experiences revealed that a poor working attitude of nursing personnel concerns the registered nurse, because the registered nurse is obliged to trust the nurse for task execution, while remaining accountable for the quality of work that is delivered at the bedside of the patient.

The registered nurse, as first-line manager and leader of the nursing team, has a functional responsibility as role model to demonstrate competence through interaction with the workforce to enhance quality in nursing care delivery. Unintentional teaching and learning is a natural consequence of direct observation. In the current study, the registered nurses portray themselves as skilful practitioners that “know what to do”, “know how to plan”, and “know how to prioritise nursing care delivery”. Yet the findings of this study indicate that the registered nurse is consumed by managerial and administrative roles and responsibilities and held away from the bedside of the patient. The absence of physical bedside presence influences patient satisfaction. The effectiveness of patient care coordination (delegation and supervision) was brought in direct relation to adverse incident trends.

- **High personnel turnover rates**

The current study portrays the existence of high personnel-turnover rates that necessitate ongoing employment of nursing staff to sustain the service delivery chain. The challenges to maintaining continuity in nursing care delivery amidst serious shortages of competent registered nurses correspond with the concerns of the Department of Health (2011). The current study reflects on the registered nurses’ responsibility to ensure adequate staffing levels to deliver nursing care to patients. The Department of Health (2011) confirms the

national concern pertaining to a severe shortage of professional nurses across all healthcare settings (Rispel & Bruce 2015:118).

The findings in this study propose that high personnel turnover results in a situation where the unit's personnel are working overtime to supplement the work complement with their own nursing personnel, who are familiar with the organisational values and working environment. The resulting phenomenon corresponds to the literature (Roth et al 2015:266): over-utilisation of personnel culminates in work-related fatigue and burnout, which contribute to nursing errors and negligence in nursing care delivery.

4.3.2.3 Organisational factors affecting the registered nurses' ability to support quality in basic nursing care delivery

The findings highlight operational challenges to managing a nursing unit with high personnel turnover rates.

- **Employment of agency personnel**

The reasons for high personnel turnover were not explored during the focus groups, but participants indicated that staff shortages necessitate the utilisation of agency nursing personnel to ensure continuity in nursing care delivery. Agency personnel are non-permanent nursing practitioners who are hired on a temporary basis in view of the business need to fulfil nursing care services when patient-nurse ratios cannot be achieved within the permanent employed workforce.

Rispel and Bruce (2015:118) suggest that South Africa faces a nursing crisis, characterised by staff shortages, declining interest in the profession and a lack of a caring ethos among nursing personnel. The study indicates that the utilisation of agency nursing personnel adds to the workload burden, because the registered nurse has an increased supervision and repetitive in-service training responsibility for remediating nursing acts of omission and commission in support of the "Back to basics" QI initiative.

Rispel and Bruce (2015:117) confirm that the clinical practice environment is directly influenced by agency personnel, who in turn contribute to poor staying power, low energy levels, abuse of leave and sub-optimal nursing care, which adversely affects the

accountability of the registered nurse and ultimately contributes to exhausting nurse professionalism. The findings similarly suggest that the quality of agency nursing personnel affects the quality of nursing care delivery.

- **Staff-to-patient ratios**

Van den Oetelaar, Van Stel, Van Rhenen, Stellato and Grolman (2016:2) suggest the existence of widespread operational challenges in healthcare organisations to determine whether nursing capacity aligns with patient needs in hospital wards.

The current study suggests that the registered nurse, as manager and administrator of the nursing unit's workforce, is responsible for scheduling staff-to-patient ratios within the margins of the organisational budget. The registered nurse finds it challenging to coordinate the human resource component (workforce) to deliver work-related outputs amidst a low ratio of registered nurses to busy, full nursing units. Fields and Brett (2015:7) suggest that recent studies reflect a significant relationship between adverse patient outcomes and poor staffing levels in healthcare delivery. Safe nurse staffing requires the deployment of sufficient nurses and skill mixes to meet the healthcare needs of patients.

Fields and Brett (2015:8-9) undertook a systematic review of 16 studies that aimed to identify, assess and synthesise available evidence on the comprehensive determinants underlying safe nurse staffing ratios. Fields and Brett (2015) include an extensive range of factors that were taken into account to determine nursing staff levels for community care settings. Fields and Brett (2015:5) suggest that nursing staffing levels are affected by the type of patient, time needed for each care activity, nursing care activities, caregiver factors, care activities assigned to registered nurses and non-registered nurses, staffing and environmental factors, as well as organisational factors, including differences in care settings and performance associated with outcomes.

Ball et al (2012:117) indicate that many studies were conducted in the United States (US), the UK, Belgium and Korea that emphasise a relationship between staffing levels and patient outcomes, and that higher registered nurse staff ratios in intensive care units are associated with lower levels of hospital-related mortality. Aiken et al (2012) report that nurse staffing and the work environment (managerial support, good multi-disciplinary relations, participative decision-making and congruence in organisational care priorities)

were found to be significantly associated with patient satisfaction, quality and safety of nursing care and nursing workforce outcomes. In contrast, Fields and Brett's review (2015:6) found no evidence that specifically describes which minimum staffing levels support safe nursing or how organisational, staffing, environmental and patient factors should be taken into account when determining nurse staffing levels in community care settings.

South Africa, having a nurse-based health system, currently has four nursing categories according to the South African Qualifications Framework: enrolled nursing auxiliaries (ENAs), with one year of training, enrolled nurses (ENs) having been trained for two years, registered nurses/midwives (RN/M), who train for four years, and specialist registered nurses/midwives (SRN/M) who possess one to two years of post-basic training (Uys & Klopper 2013:1). Uys and Klopper suggest that the 2010 statistics of the SANC indicate that the South African nurse ratio in 2006 reflected a ratio of 3:2:1:4 for ENAs:ENs:RN/Ms:SRN/Ms. Uys and Klopper (2013:1) emphasise the significance of workforce planners having clear knowledge of the nurse category ratio needed to provide nursing care on each level of health service delivery. The absence of agreed evidence-based ratios for nursing service delivery when planning a sustainable nursing workforce in the South African healthcare context remains a service delivery issue that is currently being addressed at political level. The findings of the current study indicate that personnel are over-utilised. In an attempt to meet the patient-nurse ratios, nursing personnel are scheduled for overtime. The adverse effect of not having agreed evidence-based ratios for nursing service delivery is burnout among the nursing workforce.

- **Nurse categories acting outside their scope of practice**

The registered nurse functions within a range of professional dimensions in the practice environment and remains legally accountable when fulfilling the prescribed responsibilities as set out in the scope of practice. The findings of the current study suggest that the organisation's work-related expectation does not consistently align with the prescriptions of the scope of practice, because the registered nurse has to delegate the administration of medication to lower nurse categories

Booyens (2014:138-139), Jooste (2010:56-57) and Muller and Bester (2016:208) concur that the registered nurse should delegate activities in accordance with the scope of

practice according to the workforce's level of preparation and work proficiency. Roth et al (2015:266) indicate that allowing nurse categories to work outside their scope of practice may contribute to nursing errors in hospital. In cognisance of the fact that the registered nurse retains professional accountability for task delegation, the registered nurse should exercise accompaniment, supervision and control to ensure that nursing care delivery is executed with the required competence and level of experience towards safe and efficient nursing care delivery (Muller & Bester 2016:204, 208). The findings of the current study portray the registered nurse as aware of the responsibility to delegate basic nursing care to lower category nurses for execution of care provision at the bedside of the patient, but the management-related roles and responsibilities hinder her from exercising accompaniment and supervision at the physical bedside of the patient to control the implementation of safe and efficient nursing care delivery.

4.3.2.4 Challenges to sustain quality in basic nursing care

Mayeng and Wolvaardt (2015:1) argue that quality care is a comprehensive, multifaceted concept. The attributes related to quality nursing care delivery could be defined through various lenses. Mayeng and Wolvaardt (2015:1) suggest that quality could be measured against the effectiveness of nursing care delivery to maintain continuity and safety in care provision. Mosadeghrad (2014:77) defines quality as 'value', 'excellence', 'conformance to specifications and requirements' 'meeting and exceeding customers' expectations; thus, providing services according to functional requirements when meeting and exceeding the customer's healthcare needs. When monitoring patients' safety expectations and experiences, quality measurement aims to evaluate and improve the quality of care (Kieft, De Brouwer, Francke & Delnoij 2014:1; Mayeng & Wolvaardt 2015:1).

Research conducted over the last decade proposes a wide range of factors and predictors which affect the quality of nursing care delivery and patient outcomes within the clinical practice environment. Awases, Bezuidenhout and Roos (2013:1) concur that the quality, efficiency and equity of healthcare services are subject to the availability of a competent workforce with appropriate training to deliver the required standard of healthcare service. Mayeng and Wolvaardt (2015:1) agree that quality patient care is influenced by various factors, many quality determinants of which reach beyond the control of nurse practitioners. The views of the participants in the current study correspond with the

findings of Armstrong et al (2015:2) in acknowledgement of well-documented global evidence that the numbers, competencies and effectiveness of nurses are critical predictors of patient outcomes and the quality of care in hospitals.

Studies conducted on the broad causes of nursing errors in a hospital setting cite an array of probabilities to account for the factors that affect quality in nursing care delivery. Kieft et al (2014) address the nursing work environment as a determining factor in patients' experience of the quality of nursing care. A study by Choi, Pang, Cheung and Wong (2011) address staffing levels, work responsibility management, co-worker relationships and job and professional incentives as stabilising or destabilising forces that influence the nursing work environment in the context of quality nursing care delivery. Sanders et al (2013:347) acknowledge that fatigue of nurses in the work environment has been identified as a significant barrier to safe patient care delivery. Sanders et al (2013:347) refer to the study of Barker and Nussbaum pertaining to the relationship between fatigue, performance and the work environment, but state that their study results indicate that nurses perceive their fatigue more in terms of mental than physical fatigue. Sanders et al (2013:34) maintain that all types of fatigue correspond to negative work performance. The findings of the current study address the following challenges that the registered nurse faces in attempting to support basic nursing care delivery.

