ENHANCING THE SUPPORT SYSTEMS OF NURSES IN ACCIDENT AND EMERGENCY UNITS OF REGIONAL URBAN HOSPITALS AT KWAZULU-NATAL

by

CHINISILE ALBERTINA MBOKAZI

submitted in accordance with the requirements

for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF MC MATLAKALA

November 2018

DECLARATION

Name: Chinisile Albertina Mbokazi

Student number: 4575016

Degree: Doctor of Literature and Philosophy

Title: Enhancing the support systems of nurses in accident and emergency units of regional urban hospitals at KwaZulu-Natal

I declare that the above thesis 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.

I further declare that I submitted the dissertation to originality checking software. The result summary is attached.

I further declare that I have not previously submitted this work, or part thereof, for an examination at Unisa for another qualification or at any other higher education institution.

SIGNATURE

30 November 2018
DATE

ENHANCING THE SUPPORT SYSTEMS OF NURSES IN ACCIDENT AND EMERGENCY UNITS OF REGIONAL URBAN HOSPITALS AT KWAZULU-NATAL

STUDENT NUMBER: 457-501-6
STUDENT: CHINISILE ALBERTINA MBOKAZI
DEGREE: DOCTOR OF LITERATURE AND PHILOSOPHY
DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
SUPERVISOR: PROF MC MATLAKALA

ABSTRACT

Introduction: Working in the hospital accident and emergency unit is perceived to be very stressful. However, minimal or no organizational support measures are made available to enable the nurses working in these hospital units to cope effectively with stressful incidents. The purpose of the study was to develop strategies to enhance the support systems of nurses in the accident and emergency unit.

Method: The study used a qualitative approach to explore the experiences of and describe the coping strategies used by nurses working in the accident and emergency units of regional urban hospitals at KwaZulu-Natal, in South Africa. Fourteen participants were interviewed in the accident and emergency units of four (4) hospitals. Data were collected through in-depth individual interviews. The data were analysed manually following the steps explained by Creswell (2009:186).

Findings: The interviews led to the description of the nurses' experiences in the accident and emergency units. Four themes emerged from the findings of the interviews, and included working under pressure and stressful conditions, the need for safety and security, limited resources and psychological and emotional problems. Among the problems discussed within the themes, there was anger that was directed by the patients and their relatives to the nurses; absenteeism that contributed to an increase in work pressure; emotional disturbance; lack of physical security; and lack of continuous support from the hospital management.

Conclusion: Five strategies were developed to generate a support systems for the nurses whose hospital units formed part of the study and were as follows: develop or strengthen an existing employee assistant program (EAP) specifically for counselling and support of the nurses within the unit; address staff absenteeism through the provision of extra staff through overtime or agency work; enforce attendance of monthly debriefing sessions; strengthen the security system through increasing and

evenly distributing the security staff; and give attention to all the problems and provide a quick response. The strategies developed are trusted to remain as a point of reference whenever a need arises.

KEY WORDS

Accident and emergency unit, emergency nurse, KwaZulu-Natal, regional hospital, security in hospital, support system.

ACKNOWLEDGEMENTS

- I thank God, the Almighty for giving me courage and strength to commence and complete this study.
- Thank you to my devoted and patient supervisor Professor MC Matlakala for her wisdom and experience demonstrated during her supervision of my work from commencement to completion.
- I am grateful to the Department of Health, KwaZulu-Natal for granting me permission to proceed with my study at the regional urban hospitals within their province.
- My gratitude is extended to the managers of the regional urban hospitals that were targeted for my study, for granting me the opportunity to utilize their facilities.
- Thank you to all the research participants who willingly contributed the information that enriched this study.
- I am indebted to my family members, especially my late mother and father, Girlie and Simon Mbokazi. I thank them for their faithful mission of bringing me up.
- I thank my two sisters and one brother, Rose, Beauty, and Jonathan respectively who have always patiently accommodated my distances away from them while working and pursuing my studies.

DEDICATION

This study is dedicated to God, my family members, and those who may find it worthwhile to benchmark from it for the improvement of their hospital accident and emergency unit services for the benefit of the nurses and the patients.

TABLE OF CONTENTS

CHAPTER 1 1
ORIENTATION TO THE STUDY 1
1.1 INTRODUCTION 1
1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM 5
1.3 RESEARCH PROBLEM 12
1.4 RESEARCH PURPOSE 14
1.4.1 Research objectives 14
1.5 SIGNIFICANCE OF THE STUDY 14
1.6 DEFINITION OF TERMS 16
1.6.1 Accident and emergency unit 16
1.6.2 Coping Skills 16
1.6.3 Nurse 17
1.6.4 Strategy 17
1.6.5 Support system 17
1.7 THEORETICAL FOUNDATION OF THE STUDY 18
1.7.1 Research paradigm 18
1.7.2 Assumptions underlying the study 18
1.7.2.1 Meta-theories 19
1.7.2.2 Ontological assumptions 20
1.7.2.3 Theoretical assumptions 21
1.7.2.4 Methodological assumptions 23
1.8 THEORETICAL FRAMEWORK 24
1.9 INTRODUCTION TO RESEARCH DESIGN AND METHODS 25
1.10 STRUCTURE OF THE THESIS 27
1.11 SUMMARY 27
CHAPTER 2 28
LITERATURE REVIEW 28
2.1 INTRODUCTION 28
2.2 DEVELOPMENT OF INTERVENTION STRATEGIES 30
2.3 PREDICTORS OF STRESS IN THE ACCIDENT AND EMERGENCY UNITS 31
2.3.1 Administrative - organizational factors 32
2.3.1.1 Environmental conditions 33
2.3.1.2 Overcrowding in the A&E units 33
2.3.1.3 Workload and inadequate human and material resources 34
2.3.2 Accident and emergency job specific factors 35

2.3.2.1 Violence in the A&E units 35
2.3.2.2 Sudden death 37
2.3.2.3 Dealing with severe to mutilating injuries and critical illnesses 38
2.3.2.4 Other life threatening conditions 39
2.4 EFFECTS OF EXPOSURE TO CRITICAL EVENTS 40
2.5 NURSES' COPING STRATEGIES WITH CRITICAL INCIDENTS 42
2.6 SOCIAL SUPPORT 45
2.7 SUMMARY 49
CHAPTER 3 50
RESEARCH DESIGN AND METHODS 50
3.1 NTRODUCTION 50
3.2 RESEARCH APPROACH FOR PHASE I 51
3.2.1 Qualitative approach 52
3.3 RESEARCH DESIGN 53
3.3.1 Exploratory research design 53
3.3.2 Descriptive research design 54
3.4 RESEARCH METHOD 54
3.4.1 Setting for the study 55
3.4.2 Population 55
3.4.3 Sample and sampling method 55
3.4.4 Sample size 56
3.4.5 Recruitment method 56
3.4.6 Eligibility criteria 57
3.4.7 Data Collection 58
3.4.7.1 Data collection approach and method 58
3.4.7.2 Data collection period 60
3.4.8 Data analysis method 60
3.5 ETHICAL CONSIDERATIONS 60
3.5.1 Protecting the rights of institutions 60
3.5.2 Protecting participants 61
3.5.3 Scientific integrity 62
3.5.4 Processing and analysing of interview data 62
3.6 TRUSTWORTHINESS 63
3.6.1 Credibility 63
3.6.2 Dependability 64
3.6.3 Confirmability 64
3.6.4 Transferability 65