- **Insufficient time to enhance professional socialisation**

Ryan, Powlesland, Phillips, Raszewski, Johnson, Banks-Enorensen, Agoo, Nacorda-Beltran, Holloway, Smith, Walczak, Washington and Welsh (2017:183) emphasise the importance of taking enough time to inform and educate staff to sustain quality in care delivery. In the current study, the participants suggested that the lack of time to teach and remediate other nursing personnel in the nursing unit might contribute to adverse effects, with a negative reflection on the competence of the registered nurse.

The registered nurse as first-line manager and leader of the nursing team is a functional role model in the clinical practice environment and should demonstrate competence when managing work quality through interaction with the workforce to enhance quality in nursing care delivery. Dinmohammadi, Peyrovi and Mehrdad (2013:27) indicate that work quality could be enhanced when lower nurse categories physically observe the standards of professionalism during patient interaction. Socialisation is an intended and unintended

consequence of the educational process and work experience (Dinmohammadi et al 2013:27). Professional socialisation is defined as the process of developing and internalising a professional identity through the acquisition of knowledge, skills, attitudes, beliefs, values, norms and ethical standards (Dinmohammadi et al 2013:26). These authors (2013:26-27) suggest that these competencies are critical in fulfilment of the professional responsibilities towards the patient. The most positive outcomes of professional socialisation include the acquisition of a professional identity, ability to cope with professional roles, professional and organisational commitment and thus improvement in the quality of nursing care provision (Dinmohammadi et al 2013:32). Ryan et al (2017:181) suggest that nurses progress through transitional emotional and motivational developmental phases to develop the desired attributes which are consistent with nursing competence. Nurses socialise into competent practitioners as they gain knowledge, skills and experience (Ryan et al 2017:181). The findings of the current study suggest that the registered nurses are not able to optimise their legal mandate to socialise lower nurse categories to the expected professional standards and desired competencies at the bedside of the patient.

- **Nursing workload**

The findings of the current study suggest that the registered nurse experiences her roles and responsibilities as unrealistic, perceiving herself as working under tremendous pressure and stress to keep up with the workload. Various studies confirm the relationship between the work environment, nursing workload, work satisfaction and patient experiences of quality nursing care delivery (Aiken et al 2012:4; Choi et al 2011:1290; Cucolo & Perocca 2015:123; Khamedi, Mohamaddi & Vanaki 2015:476; Izumi 2012:3; Wang, Dong, Mauk, Li, Wan, Yang, Fang, Huan, Chen & Hao 2015:5). A study done by Abdollahzadeh et al (2017:8) relates nursing workload to work-related stress and pressure with the probability of raised workplace incivility. Nurses' psychological comfort facilitate a better tolerance to stress and enhances better behaviour that result in the prevention of workplace incivility and conflict between doctors and nurses (Abdollahzadeh 2017:8).

The findings of this study correspond to the findings of Khamedi et al (2015:476) in the suggestion that workload pressure is related to the lack of professional preparedness and absence of the required competencies for role and task execution assigned to nursing

personnel. The current study raises the need for training to enhance professional preparedness to enable the registered nurse to cope with the professional and personal expectations and requirements underlying quality nursing care delivery. The suggestion of Doherty et al (2010:30) that ward sisters may not have the necessary expertise to perform the managerial aspects of their role with competence and confidence echoes the outcry from the participants for skills-based training, a need which was recurrently conveyed during the focus groups. Doherty et al (2010:30) reiterate that registered nurses should be empowered with sufficient support from management to re-establish their role from 'nurturing mothers' to leaders of entrepreneurial teams, fitting the profile expectation of professionalism and competence.

- **Role conflict, role strain and role overload**

Role overload occurs when professionals are faced with reasonable requirements, but due to time constraints find it impossible to meet all the demands (Palomino & Frezatti 2016:168-169). Yunis and Mahajar (2015:19) and Moustaka and Constantinidis (2010:212) argue that role overload, role ambiguity and role conflict may cause occupational stress. Moustaka and Constantinidis (2010:212) explain that role conflict exists when conflict arises between the professional roles of a nurse. Role conflict is strongly related to the nature of professional training (Palomino & Frezatti 2016:168). The findings of the current study show the existence of role conflict, role strain and role overload that manifest in multiple managerial-clinical responsibilities that remove the registered nurse from nursing care delivery and direct support of "Back to basics" at the bedside. The accounts from participants do not portray professional role ambiguity; the data that were elicited during the focus groups did not suggest a lack of information with regard to work requirements, or uncertainties about the scope of work, responsibilities or specific nursing care activities that ought to be performed in the absence of adequate information and guidelines. In this study the expectation of quality in basic nursing care delivery is perceived as a challenge because the registered nurse is operationally compromised and unable to increase her physical bedside presence.

Palomino and Frezatti (2016:176) suggest that job satisfaction and personnel retention will be enhanced when organisational policies and practices enable professionals to deal with role conflict while performing their duties. Policies and work practices should provide clarity of roles and definition of responsibilities as contained in the work objectives

pertaining to the position of the worker. Within the healthcare arena, with specific reference to role conflict due to role overload in the clinical practice environment, Yunis and Mahajar (2015:18) indicate that nurses in the Malaysian healthcare environment, with inadequate nurse staffing levels, found it difficult to provide safe and efficient patient care in the face of unrealistic nurse workloads, resulting in role overload and eventual burnout. Yunis and Mahajar (2015:19) had hypothesised that role ambiguity and role overload had no relationship with burnout, but the correlation analysis of their study confirmed that role overload and role ambiguity do have a significant influence on burnout and that negative organisational factors undeniably lead to poor emotional health (Yunis & Mahajar 2015:19-20). The literature provides significant evidence with regard to the probability that registered nurses in the current study experience role conflict due to the nature and extent of their managerial-clinician roles and responsibilities in the clinical practice environment.

4.3.3 Record and information management

Administrative tasks were perceived as multiple documentation and recordkeeping activities in terms of unit-related responsibilities and patient-care related activities. The increased vigilance with regard to recordkeeping in hospitals is aimed at the prevention of litigation. Armstrong et al (2013:243) suggest that recordkeeping is an important part of the nurse's responsibility and part of her obligation to communicate information about the patient to other healthcare professionals. Additional quality control measures are implemented to enhance the evidence trail of nursing care delivery. The findings of the current study suggest that registered nurses perceive the implementation of 'check-rounds' and 'check-lists' as unrealistic and adding to their operational burden of efficient time management. Documentation and record keeping are taking up a large component of the registered nurses' time, and the responsibility for maintaining and supervising the adherence to documentation requirements keeps the registered nurse away from the bedside of the patient.

Jooste (2013:87) indicates that proper records provide the foundation for rendering quality nursing care, and therefore documentation must be done to communicate specific information to a person or to the nursing team. Standards for nursing care are based on accurate and complete recordkeeping (Jooste 2013:88).

The findings of the current study, however, reflect the frustration of the registered nurse because duplication of administrative processes when doing recordkeeping consumes a large portion of the time spent in the nursing unit.

4.3.4 QI responsibilities

Portela, Pronovost, Woodcock, Carter and Dixon-Woods (2015:1) propose that improvement interventions, which are purposeful efforts to secure positive change in the practice environment, have become an increasingly important activity within the healthcare environment. The study indicates that registered nurses are willing to support QI initiatives but that they are confronted with several challenges towards the realisation of sustainable implementation of QI initiatives.

4.3.4.1 Challenges to supporting QI initiatives

The findings portray the following challenges that the registered nurse faces in supporting the “Back to basics” QI initiative.

- **Insufficient involvement of the registered nurse in the development of QI initiatives in the clinical practice environment**

The participants shared their perceptions that quality initiatives are driven from an organisational point of view, without adequate representation of the registered nurse category to provide inputs when QI initiatives are developed. Roussel, Dearmon, Buckner, Pomrenke, Salas, Mosley and Brown (2012:203) address the critical importance of staff engagement in improving the work environment and patient care processes.

The study show that QI initiatives are perceived as not being evidence based, and consequently do not speak to the real situation in the practice environment and healthcare-relevant needs of patients. The methodologies underlying successful improvement interventions remain contested, with limited empirical studies to support the body of work in the area of QI interventions (Portela et al 2015:1). Portela et al (2015:5) maintain that QI reports are not without problems, because the fidelity and quality of reporting, as well as the measurement of quality and interpretation of data in QI projects, often provide unreliable data.

- **Insufficient understanding of the nature and extent of QI initiatives to enhance effective implementation**

Portela et al (2015:1) suggest that improvement initiatives should provide clear intervention strategies with operational definitions of key terms relating to the context and complexity levels of interventions, as well as mechanisms of change associated with improvement critiques. The participants indicated that registered nurses needed more clarification on the concept of the “Back to basics” initiative, and more in-service training to enable them to balance the managerial and clinical responsibilities to enhance quality in basic nursing care delivery.

A study by Roussel et al (2012:203) addresses the ‘Transforming Care at the Bedside’ (TCAB) QI initiative, which was originally developed to transform care to patients at the bedside, and in addition to establish a positive care experience for the nurse. The TCAB initiative established a framework for change in medical-surgical units and enhanced safety and reliability, team energy and patient-centeredness, with an increased perception of the value of service delivery (Roussel et al 2012:204). Thrall and Cavaliero (2012:187) indicate that the TCAB QI initiative reported a decrease in fall incidents and pressure ulcers; new QI initiatives continue to be developed on the success of the TCAB programme.

- **Insufficient ownership of the QI initiative at execution level in the nursing unit**

The value of direct patient care involvement was acknowledged from a patient-centred perspective although the participants indicated that the operational expectations underlying the registered nurses’ operational roles and responsibilities make it an almost impossible job to fulfil in view of the existing challenges of role strain and role overload. Active leadership with innovative ideas to instil positive culture changes towards commitment and ownership for the implementation of “Back to basics” QI initiative did not emerge in the findings of this study. Thrall and Cavaliero (2012:187) state that the innovation and transformation initiative includes tools to address leadership growth, culture change and implementation of health reform. Sanders et al (2013:346) confirm that shared leadership enables representation and inclusion of clinical nurse practitioners from all nursing disciplines, with significant impact to create a healthy work environment.