3.7 RESEARCH METHODS FOR PHASE II……66
3.8 SUMMARY 66
CHAPTER 4..... 67
ANALYSIS, PRESENTATION, AND DESCRIPTION OF THE RESEARCH FINDINGS 67
4.1 INTRODUCTION 67
4.2 DATA MANAGEMENT..... 67
4.3 DATA COLLECTION PROCESS 68
4.4 DATA ANALYSIS..... 69
4.5 RESEARCH RESULTS 71
4.5.1 Sample characteristics..... 71
4.5.2 Themes..... 72
4.5.2.1 The positive aspects of working in the accident and emergency unit..... 73
4.5.2.2 The challenges of working in the accident and emergency unit 75
4.5.3 The nurses coping strategies during the challenges..... 88
4.5.3.1 Control of emotions 89
4.5.3.2 Maintaining good interpersonal relationships..... 89
4.5.3.3 Summoning assistance from the hospital managers and security..... 90
4.5.3.4 Prioritizing the tasks 90
4.5.3.5 Explaining problems to patients..... 91
4.5.3.6 Social coping strategies..... 91
4.6 DISCUSSION OF THE FINDINGS……..92
4.7 SUMMARY 101
CHAPTER 5..... 102
PRESENTATION OF THE STRATEGIES..... 102
5.1 INTRODUCTION 102
5.2 THE PURPOSE OF THE STRATEGIES..... 102
5.3 THEORETICAL FRAMEWORK 102
5.4 METHODOLOGY FOR DEVELOPMENT OF STRATEGIES 104
5.5 SUPPORT STRATEGIES..... 105
5.5.1 Stressor: Anger directed to the nurses by the patients and relatives 105
5.5.2 Stressor: Constant pressure of work overload to the nurses remaining on duty following the high rate of absenteeism 106
5.5.3 Stressor: Emotional disturbance from incidences relating to death of children and uncooperativeness of the patients and relatives..... 107
5.5.4 Stressor: Lack of physical security..... 107
5.5.5 Stressor: Lack of continuous support from the hospital managers 108

5.6 VALIDATION OF THE STRATEGIES 109
5.6.1 List of strategies 109
5.6.2 Instructions regarding the validation of each strategy 110
5.6.3 Results of the validation of the strategies 112
5.6.4 Calculation of validation scores 112
5.6.5 Evaluators' comments on low rated strategy (disagree) 114
5.7 SUMMARY 115
CHAPTER 6 116
CONCLUSIONS AND RECOMMENDATIONS 116
6.1 INTRODUCTION 116
6.2 THE PURPOSE OF THE STUDY 116
6.3 RESEARCH DESIGN AND METHODS 116
6.4 CONCLUSIONS FROM THE STUDY 117
6.4.1 Exploration and description of the nurses' experiences in the A&E unit 117
6.4.1.1 Conclusions based on literature review 117
6.4.1.2 Conclusions based on interviews 118
6.4.2 Description of coping strategies 119
6.4.2.1 Conclusions based on literature review 119
6.4.2.2 Conclusions based on interviews 120
6.5 RECOMMENDATIONS 121
6.5.1 Sensitizing hospital managers about the A&E unit challenges 121
6.5.2 Reviewing and improving the communication system for announcing changes in the A&E unit. 122
6.5.3 Future research 122
6.6 CONTRIBUTIONS OF THE STUDY 123
6.7 LIMITATIONS OF THE STUDY 123
6.8 SUMMARY 124

LIST OF REFERENCES 124

ANNEXURES 136

LIST OF TABLES

Table 1.1: Summary of study objectives, methods and data analysis…….27

Table 3.1: Phases I and II of the research process…….51

Table 4.1: Quotes from the participants and assigned codes 71

Table 4.2: Demographic data/Description of participants 72

Table 4.3: The positive aspects of working in the accident and emergency unit.....73

Table 4.4: The challenges of working in the accident and emergency unit 76

Table 5.1: Criteria for validation of individual strategies.....111

Table 5.2: Biographic information of experts 112

Table 5.3: Sample of the validation results from an individual validation officer.....113

Table 5.4: Condensed record of the validation results and scores 114

LIST OF ANNEXURES

ANNEXURE 1: Regional hospitals at KZN 137

ANNEXURE 2: Ethical clearance certificate 138

ANNEXURE 3: Request to conduct research 139

ANNEXURE 4: Approval letter – Department of Health of KwaZulu-Natal 141

ANNEXURE 5: Consent form 142

ANNEXURE 6: Data collection form 144

ANNEXURE 7: Turnitin originality report 145

LIST OF ABBREVIATIONS

AANA	American Association of Nurse Anaesthetists
A&E unit	Accident and emergency unit
DoH	Department of Health
EAP	Employee Assistance Programme
KZN	KwaZulu-Natal
STS	Secondary Traumatic Stress
PTSD	Post-Traumatic Stress Disorder
UNISA	University of South Africa
USA	United States of America

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Hospital accident and emergency (A&E) units are regarded as one of the busiest areas of work among the areas of work where nurses are involved. These units put pressure on the nurses due their nature of work and function, the repetitive exposure to an increased pace of work and work related traumatic events that take place in the A&E units. Amongst a number of factors identified and noted to contribute in making A&E units the busiest areas of hospitals, is that the environment in the units frequently subject nurses to excessive pressure and traumatic events, influence the delivery of health care, as well as impact on nurses performance and coping skills. These factors include overcrowding, staff shortage, and the poorly resourced hospital environment (Rosedale, Smith, Davies & Wood 2011: 537).

According to Pino and Rossini (2012:2) job related pressures are relevant stress determinants for nurses. However, the way in which the individuals concerned perceive the situation is fundamental in determining whether or not the situation is stressful and whether the interventions in the form of organisational support are required to reduce the levels of stress. Coping skills or strategies are daily responses triggered by the ongoing interaction between nurses and their environment, during which the nurses hope to overcome the challenges associated with this interaction.

Though stress is common among hospital healthcare professionals, McCarthy, Power, and Greiner (2010:5) note that stress levels vary within different areas in the same hospital. While medical wards, accident and emergency (A&E), and paediatric units are perceived to be having higher stress levels than other units such as outpatient department, theatre and recovery rooms, they also exhibit their own unique differences when job characteristics involved are taken into account. The observation is that though paediatric units seem to rank the highest with overall stress levels, the A&E units exhibit the highest stress levels related particularly to specific job characteristics

such as physical environment, job demands, job strain and inadequate supervisor support. This situation is noted with the suggestion that such information is important for a hospital to possess, where there are plans to provide necessary support for staff. In this regard, A&E units are identified among the hospital units as those that are in serious need for support. According to the Emergency Triage Education Kit (2009:3) the urgency under which staff in this unit function to achieve an optimal outcome through timely and accurate assessment of seriously ill patients, is the justification for management support.

Several studies confirm the existence of high stress levels in A&E units on the basis of the high prevalence of burnout and post-traumatic stress disorder encountered in them (Adriaenssens, de Gucht & Maes 2012:1422; Ariapooran 2013:16; Popa, Raed, Purcarea, Lala, Bobimac & Davila 2010:214). A further related finding is that stress triggers, the way stress is experienced by staff involved, and the anticipation of support interventions also vary according to different areas of nursing.

Abdalrahim (2013:6), in a study of stress among the psychiatric Jordanian nurses, in the Middle East, found that stress among psychiatric nurses was related to interpersonal relationship with patients and colleagues, which led to poor health. Social support, particularly family support, was perceived by nurses as an essential component in their coping strategies. Uren and Graham (2013:14), in a study to explore emotional experiences of caregivers within a community-based palliative care institution in South Africa, noted that the care givers re-iterated their need for someone to confide in, but felt that support was not easily found or was coupled with a fear of occupational repercussions.

Health care professionals in emergency units are at risk for experiencing increasing stress within their working environment as a result of being constantly exposed to critical incidents involving emergency situations (Aslam 2011:1; Healy & Tyrrell 2011: 32; Lavoie, Talbot & Mathieu 2011:1514). A critical incident refers to any event that has a stressful impact sufficient enough to cause the individual to lose sense of control, connection and meaning in his/her life (Cicognani, Pietrantoni, Palestini & Patri 2009:450). The critical incidents often cited on investigations with the health care personnel involved, are related to patient suffering and death, uncooperative

behaviour from patients and relatives, unreasonable work demands, conflict with team members, unfavourable work conditions, and lack of support from administration/employers. If ever there is support, it is often inadequate (Gholamzadeh, Sharif & Rad 2011:42; Healy & Tyrrell 2011:34; Adriaenssens, de Gucht & Maes 2012:412). The mentioned events are often unpredictable, and occur simultaneously on a daily, if not on hourly bases, which explains the reason working in A&E units is particularly stressful (Healy & Tyrrell 2011:32).

Nurses who work in A&E units continuously are therefore perceived to have a high level of psychological distress, which increases their susceptibility to psychiatric problems (Aslam 2011:1) and physical symptoms, often referred to as compassion fatigue (Ray, Wong, White & Heaslip 2013:255). Compassion fatigue is a state of tension and pre-occupation with traumatised patients by re-experiencing the traumatic events, avoiding or numbing of the reminders, and persistent arousal associated with the patient (Ray et al 2013:255) due to being frequently exposed to emergency situations.

Fjeldheim, Nöthling, Pretorius, Basson, Ganasen, Heneke, Cloete and Seedat (2014:1) concur with these observations by stating that the psychological and physical symptoms intensify when exposure to critical incidents increases. Although these negative responses to the situation are often reported, there is an indication that some nurses may derive pleasure and motivation from A&E experiences a situation referred to as compassion satisfaction (Cicognani, Pietrantoni, Palestini & Patri 2009:460; Ray, Wong, White & Heaslip 2013:255-256).

While Aslam (2011:1) notes that the predictors of occupational stress are inclusive of young age, high psychological job demands, psychological job control, low social support at the workplace, and job strain; Healy and Tyrrell (2011:34) in a study conducted to investigate stress in emergency departments and experiences of nurses and doctors in Ireland, identified a relationship between certain demographic characteristics and a number of stress variables. According to this observation, demographic characteristics such as age, the number of years since the first professional qualification, the number of years in A&E experience, gender, and nurses' grade determine the degree to which staff can cope with some of the A&E stressors.

For instance, the study revealed that A&E experience, among other things, plays a significant role in determining the coping ability of some of the nurses in the event surrounding the death of a child or young person. This is an indication that the A&E nurses can cope to a certain extent, given certain conditions and personal strengths. When the situation becomes uncontrollable, and the psychological and physical problems intensify, a variety of coping skills, ranging from negative to positive may be displayed.

The fact that A&E units are perceived to be overwhelming as a result of very high levels of job stress, suggests that ordinary personal strengths and minimal support to enable nurses to cope with the situation are not sufficient. Deliberate efforts to assist nurses sustain their performance need to be in place and constantly revised. Uren and Graham (2010:10) state that this highlights the importance of long-term effect of coping strategies as well as the need for interventions to assist nurses to manage stressors consistently. Aslam (2011:1) recommends that interventions in this regard should be based on researches that identify organisational, family and social factors, which will contribute in the reduction of perceived occupational stress. At the same time, these factors should enhance the supportive strategies, which are already in place.

In a preliminary study conducted in India to determine job stress among emergency nursing staff, Singh (2013:407) revealed the nurses' indication that they would take help and support from others in coping with stressful events. This suggests possible future attention to this aspect of emergency staff affairs for the benefit of patient care in the hospital accident and emergency units. Van der Colff (2009:9) adds that organizational support should be managed by the organization to prevent burnout of nurses and to contribute to their work engagement.

In response to the nurses' need for support, work-related issues that have a physiological, psychological, and emotional impact on their health need to be identified with a focus to providing support interventions that seek to achieve clear aims. The relevance of this approach especially where A&E work experiences may be seen to pose a concern, is in line with the findings in a study by Czabata, Charzynska and Mroziak (2011:70) who recommended intervention strategies for promotion of mental

health at work. The study revealed that many intervention strategies are designed to achieve stress reduction, mental health improvement, increased job satisfaction and job effectiveness.

Relevance in providing support also involves seeking to strike a balance between compassion satisfaction and compassion fatigue. The observation is that compassion fatigue decreases when compassion satisfaction increases and vice versa (Sacco, Cyurzynski Harvey and Ingersoll (2015:33). Thus, while implementing support strategies that relieve compassion fatigue, it may prove worthwhile to employ those strategies that reinforce compassion satisfaction. Khamisa, Oldenburg and Ilic (2015:661) referring particularly to the South African situation, emphasize the importance of relevance by stating that it is also important to observe salient features of a place that need attention. Rosendale, Smith and Davies (2011:1) note the salient features of government hospitals in South Africa as poor resources, overcrowding, and understaffing. Under such circumstances, especially if there are no planned interventions, determined focus, and relevance in providing support, nurses feel obliged to respond to A&E incidents according to what they think constitutes work culture expectations, or alternatively deal with situations as they arise.

These include keeping calm or staying in control, keeping going through emotions, carrying out the duties in a manner they were trained to do, listening to everybody around or stepping back to keep oneself intact (Betchel 2009:52). Eventually it becomes rare that their feelings and opinions about the situation are known.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

The source of the problem in this study is the realization that working in the hospital A&E unit is perceived to be very stressful whereas minimal or no organizational support measures are made available to enable nurses working in these hospital units to cope effectively. Lavoie, Talbot and Mathieu (2011:1514) elaborate on this point by indicating that for young nurses particularly, working in an A&E unit may be stressful because they may not have the personal training for dealing with unstable patients, grief stricken families, victims of abuse, and violent outbursts.