Roussel et al (2012:204) concur with the current study regarding the need to involve frontline nursing staff's expertise in decision-making. Sanders et al (2013:346) discuss the advantages of the Magnet-designated hospital environment, which was implemented as a QI initiative abroad in several hospitals. Magnet-designated hospitals embrace shared leadership approaches to achieve and sustain a healthy work environment (Sanders et al 2013:346). Sanders et al (2013:346) reflect on strategies to enhance nurse competence when managing increased patient volumes, as well as implementing QI strategies aimed at the enhancement of physician-nurse relations as part of the hospital's wellness programme.

Sanders et al (2013:349) discuss the "capacity management QI initiative" that was undertaken when the chief nursing officer executed a pertinent leadership role to educate the clinical nursing staff on best practices when managing high patient volumes. Nurse practitioners applied these taught principles to create their own solutions to meeting the demands and challenges of the work conditions, such as creating sufficient time to conduct bedside end-of-shift reports for safe transfer of care, and adding flexible personnel on staggered shifts to match high-volume peak time patient intervention (Sanders et al 2013:349). Sanders et al (2013:353) report on the successes of this approach, followed by an initiative where more than 80% of the nursing residents participated in a committee or council to govern nursing care matters.

- **Organisational work culture challenges to commit to the "Back to basics" QI initiative**

The findings indicate that registered nurses have limited time to enhance professional socialisation at the bedside of the patient. Time restraints due to the proportion of time spent on administrative- and managerial work responsibilities compromise the role of the registered nurse to model the desired caring values to the workforce. Okaisu et al (2014:6) suggest that the organisational culture seems to drive and sustain change in QI initiatives. Culture change may be achieved through socialising newly recruited nurses into new ways of thinking to obtain a workforce with the expected values, beliefs, attitudes and competencies. To steer sustainable change in nursing practice, the problems and challenges underlying the organisational and individual dynamics should be considered and attended to with an integrative leadership approach. Sustained change is realised when multiple interventions are implemented (Okaisu et al 2014:6).

The results of the capacity management QI initiative reported by Sanders et al (2013: 353) were due to a change in the work culture, in that nurses displayed commitment to the organisation and perceived their jobs as a career rather than just being a job. A passion was nurtured among nurses to use evidence as the basis of practice. Involvement of clinical nurses in the decision-making processes related to patient care matters resulted in an overall experience of renewed energy among the entire nursing workforce (Sanders et al 2013:353).

4.4 NURSING CARE DELIVERY EXPECTATIONS

The nurse practitioner has to apply a range of collaborative and communication skills to balance the patient's care expectations in alignment with the healthcare organisation's business objectives and medical physicians' healthcare agenda. The following stressors that emerged from the study are discussed.

4.4.1 Organisational expectations

The findings in this study portray the existence of unrealistic work expectations which contribute to personal stress. Moustaka and Constantinidis (2010:211) indicate that stress amongst nurses may be experienced as a result of the work demands, which in turn contribute to a wide range of responsibilities. Registered nurses have been encouraged to move from routine supervision to 'leadership' to enhance value for money by means of a flexible, highly skilled educated workforce (Doherty et al 2010:36). Bakker and Demerouti (2014:7) add that the changing nature of the work has resulted in working conditions that differ from those of four or five decades ago. Contemporary jobs are complex in terms of functions and networking structures, with information technology as a central component of job execution (Bakker & Demerouti 2014:7).

The literature recognises that when the work-related demands are perceived to exceed the individual's ability to cope, they trigger psychological distress (Moustaka & Constantinidis (2010:211). Sarafis et al (2016:1) define occupational stress as a situation where the job-related factors interfere with and change the psychological and physiological conditions, which in turn force the person to deviate from normal functioning. High work-related demands in combination with too many responsibilities and too little authority have been identified as a primary source of occupational stress among nursing

personnel (Sarafis et al 2016:3). A systematic review done by Moustaka and Constantinidis (2010:212) indicated that nurses may experience conflict between the work roles related to the professional expectations and the reality of their work. Moustaka and Constantinidis (2010:213) found a strong relation between nurses' occupational stress and an increased staff turnover rate.

The current study's findings reflect congruence with this and depict a similar work-related climate in which nurses perceive their working circumstances as stressful. Registered nurses find it challenging to sustain quality amidst high personnel turnover. Organisational expectations that are perceived as unrealistic amidst the reality of workforce-related constraints may contribute to occupational stress. It could also be argued that the high personnel turnover may be a direct adverse result of occupational stress among the registered nurses. The nature and extent of managerial and administrative responsibilities supersede patient-related care responsibilities, and it is impossible to provide direct patient care at the bedside of the patient amid the organisation-related performance indicators.

Moustaka and Constantinidis (2010:210) suggest that stress experienced by hospital nursing staff has been increasingly recognised as a factor that influences work performance. The current study indicates that registered nurses are physically and mentally challenged by being obligated to adhere to the work-related demands. The findings of this study suggest that nursing units are operationalised as business units and that work performance is aligned with business objectives. It is perceived that nursing care delivery is determined by the organisational budget and that cutting down on personnel has an adverse effect on quality of patient care.

The findings of the current study convey a perception that management acts mainly in a disciplinary capacity, being visible only when problems arise in the nursing unit. This study implies that the registered nurse does not perceive management as acting in a supportive capacity. Moustaka and Constantinidis (2010:211) recognise that the lack of support for staff significantly contributes to stress in the workplace. Roth et al (2015:268) caution that a workplace that makes it difficult to function produces anxiety and makes nurses vulnerable to mistakes.

The findings of the current study reflect the registered nurses' feelings of being overwhelmed when assuming responsibility and accountability for patient care in the nursing unit, especially if the quality of nursing care is affected by the acts and omissions of lower category nurses. Doherty et al (2010:37) cite Allen (2001), Doherty (2007) and RCN (2009) as suggesting that despite the mandate of managerial empowerment, the registered nurses experience dissatisfaction, stress and disillusionment with their role fulfilment. Koinis, Giannou, Drantaki, Angelaina, Stratou and Saridi (2015:17) indicate that interventions to promote mental health, such as coping mechanisms, play a central role in the management of stressful events. Koinis et al (2015:17) propose that psychological support and counselling programmes, which provide active support on behalf of the hospital's managers, and wider participation of nurses in decision-making processes, would significantly help to alleviate stressors between the individuals and their environment. Sarafis et al (2016:8) concur that health education and specific training programmes for nurses to improve their knowledge and ability to cope with stress, such as conflict solving and positive appraisal, would reduce stress responses, towards establishing a more supportive work environment.

4.4.2 Patient care expectations

Koinis et al (2015:12) propose that work-related stress in combination with the patients' demands could be a burden on the nurse's emotional state. Continuous interaction with patients and their family members and relatives can create feelings of anger, embarrassment, fear and desperation among nurses, especially when situations do not render pertinent solutions to patients' problems. The findings of Sarafis et al (2016:7) ranked patients and their family members as the second most significant stressor in their study, because continual interaction, lack of cooperation and the nurse's perceived sense of unpreparedness to cope with multi-dimensional patient needs, causes feelings of anger and anxiety amongst nurses.

The current study suggests that a large portion of the registered nurses' time is dedicated to interaction with the patient's family and relatives. Bellou and Gerogianni (2007:1) argue, however, that the family plays a significant role in hospital treatment of patients because it provides psychological and emotional support to patients when undergoing treatment in hospital

The findings of this study indicate an increase in the care expectations regarding basic nursing care delivery in certain nursing units, due to the nature of patients' health-related needs and problems. Patients are well informed about their patient rights and often challenge nurses with the health-related knowledge and high demand for care because of expectations that they have acquired on websites. Back (2015:19) suggests, however, that patients should not be blamed for being demanding. In a 'tectonic shift', patients and families seek and absorb information and execute their right to verify what they have heard by asking questions. Before the availability of the internet, patients did not have any resources other than relying on the care interventions of healthcare workers (Back 2015:19). Back proposes, in fact, that the 'myth of the demanding patient' reflects on the insufficient communication skills of healthcare professionals.

4.5 CLINICAL CARE RESPONSIBILITIES

The registered nurse functions operationally within a range of professional dimensions and has a legal obligation to fulfil the required roles and responsibilities as portrayed in the scope of practice. As employee of the hospital, the nurse has an obligation towards the employer to render the required services that she or he was appointed for. Armstrong et al (2013:237) argue that the majority of nurses are employed by a hospital or clinic without formal contractual agreements with patients, although the existence of an unwritten contract between all nurses and their patients to provide safe and efficient nursing care cannot be contested. Armstrong et al (2013:237) suggest that the commitment to provide quality and efficient nursing care to a patient exists subliminally in the form of an 'unwritten contract' between the nurse as care provider and the patient as consumer of healthcare. The unwritten contractual agreement between the nurse and patients is based on mutual trust and respect and applies to hospital nurses (Armstrong et al 2013:238). The findings of the current study indicate that the registered nurses do perceive their duty as a broad responsibility to deliver work outputs that reflect safe and efficient nursing care and patient satisfaction.

4.5.1 Ethical-legal framework

The professional regulatory body and the healthcare organisation by which the nursing practitioner is employed govern professional practice and nursing care standards. The nursing practitioner is held accountable for nursing actions and omissions in accordance

with the scope of practice as stipulated in the Nursing Act (South Africa 2005). This study portrays acknowledgment from registered nurses regarding the legal obligation to practise in accordance with the scope of practice, which prescribes responsibilities and accountability for nursing care delivery. De Freitas et al (2014:454) concur that the nursing profession is cognisant of the obligation to provide quality nursing care within the ethical-legal framework of the patient, the institution, ethics, law and professional standards.

The current study illustrates the understanding of the registered nurse that each nurse category has a distinctive role and responsibility with regard to basic nursing care delivery at the bedside of the patient, and that the registered nurse is responsible for supervising the overall execution of patient care activities.