Mazzotta (2015:13) suggests that it is the responsibility of the institutional leaders and educators to promote the nurses' wellbeing by providing necessary support structures. The fact that debriefing does not always take place immediately following a traumatic event suggests that continuous employee assistance programmes should be made available. Nurses can also contribute by expanding their own personal coping skills, which can be extended to co-workers through humour, friendship, exercise and spiritual practice. Nurse leaders may support by providing space to practice some of the interpersonal support activities where necessary. For instance, a room for spiritual expression may be made available. Pino and Rossini (2012:6) concur with this suggestion by stating that nurses who work under stressful conditions mainly look forward to supervisors and co-workers as sources of support though they may also have as individuals, their private extra-organizational support structures such as families and friends.

The source of stress in the A&E units is associated with the uniqueness of these units regarding the set up and functioning order, which somehow disrupts the proper implementation of the general administrative aspects of a workplace. For instance, long corridors and open spaces where patients wait affect communication and procedures as they demand a lot of physical energy to accomplish necessary movements within the unit, and many treatment rooms, which require complete alertness in channelling patients to correct places. Regarding some of the work circumstances, the experience of one, automatically leads to the experience of another such as that once the unit becomes overcrowded, work overload, and staff shortage are inevitable.

According to Rosseti, Gaidzinski and Fugulin (2013:1) A&E units are often entrance points to the health care systems. They receive definite emergency patients, patients whose clinical picture seems to be classifiable under emergency cases, patients diverted from primary and specialised care, and social emergencies. All these service demands blend in the A&E units, and overload them to the extent of compromising the quality of care rendered to the patients. Thus, nurses working in these units find themselves without sufficient staff to meet the patients' needs, and thus, work overload.

Besides overloading, nurses are predisposed to criticism and conflict incidences as the likelihood of arguments increases between them and the patient/s and/or relatives/friends over attendance issues. Violence in the form of verbal and physical abuse threatens and often eventually results. Engaging in such arguments reduces the time that should be spent by the nurse on the patients. In addition, it disturbs the calmness and stability that can be expected from the nurse (Mohmoudi, Mohmmadi & Ebadi 2013:148).

Rosseti, Gaidzinski and Fugulin (2013:1) observe that the A&E units function under the atmosphere of unpredictability and uncertainty, of which Wong (2012:3) refers to as the occurrence of relatively rare and overwhelming incidents such as disasters. This requires speed of reasoning and promptness in carrying out the process of decision-making from the staff concerned. Mohmoudi, Mohmmadi and Ebadi (2013:145) posit that the unique circumstances in the A&E unit usually affect the decision making process. This problem may be attributed to the fact that nurses also assume multiple responsibilities and accountability to different people and resources at the same time.

In a study by Adib-Hajbaghery, Kamechian and Alavi (2012:1) on nurses' perception of occupational stress and its influencing factors in Iran, the nurses confirmed the state of unpredictability and uncertainty in their work. This was described by nurses as a state of always being under alarm, necessitating readiness to act any time within the least possible time available. This can affect the nurse mentally in that even outside duty at home, such alarm calls can still be hallucinated at the occurrence of the smallest sound. This keeps the nurse in constant stress to the extent of wearing off.

Naturally, reaction by nurses to critical incidents in the A&E units is predictable. However, the closer the employee or victim is to the critical incident is what determines the extent of reaction towards that incident (Davies (2013:2). This also explains the occurrence of trauma due to secondary exposure to the incident whereby professionals who deal with survivors of trauma also sometimes physically and psychologically suffer the same experiences that the people who had direct (primary) exposure to the incident suffered (Diehn 2015:1). It is for this reason that nurses may reach a point where it seems impossible to go on, or else where they are directly

confronted by adverse situations like violence, they may also feel like retaliating by shouting at the patients (Uren & Graham 2013:6).

The results of all the A&E problems have been noted to include delay in providing care, failing to provide necessary care (Aacharya, Chris & Gastmans, 2011:1); unpredicted nature of admissions resulting in the inability to plan in advance for them, anger, humiliation and loss of control of emotions in the face of criticism and aggression (Gholamzadeh et al 2011:45; Sanders, Pattison & Hurwitz, 2011:84). Cicognani et al (2009:449) note compassion fatigue, burnout, post - traumatic str ess disorder (PTSD), low personal accomplishment and emotional exhaustion as long term effects of repetitive exposure to stressful events.

According to Edmunds (2010:1) stressful events can leave an indelible mark to those who are affected by them while those who care for or help individuals who are affected by traumatic events can also experience stress. Under the circumstances of watching patients undergoing devastating illnesses or trauma, the nurse may react by turning off her own feelings regarding the situation. According to Aslam (2011:1) psychological problems that can ensue include among other things, tension, up tightness, low mood, exhaustion, and avoidance symptoms.

Maloney (2012:3) adds behavioural manifestations such as social withdrawal, substance abuse, smoking, and aggressive behaviour to the list of negative effects. Ray et al (2013: 255) note that compassion fatigue symptoms will also manifest in the form of pre-occupation with traumatized patients or traumatic events. Edmunds (2010:1) warns that if the nurse is not rescued from this harm, feelings of guilt and anger follow.

A further observation by Healy and Tyrrel (2011:37) is that the effect of stressful events can be profound, but staff are often ill prepared and under supported to cope with them. Where more efforts could be expected from employers to assist staff cope with the situation, it is noted that in a number of instances everybody is assumed to be coping. As a result, nurses scarcely report traumatic experiences encountered in A&E units. According to Fjelheim at al (2014:2) this is also suggestive of a time dependent desensitization to the effects of repeated work related traumatic exposures.

Irrespective of this tolerance, it is noted that a connection will always be established between exposure to stressful situations and health in general (Lyon 2012:2), that is, poor health and negative attitude, leading to poor performance, can be expected. Pascasie and Mtshali (2013:2) in a study for descriptive analysis of emergency department overcrowding in a selected hospital in Rwanda, observe that under these circumstances the result is also poor outcomes of care and a greater likelihood of the absence of care. Gacki-Smith, Juarez, Boyett, Homeyer, Robinson and Maclean (2009:2) therefore recommend that hospital authorities should develop a positive attitude towards the reporting of incidents. Reporting procedures in the form of policies should be provided.

Carrus, Corbett and Khandelwal (2010:1) observe that many programmes to improve A&E performance do not produce long lasting results. This is because they focus on processes and do not give attention to staff attitudes or well - being, whereas the refining of performance management systems (which is an administrative aspect), combined with measures to enhance staff capabilities (which is a supportive strategy), can both buttress the improvement system. It is recommended that while the department refines its performance management systems, staff must also be willing to part with the old-fashioned ways of functioning, which entail departmental segregation. Problems can be solved by securing support through extra – departmental collaboration.