4.5.2 Direct patient care provision

The findings of the current study suggest that the physical execution of basic nursing care is not regarded as the duty of the registered nurse, because unit management and administration takes the registered nurse away from the bedside of the patient. According to Doherty et al (2010:38), direct patient care is unsustainable amid the wide-ranging nature of the registered nurse's administrative and managerial roles and responsibilities. The participants concurred with this finding of Doherty et al (2010:38), that delivering basic nursing care in person is no longer considered to be the job responsibility of the registered nurse.

A time-and-motion study done by Armstrong et al (2015:4) studied the proportional time that unit managers spent on various activities in the nursing unit, including time spent on patient care. The activities of nursing unit managers in the time-and-motion study by Armstrong et al (2015:4) reflect similarities to the findings of the current study with regard to the execution of responsibilities in terms of hospital administration, patient administration, staff management, education, communication and support. This study does not elaborate on the registered nurse's direct contribution to basic nursing care delivery at the bedside of the patient. The findings of the current study suggest that the registered nurse fails to provide direct patient care in view of her other work-related responsibilities. Being responsible for fulfilling multifunctional managerial and administrative tasks in adherence to legal and operational requirements may account for

role conflict and consequential disengagement from direct patient care. Probst et al (2017:95) suggest that reduced time with patients has negative effects on the practice environment and patient outcomes. The findings of the current study reflect congruence with this suggestion of Probst et al (2017), in view of patient complaints that were directly related to basic nursing care omissions aggravated by the reduced clinical visibility of the registered nurse while being absorbed by administrative responsibilities.

Roussel et al (2012:204) point out that nurses comprise the majority of healthcare personnel that provide direct patient care to patients, and have tremendous potential to influence quality and safety in patient care delivery. Roussel et al (2012:205) suggest that the core principle of TCAB is the facilitation of QI by relying on nurses that provide direct care to patients. Ryan et al (2017:181) state that many studies have found that excellence in nursing care depends on nurses' attitudes, values and behaviour. Roussel et al (2012:207) support the crucial responsibility of the nurse to direct the transformation of bedside nursing care among clinical nursing staff by explaining the essential attributes of physical involvement, cognitive vigilance and emotional connectedness. The registered nurse, as first-line manager and mandated process owner of basic nursing care delivery, remains instrumental in the realisation of the "Back to basics" QI initiative.

However, performance is measured against specific business-driven targets, and managers are being held accountable for target achievement (Doherty et al 2010:37). Doherty et al (2010:37) explain that the increase in accountability has resulted in an elaborated role, because the registered nurse has to assume the responsibility for capacity management, in contrast to the historical emphasis of a clinically dominated organisation. De Freitas et al (2014:454) propose that despite the unique challenges of each country to meet the healthcare needs within their circumstances and healthcare expectations, studies continue to indicate errors in the quality and safety of nursing care. Adverse healthcare incidents and missed care lead to an increase in medico-legal incidents. Unwanted events harm the health organisation's image (De Freitas et al 2014:454). Chan et al (2012:2024) explain that although the nursing profession subscribes to an ideology of individualised patient care, the organisation of nursing work focuses on practical, time-based matters that require adherence to the workplace environment.

4.5.3 Reflection on past nursing practices

From a historical perspective, different models of nursing care have emerged over the years in response to economic conditions, political circumstances and changes in the social profile of the consumer of healthcare (Musanti, O'Keefe & Silverstein 2012:219). Doherty et al (2010:36) indicate that organisational changes have imposed greater managerial responsibility and entrepreneurship, leading to an increase in managerial expectations of the registered nurse in the UK since the 1980s. Adherence to the historical image of the nurturing 'mother', with emphasis on caring and concern for patients, has been challenging in view of the expanded managerial roles and responsibilities of the registered nurse. The findings of the current study convey elaborated accounts related to the managerial and administrative roles and responsibilities of the registered nurse that absorb their time and keep them away from physical bedside patient care.

Musanti et al (2012:219) reflect on the total care delivery model that steered nursing care delivery from 1930 to early in the 1980s. The functional care delivery models were applied in the 1940s; team nursing care delivery then followed in the 1950s and was replaced by the primary care delivery models from 1960 to 1970. These basic models progressed over time and set the foundation for modern nursing care delivery models (Musanti et al 2012:219). The rationale behind acknowledgement of the work environment as a determinant of quality in nursing care delivery transpired in the 1980s to 1990s, when shortage of nurses had to be taken into consideration regarding sustainable healthcare service delivery (Musanti et al 2012:219). The demand for nurses steered investigation into factors that would retain nurses in the nursing profession.

Musanti et al (2012:219) suggest that the Magnet Recognition and the Pathway to Excellence programmes were established to identify and develop work environments to attract and retain well-qualified nurses. Both of these programmes provide structure, standards and outcomes for nursing practice that endorse the importance of a conducive work environment in enhancing patient and nurse outcomes and organisational success (Musanti et al 2012:219). The Magnet Recognition and the Pathway to Excellence programmes steer the development of professional practice models with integrative approaches towards professional values, multi-disciplinary collaboration, and workforce compensation, to enhance patient care delivery (Musanti et al 2012:219). Shared

governance structures engage stakeholders to take ownership of the products and outcomes in healthcare delivery.

Hunt (2014:184) argues that the ethic of caring in nursing depends to some extent on the consistency with which the healthcare organisation's decision makers assign sustainable nurse-patient ratios to nursing units, enabling adequate development of caring relationship with patients. Hedges et al (2012:28) confirm that traditional care delivery models (total patient care, functional nursing, team nursing and primary nursing) were developed to address past socio-economic and cultural values in healthcare, with emphasis on delegation of duties and work allocation. Hunt (2014:184) suggests that task-oriented approaches to nursing care delivery promote the practitioner's autonomy of thought and action. Hedges et al (2012:28) indicate that the implementation of care delivery models based on caring theories and relationships have shown improvement in overall patient satisfaction, especially when patients' personal and emotional needs are attended to. Hunt (2014:184) concurs that primary caring styles enhance the development of care relationships with patients. Hedges et al (2012:28) propose that organisations must look beyond division of workload and consider the work environment from a caring-focused delivery model to achieve family-centred, relationship-based care with optimal patient safety and reduced cost, towards quality in nursing care delivery. In order to initiate the development of relationship-based caring approaches, the administrator and nurse must meet each other as moral beings on non-coercive, supportive working grounds (Hunt 2014:185).

When a healthcare organisation wants to improve the care environment through teamwork, nurses should be engaged in the process of team briefing and debriefing (Hedges et al 2012:28). Briefing and debriefing activities provide a consistent forum to enable inputs from nurses about safety and operational issues and enhance a constructive relationship with co-workers and colleagues. Hedges et al (2012:28) refer to the Salas Theory of Teamwork, which supports teamwork through briefing to establish an awareness of 'the self' as part of the team. Teamwork facilitates communication among team players, combining the need to help one another and to adjust to work environment changes with enhanced leadership (Hedges et al 2012:28).

4.6 SUMMARY

Chapter 4 discussed the findings of the study and integrated them with existing literature to contextualise the perceptions of the registered nurses regarding the “Back to basics” QI initiative, in the medical-surgical nursing unit. The challenges that nurses experience in the realisation of basic nursing care delivery at the bedside of the patient reflect congruence with global and national research done in similar studies.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

“The definition of insanity is doing the same thing over and over again, but expecting different results”

Albert Einstein

5.1 INTRODUCTION

Chapter 4 presented a discussion of the findings and their integration with the literature to contextualise and confirm the phenomena under study. The four themes encompass the perceptions of the registered nurse with regard to her roles, responsibilities and underlying challenges in supporting the “Back to basics” QI initiative.

Chapter 5 discusses the conclusions in view of the study objectives. The chapter also presents an outline of a continuing professional development (CPD) plan for registered nurses in the general nursing discipline to empower them to deal with the demands and expectations of the clinical practice environment. Recommendations are drawn and limitations of the study are identified.

5.2 CONCLUSION ON THE FINDINGS

In this section, conclusions are drawn from the findings to address the purpose of the study in terms of the following study objectives:

- Explore nurses’ perceptions of their roles and responsibilities in supporting the healthcare organisations’ “Back to basics” QI initiative.
- Describe challenges that nurses face in the realisation of “Back to basics” nursing care delivery within the organisational QI strategy.
- Recommend practical ways to enhance QI initiatives at the bedside of the patient.

The conclusions address the study objectives as follows:

5.2.1 Supporting the healthcare organisation's "Back to basics" QI initiative

The registered nurse fulfils multiple roles and responsibilities in the clinical practice environment in supporting the "Back to basics" patient-centred quality creed. The managerial- and administrative responsibilities in the nursing unit are interrelated and inseparable. The care management roles of the registered nurse extend into multiple hospital- and patient-related administrative responsibilities for managing patient care delivery. The majority of the registered nurses' roles and responsibilities revolve around managerial and administrative duties to coordinate patient care. The operational responsibilities underlying the roles of manager and administrator enable the registered nurse to accomplish nursing care delivery in the clinical practice environment.

The care management roles of the registered nurse involve the coordination of patient care. Nursing care delivery is coordinated through the application of an assessment-delegation-supervision triad to plan, organise and direct basic nursing care provision. The findings suggest that the assessment-delegation-supervision triad is utilised to 'get the job done'. Task delegation and supervision of lower nurse categories is central to the registered nurse's responsibility for sustaining basic nursing care at the bedside of the patient. Encounters with the workforce, however, engender a lack of confidence in the competence of nurses. The registered nurse finds it challenging to sustain continuity of care in the face of high personnel turnover rates on the part of the permanent workforce, and agency personnel with disparate qualifications. Workforce-related challenges such as diverse clinical competence levels, lack of communication proficiencies and inconsistent adaptation to the expected care values challenge the registered nurse to enhance quality in basic nursing care delivery.

The registered nurse experiences the human resource responsibilities as challenging to schedule staff-to-patient ratios within the margins of the organisational budget. Staff scheduling brings to light imbalances in work-skills mixes, and critical shortages of registered nurses necessitate the delegation of direct patient care tasks to lower nurse categories. Even the administration of medication is delegated to enrolled nurses, who are then acting beyond their scope of practice, although the registered nurse retains legal accountability.

Patient-related administrative responsibilities require rigorous documentation to counter litigation. However, unrealistic organisational demands to maintain scrupulous record trails lead to self-preserving practices of inaccurate documentation to avoid disciplinary action. The managerial responsibilities, together with the repetitive, duplicative nature of administrative processes, cause work distribution imbalances between the registered nurse's care management and care provision responsibilities.

Remediation of improper work conduct and repetitive re-training of unevenly qualified nurses consumes a large portion of the registered nurse's time away from the bedside of the patient. Time constraints affect the registered nurse's physical bedside availability. The extent of non-direct patient care responsibilities hinders the registered nurse from enhancing the professional socialisation and strengthening of professional identity of the lower nurse categories, which would help them to acquire knowledge, skills, attitudes, beliefs, values, norms and ethical standards.

Care management involves professional collaboration with physicians and multi-disciplinary team members to plan, coordinate, direct, evaluate and communicate patients' needs. Being available to meet the professional or personal needs of doctors, interdepartmental and multi-disciplinary colleagues, families, relatives and visitors results in work interruptions likely to compromise quality and safety in nursing care provision. Moreover, workplace incivility amongst doctors and nurses, often characterised by bouts of verbal confrontation, causes psychological discomfort and stress that adversely affect the development of therapeutic relationships with patients.

Registered nurses experience difficulty in balancing care management and direct care provision at the bedside of the patient. Registered nurses are pressured to meet the expectations of both the organisation and patient. All these expectations lead to role conflict, role strain and role overload in registered nurses. Meeting requirements and expectations from the organisation and stakeholders involved in the clinical practice environment, coupled with the perception of having too many responsibilities without sufficient authority, culminates in feelings of frustration, work-related stress, absenteeism and staff resignation. A lack of professional preparedness and the required competencies to deal with role and task execution was identified. The need for empowerment to cope and deal with the demands of the work environment was conveyed as "a cry for help" for professional development and in-service training.

5.2.2 The realisation of the “Back to basics” QI initiative at the bedside of the patient

The study reveals that the registered nurse is the custodian of various QI initiatives in the clinical practice environment. The “Back to basics” QI initiative is an ongoing organisational expectation to enhance patient-centred nursing care at the bedside of the patient.

Taking ownership towards the realisation of optimal “Back to basics” quality nursing care at the bedside of the patient was received with ambiguity in this study. The value of basic nursing care provision as strategy to enhance patient satisfaction was acknowledged. The findings however, indicated that the required operational distribution of 40% worktime dedicated to administration and 60% worktime dedicated to bedside nursing is unrealistic against the backdrop of the work-related realities. “Back to basics” patient care was perceived as an almost impossible job to fulfil.

There is a normative understanding amongst participants that each nurse category has a distinct responsibility with regard to basic nursing care delivery at the bedside of the patient. The registered nurse category finds it challenging to assume prominent direct basic nursing care responsibilities at the bedside of the patient amid her current operational realities and time restraints. Rendering basic nursing care in person is no longer considered to be the job of the registered nurse. The findings indicated the need for conceptual and operational clarification on the concept “Back to basics”. Solution-driven in-service training might enable registered nurses to balance the managerial and clinical responsibilities to enhance efficient realisation of the “Back to basics” QI initiative towards quality in nursing care provision.

Registered nurses facilitate the workforce to attend in-service training sessions to improve the quality of nursing care and patient satisfaction. The findings suggest that efficient realisation of the “Back to basics” QI initiative could affect the quality of nursing care at the bedside of the patient because successful realisation of the “Back to basics” QI initiative is validated through patient satisfaction. The number of challenges that the registered nurse faces in fulfilling the operational duties often result in patient dissatisfaction. Contravention of the expectation of quality care culminates in additional administrative responsibilities to attend to patient complaint management. The complaint

management process requires an isolated work area, which compromises the clinical visibility and supervisory role of the registered nurses and adversely affects their ability to build therapeutic relationships with patients. The findings of this study suggest that the majority of patient complaints are related to acts and omissions in basic nursing care. These cast a negative reflection on the competence of the registered nurse.

Perceptions were maintained that the healthcare institution consults external resources to address internal quality problems without realistic acknowledgement of the practice realities or actual care needs of the patient. The findings indicate that internalisation of new behaviour towards quality nursing care realises inconsistently because in-service QI strategies do not always align with the learning needs of the staff. The findings of this study address the need for representative involvement in the development of QI initiatives.

5.2.3 Practical ways to enhance QI initiatives at the bedside of the patient

The intrinsic success of QI initiatives is dependent on the commitment of the frontline stakeholders in the clinical practice environment. Staff engagement affects the work environment, as well as patient care processes, which ultimately affect the quality of nursing care. The management of the “Back to basics” QI initiative was not explored. The study focussed on the enhancement of QI initiatives in view of the participants’ perceptions as depicted in the study findings. This section addresses objective three of the study and provides practical recommendations to enhance QI initiatives at the bedside of the patient.

Pre-establishment of quality indicators should reflect a balanced inclusion of the healthcare organisation’s mission, and the expectations of patients, doctors and multi-disciplinary team members as clients and shareholders in the healthcare service delivery arena. During the development phase of QI initiatives, inviting frontline nurses, as key team members to share their expertise, may facilitate personal commitment to drive sustainability in QI initiatives among the workforce. Specific, measurable, achievable, realistic objectives are needed, with timeframes to evaluate progressive achievement during the implementation phase of QI initiatives; these should be communicated to the registered nurses in the pre-implementation phase of a QI initiative. Clear roles and responsibilities for each nursing category, with key performance indicators, should be

developed through a process of negotiation and buy-in from the workforce before commencing the implementation phase to enhance individual ownership.

The development of a formal action plan that reflects the ideas and plans of the nursing workforce should be shared with other nursing units involved in the initiative, to promote teamwork. Group synergy among nurses in similar working circumstances may enhance the work environment and improve the work culture. The registered nurse should encourage the nursing workforce of the unit to share their ideas on how QI initiatives could realistically be implemented in the workplace environment. The registered nurse, as supervisor, could identify leaders among the nursing personnel and delegate specific responsibilities underlying the QI initiative to individuals, to establish ownership for their own work inputs within the nursing team.

Before the actual implementation of QI initiatives, the workforce should be orientated to the functional definitions, meaning, aims, objectives and advantages of the QI initiative. Workforce empowerment may enhance motivation and increase productive engagement among nursing personnel. Regular progress meetings during the implementation phase of QI initiatives should focus on functional challenges and problem resolutions to maintain adherence to the project objectives. Continual feedback on goal and objective achievement should be communicated to the nursing workforce to maintain individual involvement and team effectiveness in the QI initiative.

Incentives to reward extraordinary performance, such as 'quality champion of the month' accolades and annual recognition certificates for measurable patient-centred QI may enhance the success of QI initiatives.

5.3 RECOMMENDATIONS

Recommendations are based on the findings of this study. The researcher makes the following recommendations for practice, the healthcare organisation, education and training and for further research:

5.3.1 Recommendations for practice

Recommendations for practice are based on the findings in view of the challenges that nurses face in fulfilling their roles and responsibilities in the clinical practice environment. It is recommended that:

- Clinical practitioners (specifically, registered nurses that work in the general nursing units) should be included in steering committees to provide their inputs in decision-making processes that affect the clinical practice environment directly. The inclusion of nurses that truly understand the grass-root circumstances in the practice environment will enhance attainability in clinical governance.
- It is recommended that the private healthcare sectors develop sub-committees where registered nurses represent clinical practice matters on recognised forums to address the need for endorsed evidence-based nurse-patient ratios at legislative level.
- The operational responsibilities of the registered nurse should reflect a balanced, realistic and attainable work distribution between care-management and care-provision functions.
- The operational roles and responsibilities should reflect alignment with the scope of practice for to each nurse category and managers should ensure operational adherence thereof.
- Patient acuities should be taken into consideration when patient-nurse ratios are considered.
- Practice should empower and support the registered nurse through continuous clinical leadership training and mentorship programmes to enable them to achieve and maintain quality in nursing care standards.
- CPD programmes should focus on the empowerment of the registered nurse to execute the required skills when employing the assessment-delegation-supervision triad to delegate nursing tasks efficiently to nurses according to their scope of practice and level of training and expertise.
- Registered nurses should be encouraged to enrol in professional associations and attend professional clinical practice conferences and meetings to enhance practice knowledge, and to establish a platform to voice the needs and challenges experience in the clinical practice environment.

5.3.2 Recommendations for the healthcare organisation

To address the perceptions of a strenuous work environment, with several challenges that arise in supporting basic nursing care delivery, the researcher recommends that:

- The registered nurse, as process owner of basic nursing care delivery, should be directly involved in care delivery at the bedside of the patient to reinforce professional socialisation of lower nurse categories.
- The “Back to basics” QI initiative provides the mandate for the registered nurse to enforce quality care and, in turn, decrease professional misconduct and litigation related to poor basic nursing care.
- Establishment of a ‘healthy workplace committee’ to invest in the physical, mental and social wellbeing of the workforce may enhance the workforce’s morale and functional productivity.
- Strengthening of the physician-nurse relations as part of the hospital’s wellness programme may optimise multi-disciplinary collaboration and advance the psychological wellbeing of nursing personnel towards improved patient outcomes.
- Auditing of patient files should be done by a team of clinical experts with a comprehensive approach to evaluate the quality of basic nursing care provision and to verify the authenticity of nursing interventions. The audit tool should be utilised during in-service training sessions as a teaching and learning opportunity for all nurse categories to promote recordkeeping evident of comprehensive basic nursing care delivery.
- The researcher recommends that the healthcare organisation adopts structured approaches to nursing recruitment programmes to identify nurses with the potential of being socialised into new ways of thinking and doing, to improve the quality of nursing care delivery.
- The interview guide that is utilised during recruitment of prospective nurse candidates should include assessment activities to evaluate the cognitive, psychomotor and attitudinal competence of all nurse categories before appointment to enhance workforce competence.
- The healthcare organisation may consider the appropriateness of adopting existing quality programmes to attract and retain well-qualified nurses.