A rare situation, namely, compassion satisfaction, is the identification of candidates who derive pleasure under stressful conditions. They respond positively to the situation, and receive gratification from care giving (Ray et al 2013:255). The positive response from this group is associated with self-efficacy. Pino and Rossini (2012:8) encourages this type of response by indicating that staff can be helped to turn their perceived threats into positive challenges that can enable them to go on managing the situation.

In South Africa, a number of factors have been identified and noted to contribute in making A&E units the busiest areas of hospitals. This frequently subjects nurses to excessive pressure and traumatic events, influence the delivery of health care, as well as impact on nurses' performance and coping. The factors identified by Rosedale,

Smith, Davies and Wood (2011:537) that put A&E units under excessive pressure, are such as overcrowding, staff shortage, and the poorly resourced hospital environment. This situation also means that patient waiting times dramatically increase, which in turn increases the chances of verbal abuse towards nurses (Bateman 2009: 568) since A&E attendants are likely to include people with various types of aggressive behaviour. These include neurological and acquired aggression as well as aggressive behaviour triggered by unwelcoming community experiences such as domestic and public violence (Ward 2012:1). Further, there is higher rate probability of burnout and making fatigue related mistakes, and in turn, a drop in the quality of nursing care. When mistakes occur, and influence negatively on patients' health, it means that the nurse involved or supervising nurse is to blame (Bateman 2009:568).

Patients attending A&E units present with problems that range from mild to severe though adding more pressure. Within this attendance, Wallis (2011:171) specifically draws attention to trauma, which is at the epidemic level in South Africa, and that trauma is responsible for 40% of hospital emergency centre turnouts. In a retrospective audit of trauma-related mortality conducted at the three government hospitals, namely, Edendale, Greys and Northdale Hospitals in Pietermaritzburg, in the KZN province of South Africa, Moodley, Aldous and Clarke (2014:101) comment about the inability of the hospital-based mortality data to capture the actual mortality rates due to trauma since many corpses from trauma scenes are taken straight to the state mortuary.

However, the audit was able to reveal trauma demographics including interpersonal violence demonstrated by the high proportion of penetrating wounds (gunshot and stabbing) as well as blunt trauma (intentional and unintentional) mainly from road traffic accidents). While these types of trauma are noted, there is also a remarkable rise in the crime rate statistics involving sexual offences and violence against women at KZN. According to KwaZulu-Natal Department of Community Safety and Liason (2010:6) the KZN sexual offences statistics for 2006 – 2007 has shown that in the KZN townships of KwaMashu, Inanda, and Umlazi, over 400 rapes were reported annually. Erasmus (2014:1) reports on a further rise of these statistics to 627 cases annually in the mentioned townships (referred to in the Erasmus report as Durban Central) which is followed by Port Shepstone with 461 cases per year. In terms of these reports, there

is an indication of a high frequency of A&E nurses' exposure to such critical incidents and adverse events.

Under normal circumstances, the A&E units operate on an open door policy, as well as 24 hours around the clock. Thus, there is continuous arrival of patients, and during the night the units have to accommodate problems for the closed Out Patients Departments (OPDs). Patients with acute medical and gynaecological conditions therefore also arrive at night. In many instances, certain patients tend to be in and out or stay longer in the department as a result of the need for extra services such as X-Rays, referral to specialists on call, resuscitations, emergency rehydration such as with intravenous therapy, blood taking and emergency treatments for respiratory problems such as nebulization. Patients' relatives add to the burden by requiring a share of attendance to the emergency care of the patients, thus increasing the demands for attention.

Masia, Basson and Ogubanjo (2015:358) in a study on emotional reactions of doctors and students following the loss of their patients at an academic hospital A&E unit in South Africa, noted that further pressure and stress of traumatic events in these units, are caused by constant confrontation with deaths and the variety of ways they occur. This leads to negative reactions of anger, perceiving oneself as incompetent, recurrent thoughts about the incident, sadness, helplessness, feelings of guilt and difficulty in facing death by the affected staff. Notably, failure to face death may also negatively influence the process of trying to deal with other types stressors in the environment to the extent of using denial, detachment, emotional distancing or avoidance of any stress associated situation or thoughts as coping mechanisms. The study by Masia et al (2015:357) is in line with the findings of a study by Bicham (2009:37) done on distress among nurses following patient death in the A&E unit. These mentioned studies mainly recommend formalised debriefing programs for A&E health personnel.

According to Bickham (2009:38), the findings about staff reaction to patient death have implications for continued research on the benefits of programmed debriefing sessions, development of relevant nursing policies and strengthening administrative support for A&E staff. Masia et al (2015:363) thus urge the unit managers to enhance staff support by having more staff members and proper equipment to manage the

workload. Staff can co -operate by ensuring enough sleep, meditation, good nutrition, exercise and maintenance of social support.

A significant finding about the effects of patient death on staff in the A&E unit is the identification of some elements of compassion satisfaction. Some of the participants in the study by Masia et al (2015:362) indicated that death was inevitable and therefore it challenged them to face their own mortality and that of their loved ones. Furthermore, it freed them from the fears of death as the experience provided assurance that it was unavoidable and it occurs to everybody.

1.3 RESEARCH PROBLEM

Nurses working in the A&E units are challenged by being faced with frequent occurrence of critical incidents of a diverse nature on a daily basis. These incidents involve a high pace of work and resuscitations. In KZN, South Africa, particularly in the specific hospitals chosen for this study, the situation is exaggerated by the high rate of accidents which result in patients suffering blunt and penetrating trauma, violence and sexual offences. The A&E environment in which the nurses work involve overcrowding of patients and relatives, staff shortage and work overload. The observation of the researcher is that the nurses working in these A&E units are expected to cope with their work under adverse conditions; where the attitudes of patients and their relatives, co-operation levels from colleagues and doctors, relationship with colleagues from other wards may add to the unique encounters, making dealing with the situation difficult.

The A&E units of urban regional hospitals at KZN, in South Africa are often reported to have staff shortages in relation to high patient turnover, work overload, urgency of care and sudden agonizing life threatening conditions, which cause undue and continuous pressure on the nurses. Anecdotal information indicate that the patients and their relatives have often expressed dissatisfaction regarding delays with getting their needs met and also the delay in getting the care in accordance with their expectations. The A&E unit visitors, whether as patients, relatives or friends to patients, have often quoted nurses with different opinions, that is, either with sympathy because of the situation in which they were immersed, or with criticism because the

nurses were expected by some patients and their relatives to be doing better than expected. Rarely were the nurses complemented for continuing to do their job as required, and under the circumstances mentioned.

Despite the undue pressures, A&E nurses seemed to carry on daily with their work, and A&E units continued to function as expected. It was not clear if the nurses were coping well or with a struggle given such circumstances. The source of their strength to carry on is not well understood. Consequently, it was necessary to find out the coping strategies used by the nurses to deal with their experiences of the A&E units. The hospitals provided evidence of employee assistant programmes available and indicated that the nurses did not always report their experiences nor seek help when necessary. Instead, they absented themselves from work.