5.3.3 Recommendations for education and training

Education and training plays a paramount role in securing sustainable competence in the clinical practice environment. The following recommendations aim to address the registered nurses' need for continuous professional development (CPD) to strengthen the roles and responsibilities of the registered nurse towards quality nursing care delivery:

- The initial training module should be developed with the emphasis on professional preparedness to deal with the immediate operational responsibilities in the nursing unit.
- Emphasis should be placed on practical learning outcomes.
- The CPD plan should reflect extension of the pre-registration training programme.
- CPD programmes should offer practical guidance on individual skills and personal development in the workplace.
- CPD programmes should focus on the development of sustainable competence to meet the diverse and complex demands and expectations of the modern healthcare arena.

The following outline is provided to suggest topics for inclusion in the existing CPD plan:

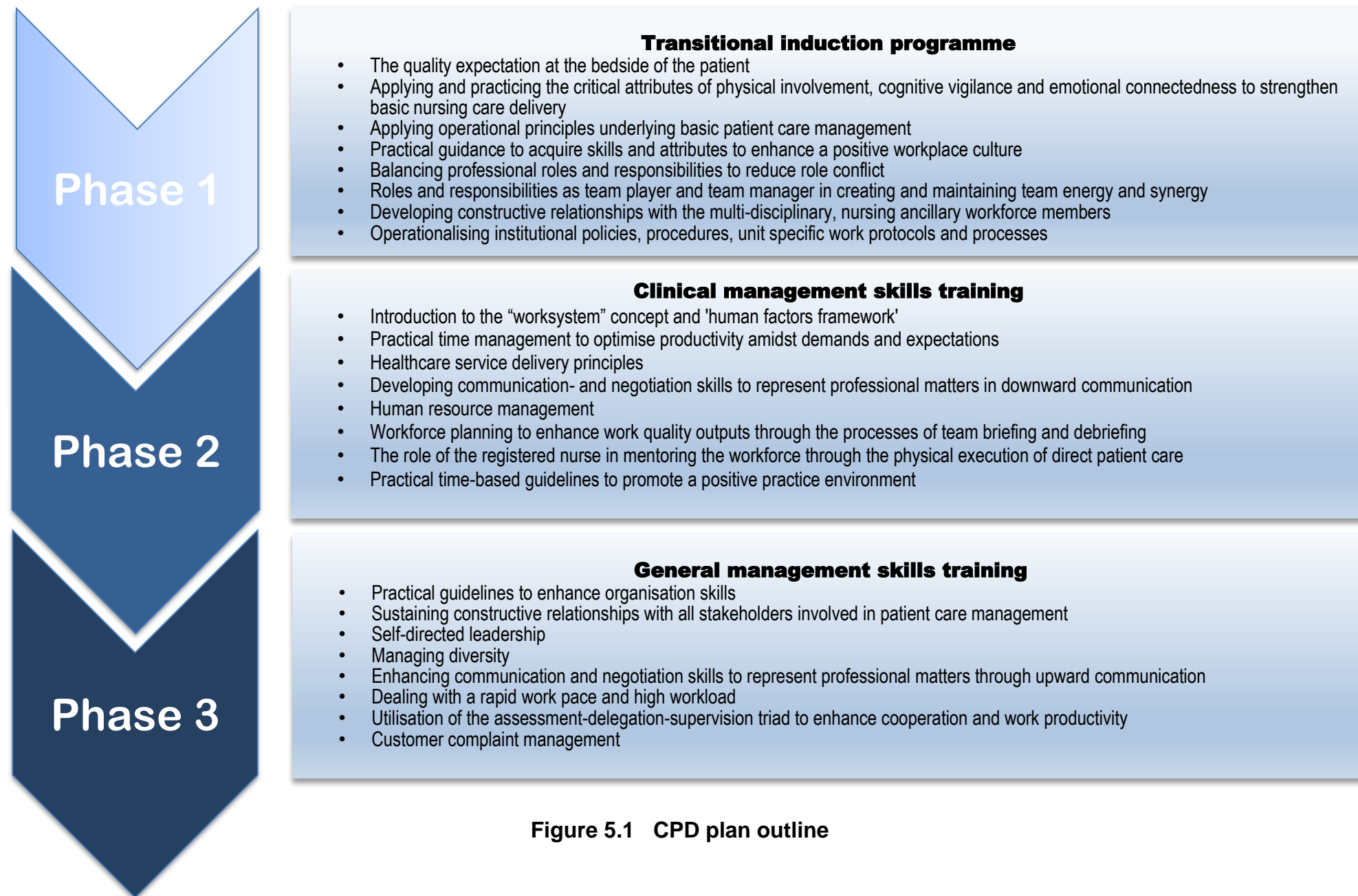


Figure 5.1 CPD plan outline

5.3.4 Recommendations for further research

The researcher suggests the following studies for further research:

- Qualitative studies to explore and describe the perceptions of various nurse categories related to their roles, responsibilities and challenges to support the “Back to basics” QI initiative. These studies could be conducted in private healthcare institutions as well as in the public sector.
- A comparative study to measure and clarify the roles and responsibilities in practice to the prescribed legislation for each nurse category.
- Conduct a concept analysis of “Back to basics” and explore nurses understanding of the concept.
- Development of an in-service training course as part of the CPD programme with input of frontline nurses and measurement of the outcomes towards internalised behaviour.
- Qualitative studies to explore the perceptions of the organisations’ management and doctors regarding the roles and responsibilities of the different nurse categories in the clinical practice environment.
- Quantitative studies to measure the managerial- and administrative workload of the registered nurse followed by time and motion studies to inform practice about the larger context of role and responsibility conflict in basic nursing care delivery.

5.4 LIMITATIONS OF THE STUDY

The researcher included a population of nurses with a direct involvement in nursing care delivery at the bedside of the patient. The focus groups consisted of unit managers and registered nurses, which could have affected the balance of perceptions related to the managerial and administrative roles and responsibilities of the registered nurse in the clinical practice environment.

5.5 CONCLUSION

“Everything rises and falls with leadership ... We know that errors become visible at the sharp end, but they almost always start with the blunt end” (Milne 2012). This study’s

hands-on, real-world perspectives of the key resource in nursing care delivery may enable nurse leadership to review existing practices to enhance quality in nursing care. Strengthening the critical pillars of clinical competence, a healthy organisational culture and supportive workplace environment will enforce the quality foundation of patient-centred nursing care. Challenges could be addressed meaningfully if we move beyond the visibility of the sharp ends that implicate nursing care as poor, and nurses as uncaring and ignorant. QI strategies can instil change by nurturing the human-focused rationale behind care and caring. Quality nursing care should encompass the essentials of patient-centred, safe basic nursing care that truly adds value to the maintenance and restoration of health and alleviation of pain and suffering.

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ANNEXURES

ANNEXURE 1: ETHICAL CLEARANCE FROM THE UNIVERSITY OF SOUTH AFRICA



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

REC-012714-039

HS HDC/365/2014

Date: 10 December 2014

Student No: 5052-938-2

Project Title: An Exploration of the perceptions of nurses of their roles and responsibilities in the realization of the quality improvement initiative "Back to Basics" nursing care.

Researcher: Roelien Els

Degree: MA in Nursing Science

Code: MPCHS94

Supervisor: Prof GH van Rensburg

Qualification: D Litt et Phil

Joint Supervisor: -

DECISION OF COMMITTEE

Approved



Conditionally Approved



for **Prof L Roets**
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

L. A. Roets (Prof)

Prof MM Moleki

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE 2: OBTAINING PERMISSION FROM THE HEALTHCARE INSTITUTION TO CONDUCT THE STUDY

Re: Application to conduct research at [REDACTED]

Herewith, please find my application for research approval to conduct a study at [REDACTED]. I am currently studying at Unisa under the supervision of Professor Gisela van Rensburg for a Master of Art degree in Nursing Science.

A qualitative research proposal has been compiled with the title: **AN EXPLORATION OF THE PERCEPTIONS OF NURSES OF THEIR ROLES AND RESPONSIBILITIES IN THE REALISATION OF THE QUALITY IMPROVEMENT INITIATIVE “BACK TO BASICS” NURSING CARE.** In my capacity as nurse educator, I am committed to quality in basic nursing care delivery. As part of the educational team, quality initiatives, aimed at the improvement of quality and safety in nursing care is a constant priority. The purpose of the study is to gain an in-depth understanding of how nurses as process owners of nursing care, perceive their roles and responsibilities to deliver basic nursing care linked to the organisational quality improvement initiative “Back to basics” nursing care at the bedside within the in real-world general nursing care context.

A qualitative, explorative descriptive study will be conducted by using focus groups within the population of Registered nurses working in general nursing care units to explore nurses’ perception of their roles and responsibilities in supporting the healthcare organisations’ “Back to basics” quality improvement initiative. Focus groups will be conducted, continuing for approximately one hour at a venue arranged with the hospital or scheduled at the [REDACTED]. The aim is to gain an in-depth understanding of the challenges that nurses face in the realisation of basic nursing care delivery to enable me to recommend practical ways to improve quality improvement initiatives at the bedside of the patient.

I undertake to conduct this study with the utmost transparency and to ensure that ethical conduct is maintained meticulously in terms non-disclose of the name and reputation of [REDACTED] and its’ employees as participants of the study. The rights of participants have been addressed in the under-mentioned documentation, and will be maintained consistently.

The following documents are attached to this letter of request for your perusal and consideration:

- [REDACTED] Submission for Research Approval to the [REDACTED] Research and Scientific Committee
- Formal document submitted to Unisa's Research and Ethics committee to request for ethical clearance of the research proposal (containing the research proposal and an abstract thereof)
- Participant information leaflet, followed by a written consent to participate in the study
- Demographic data instrument to participants

Ethical clearance was granted by the Research Ethics committee of the Department of Health Studies, Unisa. I am aware that the study may only continue after formal approval has been granted from both Unisa and [REDACTED]

[REDACTED] informed about the study and is in support thereof.

I trust your favourable consideration.

Yours sincerely

Roelien Els
Nurse educator

[REDACTED]

ANNEXURE 3: INSTITUTIONAL PERMISSION GRANTED FROM THE PRIVATE HOSPITAL GROUP TO CONDUCT THE STUDY



ATTENTION: Roelin Els

APPROVAL FOR RESEARCH STUDY

TITLE: An exploration of the perceptions of nurses of their roles and responsibilities in the realisation of the quality improvement initiative 'Back to Basics' nursing care.

The Research & Scientific Committee [redacted] hereby grant permission for your study to be conducted within company facilities. Present this letter to the Hospital or Nurse Manager of the facilities you will be using in your studies, when seeking permission at the specific facility.

The approval is conditional to your agreement on the following:

1. An electronic copy of your study is submitted to the committee prior to publication,
2. No direct reference is made to [redacted] or its various facilities in your study report or any publications thereafter,
3. The company and its facilities are not in any way identifiable in the study.

We wish you the best in your studies and look forward to the results.

Yours sincerely,

[redacted]

On behalf of the Research & Scientific Committee

Please sign as below and return this letter to the sender:

I, Roelin Els, hereby agree to the conditions (points 1-3) as listed above.

Signature: [Signature]

Date: 17/03/2015



ANNEXURE 4: LETTER OF APPLICATION TO CONDUCT RESEARCH AT THE RESPECTIVE RESEARCH SITE



Re: Application to conduct research at



Our conversation at the research day dated 5 August 2016 herewith refers. Please find my application for research approval to conduct a study at in 2016. I am currently studying at Unisa under the supervision of Professor Gisela van Rensburg for a Master of Art degree in Nursing Science.

The title of the proposed study is; **AN EXPLORATION OF THE PERCEPTIONS OF NURSES OF THEIR ROLES AND RESPONSIBILITIES IN THE REALISATION OF THE QUALITY IMPROVEMENT INITIATIVE “BACK TO BASICS” NURSING CARE.** In my capacity as nurse educator, I am committed to quality in basic nursing care delivery. As part of the educational team, quality initiatives, aimed at the improvement of quality and safety in nursing care is a constant priority. The purpose of the study is to gain an in-depth understanding of how nurses as process owners of nursing care, perceive their roles and responsibilities to deliver basic nursing care linked to the organisational quality improvement initiative “Back to basics” nursing care at the bedside of the patient within the in real-world general nursing care context.

A qualitative, explorative descriptive study will be conducted by using focus groups within the population of Registered nurses working in general nursing care units to explore nurses’ perception of their roles and responsibilities in supporting the healthcare organisations’ “Back to basics” quality improvement initiative. Focus groups will be used to collect data from participants and will be arranged by the researcher. Each focus group will continue for approximately sixty minutes and due to the aims and purpose underlying the study design, several focus groups with different participants will be conducted until data saturation has been achieved and no new information is collected on the topic from participants. For the convenience of the participants, the researcher undertakes to arrange focus groups at the hospital.

I undertake to conduct this study with the utmost transparency and to ensure that ethical conduct is maintained meticulously in terms of non-disclosure of the name and reputation of and its’ employees as participants of the study. The name of including the identification of hospital’s name will remain confidential throughout the

study as well as when disseminating and publishing findings obtained through data analysis from focus groups. The rights of participants have been addressed in the under-mentioned documentation, and will be maintained consistently.

[REDACTED] where I am currently employed, is informed about the study and is in support thereof.

I trust your favourable consideration.

Yours sincerely

Roelien Els
Nurse educator

ANNEXURE 5: PERMISSION FROM RESEARCH SITES TO CONDUCT THE STUDY

Hi Roeline

Please see [redacted] mail below.

Kind regards



From: [redacted]

Sent: 20 October 2016 03:58 PM

To: [redacted]

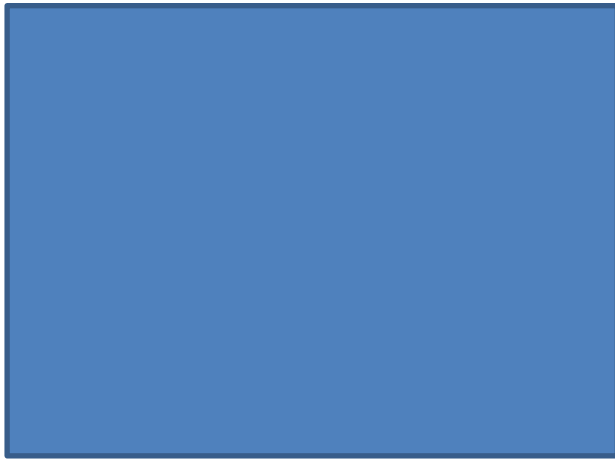
Subject: FW: REQUEST TO DO A FOCUS GROUP WITH REGISTERED NURSES (General/surgical nursing) on 31 October 2016

Hi [redacted]

I will grant her permission to do the research at [redacted] hospital.

Kind regards





From: [redacted]

Sent: 20 October 2016 03:16 PM

To: [redacted]

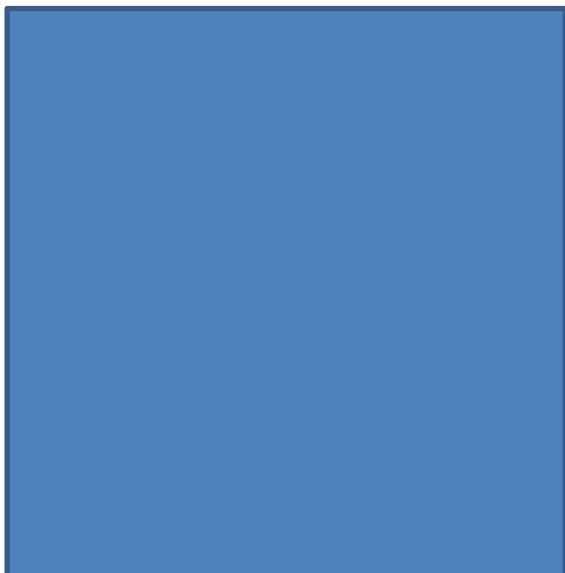
Subject: FW: REQUEST TO DO A FOCUS GROUP WITH REGISTERED NURSES (General/surgical nursing)
on 31 October 2016

Dear [redacted]

Trust you are well.

Below find a request from Roelien Els, educator at [redacted] to
do her research for her Master studies at [redacted] Hospital. Can we please give
her permission for the research to be done?

Kind regards



[REDACTED]

Subject: REQUEST TO DO A FOCUS GROUP WITH REGISTERED NURSES (General/surgical nursing) on
31 October 2016

Good morning [REDACTED]

Attached herewith, please find my request for approval to conduct a focus group with your
Registered Nurses working in General nursing science units.

I am really interested in the study population of Registered Nurses (being employed for
two or more years in the medical-surgical discipline).

With the other hospitals, the majority of participants were more senior nurses and
included a few Unit Managers. With this focus group planned at [REDACTED] I am
interested in the ideas of the “young blood”; thus general registered nursing performing
duty in relation to patient care in the hospital.

If approval has been granted by [REDACTED] to continue with this focus group:

I would request the utilisation of a venue (something like a small boardroom where seats
can be arranged in a circle). Professor van Rensburg is the co-facilitator of the focus
group. I need 6 registered nurses to conduct the focus group. Professor van Rensburg
confirmed her availability to engage as a co-facilitator on 31 October 2016. If possible, I
request that the session to be scheduled in the afternoon. I undertake to ensure that the
RN's will not be out of their working place for more than an hour and a half.

After approval has been granted to continue with the focus group, I would appreciate it
very much if you or your delegated person can just inform the registered nurses
accordingly and provide me with their e-mail contact details (names and surnames) to
enable me to communicate and provide the information leaflets to these participants in
advance.

Thank you in advance.

Kind regards

Roelien Els

ANNEXURE 6: INFORMATION LEAFLET TO PARTICIPANTS

Focus group: Information leaflet

Dear Participant

RESEARCH TOPIC: An exploration of the perceptions of nurses of their roles and responsibilities in the realisation of the quality improvement initiative “Back to basics” nursing care.

Thank you for your willingness to participate in the focus group regarding the abovementioned topic.

I am currently a student doing research for my master’s degree at Unisa. An ethical clearance certificate provided by Unisa, as well as a letter of approval from [redacted] research committee and finally from Ms [redacted] on behalf of [redacted] Hospital, serves as proof that permission for conducting this study has been granted.

The purpose of this research is to explore your perceptions as registered nurses regarding your roles and responsibilities in the realisation of the quality improvement initiative “Back to basics” nursing at the bedside of the patient. Data will be collected by using focus groups. The duration of a focus group interview will last between sixty and ninety minutes.

To obtain the best possible data from participants, I have included the following criteria to qualify for participation to the study in view of your first handed experience about the real-world context of clinical general nursing science. Your knowledge will enable you to reflect easily on your experiences when delivering basic nursing care at the bedside of the patient within a hospital setting. The following criteria must be met to participate in a focus group:

- ☐ Participants have to be registered under the Nursing Act, Act 33 of 2005 as Registered nurses
- ☐ Participants have to be employed as permanent employees within the private hospital for a period of two years or longer
- ☐ Participants have to be directly involved in patient care within the general nursing science discipline
- ☐ Participants working mixed shifts (day and night duty) as well as dedicated to day- or nightshift only, are eligible for inclusion into the study.

Your participation is voluntary and you can refuse to participate in the study. During the course of the focus group, you may discontinue at any time without stating a reason. No penalty whatsoever will be imposed for refusal or discontinuation from the study. All of the information or data provided by you will remain anonymous, meaning that this study will not divulge any information that identifies you as a participant in relation to the data provided. Your inputs will remain confidential and a coding system will be utilised to analyse your inputs. It is expected that participants sign a confidentiality binding form to protect the rights of his/her co-participants in terms of respect and confidentiality of information provided during the focus group discussion.

Your written consent implies that you are voluntarily participating in the focus group and are informed about your ethical rights and protection as a study participant.

If you have any questions, you are welcome to contact me.

Yours sincerely

Roelien Els

08749335160

ANNEXURE 7: CONFIRMATION OF CONSENT LETTER

CONFIRMATION OF CONSENT

Research project: An exploration of the perceptions of nurses of their roles and responsibilities in the realisation of the quality improvement initiative “Back to basics” nursing care.