There was a need to better understand this situation from conversations with the nurses concerned. There has been no traceable reports or literature found specifically from nurses from the KZN regional urban hospitals, on their A&E experiences, coping strategies and support systems made available to enable them survive the A&E units pressures. According to Healy and Tyrrell (2011:3) the A&E unit nurses do not become immune to stress provoking situations. Instead, they are under-supported to cope under these circumstances. Kennedy (2013:8) and Magnavita and Heponiemi (2012:1) note that a contributing factor to the lack of support might be that there is under-reporting of these incidents by nurses.

The nurses working in the A&E units of the targeted hospitals were observed to take constant sick days, and they often reported off-sick because of illnesses such as headaches, backaches, or because they were afraid of being bullied by relatives or friends who bring the patients to the emergency units. Some nurses were absenting themselves following adverse incidents that happened such as deaths of patients following resuscitation, receiving threats following confrontations with the patients or relatives, as well as unpleasant experiences after attending to serious injuries and dealing with the affected family members, friends or relatives. What was observed was that the nurses were not receiving adequate support despite the support systems available within the hospital, such as the employee assistance clinic. The nurses

indicated that they often report such adverse events to the managers, however, they are told to go for counselling at their own time and expense.

It was evident that the available support services within the hospitals were not used optimally or were not functional. Instead of providing support, the nurses were sometimes expected to write statements and give reasons for the occurrence of some incidents such as long waiting hours, confrontations or even absenteeism. This, happened only during meetings with the managers, which took place only once in a while of even more than two months. Based on the observation the researcher identified a need to investigate the experiences of nurses working in the A&E units as well as their coping strategies with a view to gather evidence that would assist to design means to assist the nurses to deal with their situations.

1.4 RESEARCH PURPOSE

The purpose of the study was to develop strategies to enhance the support systems for nurses in an accident and emergency unit at a regional urban hospital in KZN.

1.4.1 Research objectives

The objectives were designed to obtain information that would provide evidence that was used to assist in clarifying how the purpose of the study was achieved. The objectives of this study were to

- explore and describe the nurses' experiences in the A&E unit of a regional urban hospital at KZN, and
- describe the coping strategies used by nurses working in the A&E units.

1.5 SIGNIFICANCE OF THE STUDY

The significance of this study extends from the targeted nurses and hospitals to the public at large in that, the participants were given an opportunity to express their own individual experiences of working in the A&E units which is expected to lead to a better understanding of what it means or feel like for a nurse to be exposed to an A&E unit

work life. The information would form a foundation upon which to build and enhance support strategies for the future in the working life of KZN A&E unit nurses.

Description of the A&E unit experiences by the nurses would highlight the need for support and inform the hospital managers to strengthen the support needed by the nurses. Moreover, the findings of this study provided evidence that assisted to design support strategies based on the opinions of the nurses involved rather that designing and putting general support strategies in place, which can fairly suit people working in other hospital units or other A&E units instead of the A&E units targeted by the study. Burleson (2008: 208) upholds the importance for people who provide support to be aware that people differ according to experiences in their expectations and responses to support provided. Some people respond favourably while others do not. In this sense, types of support strategies provided should match the differences in people involved. Also, support should not undermine the already existing and helpful self-developed coping mechanisms. These should be nurtured and enhanced to grow and stabilize.

The hospitals in general will benefit from the findings of this study in the form of receiving scientific information about the experiences of the nurses in the A&E units. Considering the fact that A&E units are first entrance points to these health care institutions, many of the hospital improvement strategies should focus on the improvement of A&E units. This can be trusted to uplift the image of hospitals to the health care users and the public eye in general. Many KZN regional hospitals have served the public for many years. It is therefore important to maintain public attraction towards them by improving their entrance points especially for people.

The findings are not generalizable but researchers in other settings including areas of life outside health settings especially where stressful conditions triggered by critical incidents are assumed to prevail can test and use the strategies from this study. This can lead to additional knowledge on how to support those in need.

1.6 DEFINITION OF TERMS

Terms refer to words or expressions that have a precise meaning of the objects or people that fall within the topic of discussion. Polit and Beck (2012: 722) refer to them as concepts when they are abstract and inferred from situations, behaviours and characteristics. Since they are mostly vague and unclear in their meaning, Botma, Greeff, Mulaudzi and Wright (2010: 272) suggest that the researcher assigns to them definitions according to his or her own interpretation. The terms in this study were specified to the reader to demarcate the study.

In this study, the terms defined were selected because they form the fundamental words of concern in the topic under study. This emanates from the observation that they are closely knit together in the background and problem statement. Also, that they have influenced the selection of the theoretical framework within which the research topic was investigated. This was based on the understanding that A&E units depicted the environment within which pressures exceeding human (nurses') resources emanated. As a result, nurses developed various coping mechanisms to mitigate the situations. While the words 'accident and emergency unit' and 'nurse' were seen as terms because they refer to what can be seen; the word 'coping' was abstract because coping cannot be seen. Thus, the terms and concepts defined included the following:

1.6.1 Accident and emergency unit

This is the department in a hospital, designed for accommodation and immediate treatment and management of patients suffering from conditions that need emergency care. In the study, the definition of an A&E unit included the unit where patients and their relatives or significant others are attended to by nurses, upon first arrival in hospital for definitive treatment of emergency conditions.

1.6.2 Coping skills

Coping skill refers to a conscious effort to reduce stress (Gholamzadeh, Sharif & Rad 2011:44). In this study, coping skill meant a sense of mastery of the A&E unit

circumstances, overcoming and ability to apply mitigating efforts to the presence of A&E unit stressors.

1.6.3 Nurse

A nurse is a person who is registered to practice in a category under section 31(1) of the Nursing Act, (Act No 33 of 2005), South African Nursing Council. In terms of this section, categories of nurses include a professional nurse, midwife, staff nurse, auxiliary nurse or auxiliary midwife**.** In the study, nurses included professional nurses, enrolled nurses, and enrolled nursing auxiliary nurses who were working in the A&E units at the time of t carrying out of the study.

1.6.4 Strategy

A strategy refers to a way of describing how the objectives will be achieved in an organization. It suggests a path to take, and how to move along towards success. It takes into account the existing barriers and resources (people, money, power, and materials) (Community tool box 2017:2). In this study, strategy refer to the approaches adopted by the researcher towards the achievement of the purpose of the study, namely, enhancing the support systems for nurses in an accident and emergency unit at a regional urban hospital in KZN.

1.6.5 Support system

A support system refers to system within which an individual feels that he is cared for and loved, that he is esteemed and valued, and that he belongs to a network of communication and mutual obligation (American Institute of Stress 2013:1). Support systems in this study referred to procedures or structures made continuously available by hospital managers for utilization by the A&E nurses following experiences of critical events.