I (full names and surname)_____ have read the letter and consent to my participation in the study conducted by Roelien Els.

SIGNATURE OF PARTICIPANT

DATE

SIGNATURE OF RESEARCHER

DATE

PLACE

ANNEXURE 8: CONFIDENTIALITY BINDING FORM

CONFIDENTIALITY BINDING FORM

Research project: An exploration of the perceptions of nurses of their roles and responsibilities in the realisation of the quality improvement initiative “Back to basics” nursing care

I (participant’s full names and surname)
agree to participate in the focus group discussion and undertake to adhere to the following ethical principles:

- I will uphold the professional integrity of my employing hospital and will not discuss information obtained during the course of focus group discussions with anyone outside the group
- I will keep all information shared during the focus group confidential
- I will not disclose any information outside the group
- I will not link any information to any group member
- I will respect the opinion expressed by other group members

The researcher, Ms Roelien Els, agrees to take all reasonable steps to protect the personal identity and privacy of participants.

I fully understand the content of this agreement and undertake to adhere to all ethical principles as participant in the focus group.

The researcher

Name:

Signature

Date.....

The participant

Name:.....

Signature.....

Date:.....

ANNEXURE 9: DEMOGRAPHIC DATA QUESTIONNAIRE

AN EXPLORATION OF THE PERCEPTIONS OF NURSES OF THEIR ROLES AND RESPONSIBILITIES IN THE REALISATION OF THE QUALITY IMPROVEMENT INITIATIVE “BACK TO BASICS” NURSING CARE

Please complete the following information

Demographic information

Instruction: mark the applicable answer with a X

Your age:

25 – 30 years	
31 – 40 years	
41 – 50 years	
51 – 60 years	
Above 60 years	

Gender:

Male		Female	
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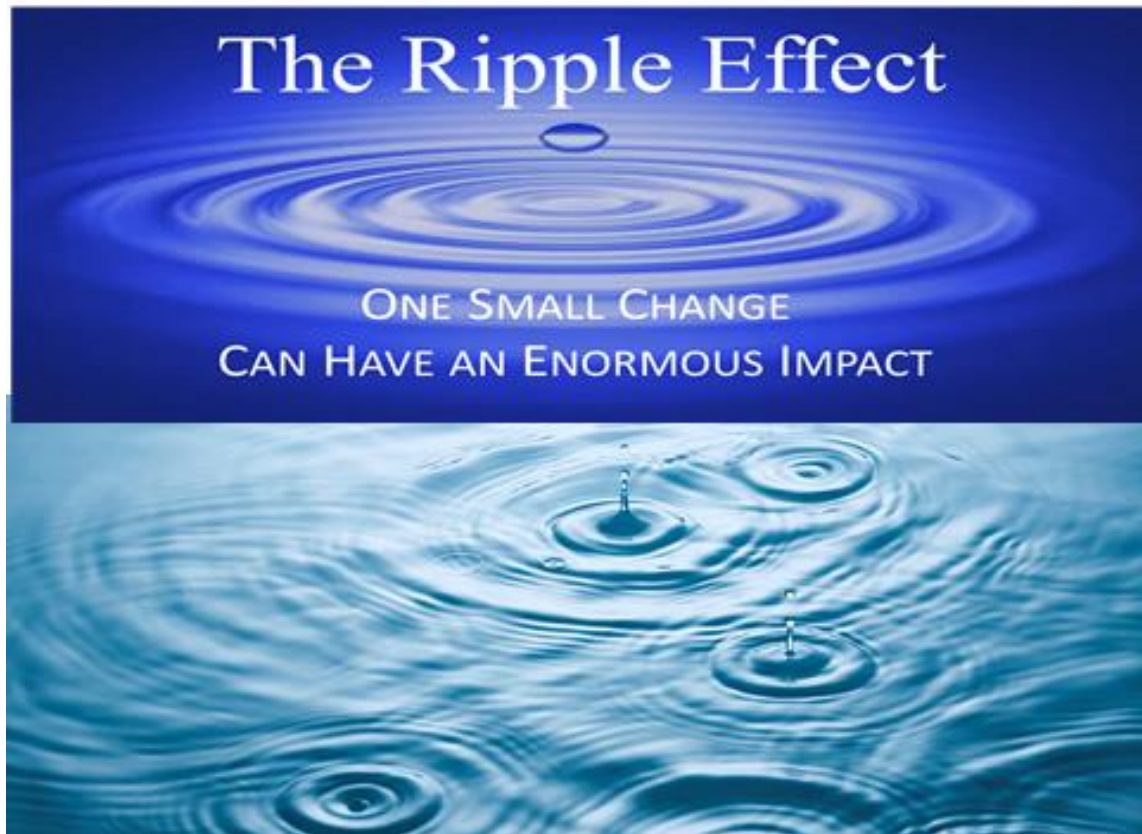
Indicate your professional qualifications:

Professional working experience in general nursing unit

2 - 5 years	
6 – 10 years	
11 – 20 years	
21 – 29 years	
30 – 40 years	
> than 41 years	

Please provide a summary of your professional capacity (job titles) of the last five years in the nursing unit where you are currently working

ANNEXURE 10: THE RIPPLE EFFECT AND GRAND TOUR QUESTION



Grand tour question

**HOW DO YOU PERCEIVE
YOUR ROLES AND RESPONSIBILITIES
IN THE REALISATION OF
“BACK TO BASICS”
TO ENHANCE QUALITY NURSING CARE
AT THE BEDSIDE OF THE PATIENT?**

**In terms of basic nursing
care delivery at the
bedside of the patient**

**how do you perceive your
roles and responsibilities**

**in the quality improvement
initiative "Back to basics"
nursing care ?**

ANNEXURE 12: EXTRACT OF ANALYSED TRANSCRIPTS

Hospital A

Coding	Participants responses
Administrative actions (repetitive)	With all the documentation she has to do because almost every paper is repeating itselfs (2.1)
	A few voices in agreement
Expectations Doctor expectations Stress/staff tension Recordkeeping Expectations Recordkeeping ineffective	When a patient comes in ... and then within 5 minutes they want him in theatre (2.2)... then the doctor starts to scream and verbal abusing because the patient is not prepared for theatre (4) so it adds up to the tension of the nurses, (5.1) they turn onto each other and it's just a ripple effect that carries over to the patient. We can't go on like that, it's ... we are nursing papers ... because if you don't write what you have done... so you are so busy covering what ... (2.1) I work overtime in ICU, I see how the nurses nurse the papers, in an isolation room, she look through the window and write down I found this and this and this .. but when I looked at them I never see them leave their papers so they are too busy producing a story on paper that they don't actually do the nursing (2.1)
R	Thank you ... What effect do you think does it have on the outcome of patient care?
Expectations Recordkeeping Expectations Recordkeeping Expectations	They don't do patient care, they are too busy covering up their actions, not to get into trouble, or to get disciplined because it must be written on paper, so they are totally (2.1) ... ja ... for every blink you are doing, you gotta be disciplined, so they are actually covering up with paper things that they didn't do because they are afraid of being disciplined. If it is on paper it is done (3).
Expectations	And even if it is not done, it is done only on paper.
Organisational requirements Recordkeeping Role and responsibility perception	Cause you must understand, self-preservation is key (1) and with the way we are doing things now, they do audits, whether the action was physically done is not important, whether it was recorded (2.1) ... what you actually done or the service you actually provided doesn't seem to be as important as the proof of providing the service.
	Voices in agreement
Administrative actions (repetitive)	So we are checking and auditing and auditing the check and checking the check after that. Why? Because we want to make sure that on paper it is done (2.1).
	It is true.
R	... do you agree with this? Is it also the experience in your ward?
Managerial Expectations	Yes, we've got a ... theatre cases all day and I have to say, I mean the same thing happen, they want the patient to walk in, getting ready for theatre. It doesn't matter what is done, vitals, what basics you got down

<p>Doctor</p> <p>expectations</p> <p>Recordkeeping</p> <p>Stress/staff</p> <p>tension</p> <p>Expectations</p> <p>(organisational)</p>	<p>for this patient... that patient must be in theatre (2.2). And we have to stand one hour ... and said listen we are taking care of our patients with responsibility and more and more nurses are scared and they are pushed ... the RNs to the front and please you sort out the doctor and they are scared (4). Stepping away and like they said they will rather put everything on paper than really giving the patient care and there's fraudulent things, there's a paper of IV checks. I tell you, you won't believe how they will write every hour, I mean ... it is impossible to do around the clock the IV checks.</p>
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Hospital D

<p>Patient satisfaction (care expectations)</p> <p>Admin</p> <p>Recordkeeping</p> <p>Direct patient care (ideal care)</p> <p>Admin</p> <p>Recordkeeping</p> <p>Expectations</p> <p>Patient satisfaction (care expectations)</p> <p>Recordkeeping</p> <p>Scope of practice</p> <p>Direct patient care (ideal care)</p>	<p>To add on to what ... has said now, I can say that nursing has come to a point that, and our diverse country has come to a point where people are becoming so much aware of their rights (4 & 2.3),</p> <p>The hospitals are implementing more and more admin work. And that admin work to protect – like when it's not written it's not done (2.1). it's taking a lot of our time that we should have for spending at the bedside. Making sure that your patient is pain free, things that we used to do, there's compassion. The days of cutting a patient's nails, keeping the patient comfortable, rubbing a patient's feet because it's dry. Small things are now taken out of nursing because of a lot of admin (2.1). And that admin is unfortunately there because if there is any case you need to have paperwork to proof your innocence. As people are becoming more and more aware of their rights, the hospitals also to be having more and more paperwork to cover that and to cover that everything is written.</p> <p>Everything that you do, you must record and recording, statistics and paperwork, really taking a lot of time and taking the RN away from the bedside away from the patient.</p> <p>Your job is to nurse the patient, to make sure that your patient is pain free, to be comfortable and keep your patients ... at the same time (2.1; 2.2; 1)</p>
R	In other words there is multiple roles, if I understand you correctly?. Different roles for example the managerial role ...
	Voices in agreement