1.7 THEORETICAL FOUNDATION OF THE STUDY

The theoretical foundation of a study refers to the assumptions or sources of information that consist of commonly held beliefs and opinions developing from the researcher's own observations or the researcher's own world view. Since these beliefs and opinions reflect current understanding, they may change when new knowledge emerges. Although they are not exclusive scientific activity, they can be used in the research study to give it scientific credibility (Brink, van der Walt & van Rensburg 2016: 20). In this study, the researcher founded the study on assumptions based on a number of theoretical perspectives that influenced the way the study was pursued.

1.7.1 Assumptions underlying the study

Assumptions are ideas that are taken for granted or viewed as truth without conscious or explicit testing. They may be difficult to identify in that they are usually unspoken and only exist as ideas that are just known or understood. However, it is important that in a research study the embedded assumptions are explicitly identified so as to determine if a need exists to research and confirm them before proceeding to developing new knowledge. According to Rebar, Gerch, Macnee and McCare (2012:221) if an assumption has been explored and knowledge accumulated about it in the past, that knowledge forms a foundation for proceeding to explore the aspects that are unknown about a particular life phenomenon.

Assumptions helped to define the nature of the study in relation to the researcher's understanding of philosophical stances (meta-theoretical assumptions), reality about the phenomena and the world (ontology), the researcher's understanding of that reality (epistemology), the researcher's knowledge about the existing theories (theoretical assumptions), and what the researcher believed constitutes good science practice (methodological assumptions) as suggested by Botma, Greeff, Mulaudzi and Wright (2010:187).

In this study, the one assumption was that the A&E nurses targeted were exposed to critical incidents which predisposes them to stress. As a result, various coping

mechanisms were assumed to be used to deal with the stress. William (1980) in Botma et al (2010:107) identified assumptions among which it is noted that people are aware of the experiences that most affect their life choices; that stress should be avoided; and that health is a priority for most people. In the study, it was assumed that the targeted A&E nurses should be aware of the A&E experiences that affect their lives by virtue of having worked for a period of a year and above in the A&E unit. Based on these experiences, they should be self-advocates regarding majors that could be undertaken to improve their health within their workplace.

1.7.1.1 Meta-theories

Meta-theories constitute the philosophies of science, which the researcher relies upon to form a foundation for the study (Sousa 2010:8). The meta-theories are worldviews or philosophical stances often referred to as paradigms for human inquiry. Since researchers often differ in their philosophical assumptions, based on ontology, epistemology and methodology, constructivism in relation to the qualitative approach of investigation have followed (Polit & Beck 2012:11). In constructivism, the exposure in research has a bearing on how the study is informed and guided towards the findings. According to Sousa (2010:1) the constructivists often pave the way for identification of a suitable theory that supports the study.

In this study, the objectives focus on the nurses' experiences in the workplace. The qualitative paradigm was relied upon since it satisfies its success through the human experiences which are not quantifiable. Following the direction of the qualitative paradigm therefore was the correct approach for exploring the nurses' experiences of working in the A&E units.

1.7.1.2 Ontological assumptions

Positivism on one hand has an objective view to reality and about the existence of knowledge. The ontological view of the positivists is that information exists naturally and independently of any external influence. Sousa (2010:8) explains that this

ontological view suggests that the world is composed of observable phenomena needing to be discovered.

Otherwise, what is not observable is not likely to exist. Constructivism on the other hand has a subjective view of reality. According to this view, knowledge results from the social construction by people involved and it is multiple in that many opinions can emerge from such social construction (Polit & Hungler 2012:13). These divergent views suggest the researchers' epistemological point of view, which refers to their beliefs regarding the manner in which knowledge can be acquired.

Many studies conducted in the A&E units arrive at similar findings that these units are overwhelming which has health implications to nurses involved (Healy & Tyrrell, 2011:34; Adriaenssens, de Gucht & Maes, 2012:1412). This has led to an objective impression that they are stressful which triggers various coping skills from nurses. According to the researcher, the adoption of this general impression can have an effect of rejecting any other alternative approach such as understanding the situation from the subjective point of view where individuals are able to express their own viewpoints about the situation, bearing in mind that the studies referred to were not based within the context of this study. Adopting the objective view is unable to support the purpose of this study, which is to enhance support strategies for nurses working in the targeted A&E units. Objectivity could lead to recommending or enhancing support strategies that do not benefit other participants who have other feelings and expectations about the situation.

The researcher believes that the situation of the targeted A&E nurses is unique within their own unique context. Thus, knowledge about their own A&E experiences is not the information that is readily available because of the results of previous studies. Nurses involved know it. Once extracted, it could be expected to form a background for the type of support that needs to be in place or enhanced specifically for them, which is the purpose of the study. Hence, the researcher believes in the appropriateness of the ontological perspective of the constructivist to give guidance towards achieving this purpose.

1.7.1.3 Theoretical assumptions

A selected theory in a research study forms a foundation upon which construction of all knowledge about the study flows. It supports the rationale for the study, the problem statement, the purpose, the significance and the research questions.

It provides a direction on how the study as a whole should be approached about searching and reviewing of relevant literature, selection of concepts to be defined, methods to be employed in processing the study as well as data handling and analysis. It thus provides a guide that undergirds the researcher's thinking, understanding of the question at hand, and planning how to investigate it (Grant & Osanloo 2014:13). Fitting a research problem into an existing theory therefore helps to make sense of the research findings (Polit& Beck 2012:142).

Based on the already reviewed empirical evidence that A&E units have high levels of stress, which have certain health implications on the nurses, the researcher noted that the study would be better supported by a theory that identifies a clear link between stress and health outcomes. Lyon (2012:11) identifies stress, coping and health outcomes as aspects that should be encompassed in such a theory. The theory has also to be clear regarding the concept of stress, how people exposed to situations linked with stress perceive or interpret their own situation, as well as the health impact of such situations on people concerned. Establishment of this link would provide the bases for proceeding to suggesting strategies to enhance support systems depending on whether this was indicated or not.

Three theories of stress were given consideration by the researcher. These include the response based theory (Seyle 1956 & 1983), the stimulus based theory (Holmes and Rahe 1967) and the transaction based theory (Lazarus 1966; Lazarus and Volkmans 1984). These theories developed as a result of the continuous testing of the relationship between the variables of stress and health with regards to the origins of stress, and its physiological, psychological and emotional effects on the individuals, as well as coping responses displayed by people affected (Lyon 2012:2).

Seyle's theory only viewed stress as a response to environmental stimuli and focused only on describing a physiological response pattern known as the General Adaptation Syndrome (GAS) where physiological responses were regarded as always uniform irrespective of the kind of stimulus. The theory proposed that cognitive variables such as perception played no role in the process of moderating stress experiences. How affected people apply cognitive skills in dealing with stress was not considered.

The exclusion of the cognitive aspect and treating the response as uniform made this theory unsuitable for basing the researcher's investigation and paving the way to new knowledge where the cognitive appraisal of the A&E working situation by nurses concerned is seen as decisive to proposing and enhancing relevant support systems. Further, coping is not very clear in this theory in that GAS as a general response does not allow for individual differences in the perception of stress as well as unique coping strategies (Lyon 2012:5). Under such circumstances, it is possible to propose general support systems that do not help others. The theories of Holmes and Rahe (1967) also could not be fitted in the study since it does not define coping though it acknowledges the health outcomes and stress. According to the theory, accumulation of adaptation efforts over a threshold level makes a person vulnerable to various health problems.

The theory of Lazarus and Folkman (1984) was identified as suitable for the study in that it fully exposes all the elements associated with stress, namely, environmental pressures, cognitive and affective factors, coping responses and some type of harm should the environmental pressures exceed the person's resources. The theory therefore maintains that stress is not measurable as a single factor. It emphasizes the importance of appraisal or self – evaluation of the situation. The concept of coping is explicitly defined as cognitive and behavioural efforts to manage the situations that are appraised as too demanding. Contrary to Seyle's response theory, coping in this theory is not an automatic response constituting physiological reactions only. Psychological and emotional responses are also involved. For instance, coping may involve efforts to minimize, avoid, tolerate, change or accept the situation.

The theory is useful in nursing though it has been scarcely used in nursing research studies concerned with emergency care. In Betchel (2009: 26) in a study of emergency nurses' experiences with critical incidents from 2 different health care systems in

Massachusetts, the researcher based this study on Lazarus and Folkman's theory with an aim of deciding where to fit the critical events in terms of Lazarus and Folkman's categories of life events. This would help to determine the magnitude of response that could be anticipated from persons concerned. In Zavatsky (2015:17) Roy's adaptation model which is built on Lazarus and Folkman's theory was used in the exploration of relationships between moral distress and coping in emergency nursing. It was recommended that the nurses' coping skills be screened before they begin working in A&E units to determine if A&E unit was the right place for them.

In this study, the theory was selected because of its relationship with the researcher's world view of the subjective nature of the A&E information that is targeted and the manner in which that knowledge can be acquired. It allows for the association of the A&E unit encounters with the environmental pressures that are appraised differently according to each person's opinion. It has assisted the researcher in adopting a systematic way of investigating the topic of study by identifying the aspects of the phenomenon such as stress, coping and health outcomes that need to be considered during the discussion of A&E experiences by the participants.

1.7.1.4 Methodological assumptions

According to Botma, Greeff, Mulaudzi& Wright (2010:188) methodological assumptions explain what the researcher believes good science practice to be. It involves the description of the procedures followed in the conduction of the study.
In this study, the researcher bases the methodology on the qualitative approach of a descriptive phenomenological design since the inquiry is on human experiences associated with working in the A&E units. According to Rebar, Gersch, Macnee and McCabe (2011:30) qualitative methods involve collection of information as people within the context of their lives express it.

Six regional urban hospitals are targeted for their being accessible to the researcher. After obtaining permission to conduct the study from the Ethical Committee of the University of South Africa, KZN Department of Health, senior management of the targeted hospitals, and the unit managers of the A&E units, the off duty books are

used to obtain the list of prospective participants. Prospective participants are given a voluntary status of being able to choose whether they are willing to participate.

The approach requires researcher to adopt the non-probability sampling method, namely purposive sampling for recruiting the participants who are most knowledgeable about the subject. The sample includes participants who have worked for a year and more in the A&E units. Student nurses are excluded from the sample because of their training requirements that they rotate the hospital units throughout their training programme.

The need to shorten the distance between the researcher and the participants and to obtain as much information as possible is realized therefore the study uses the unstructured interviews to investigate the participants. Data analysis takes place at the same time of collection in accordance with Creswell's method of data analysis (Creswell 2009: 184 in Botma et al 2010:223) whereby three main steps are followed. These include organising and preparing, developing a general sense, and coding the data.

1.8 THEORETICAL FRAMEWORK

Theory is the interpretive lens based on which one shape the study (National Institute of Health (NIH) 2005:4). This study was guided by Lazarus and Volkman's (1984) transactional theory of stress and coping. Berjot and Gillet (2011: 4) and Mwale (2013:4) refer to Lazarus and Volkman's (1984) transactional model of stress and coping, which suggests that transaction (interaction) occurs between man and the environment. Stress occurs when demands (pressures of the environment) exceed the available resources (ability to cope and mediate stress) to the extent of endangering his own well-being.

According to this model, the relationship between man and the environment goes through two important phases, namely, cognitive appraisals, and coping/response. The determination that a particular person-environment relationship is stressful or not, depends on the individual's cognitive appraisal of the situation, which involves two

phases, namely, primary, and secondary appraisal which influence the individual's response to the circumstances/ situation.

During primary appraisal, the individual evaluates the significance of the encounter/event. The result of evaluation may be either the encounter has no significance, is a benign – positive encounter (desirable), harmful, threatening or challenging (there is something to learn in it). During secondary appraisal, the individual engages or works out the coping options, that is, there is evaluation of internal/external coping options as well as more specific resources to create a more positive environment. Internal options include will power and inner strength, while external options include peers, professional health support and other sources. The coping response refers to cognitive and behavioural efforts which may involve mastering, reducing or tolerating the internal and/external demands that are created by the stressful transaction.

Reichenbach (2009:140) notes that it is difficult for any one person to know what is going on around all the time especially during complex high – stress incidents. This suggests that it is the application of steps in Lazarus transactional model that can guide the extraction of the necessary information from the A&E nurses. The stepwise approach of the model will be applied in the study to target the nurses' cognitive appraisal of the A&E situation at both the primary and secondary levels, that is, how nurses describe their A&E experiences and how they cope with them, followed by working out or suggesting the relevant supportive strategies that that they would appreciate if provided for them to help mitigate the stressful A&E circumstances. According to Scott (2012:2), Lazarus Volkman's transactional model, the primary appraisal considers whether the person has a personal stake in the encounter (are their goals thwarted) while the secondary appraisal the individual engages on how best the situation can be worked.

1.9 INTRODUCTION TO RESEARCH DESIGN AND METHODS

The study was conducted in two phases in which Phase I entailed qualitative data collection and analysis. Phase II entailed the development of strategies to enhance support systems for nurses working in the A&E units. Phase II also portrays the

outcome of the research, in that the strategies are presented. A detailed description of the phases is discussed in Chapters 3, 4 and 5.

According to Botma, Greeff, Mulaudzi and Wright (2010:182) qualitative research expresses data in the form of words related to a specific phenomenon rather than in numeric values. Words used in data for this study were related to the experiences, thoughts, insights and opinions/views. Data were therefore collected and analysed in the form of words in relation to the objectives of the research topic. The researcher engaged in in-depth exploration and description of experiences and coping strategies of nurses while working in the A&E units, to better understand and explain them. Analysis was guided by the attributes of the source of data.

This approach assumed that knowledge is maximised when the distance between the inquirer and those under the study is minimised. For this reason, the participants were accessed through subjective interaction, and their voices and the interpretation of the situation were treated as crucial to understanding the phenomenon under study. According to Polit and Beck (2012:12) reality is not a fixed entity in this approach. Rather, reality exists only within the context of the study. For this reason, the results of the study could not be generalised, however, were transferable to similar situations.

Qualitative approach was chosen because there was anecdotal information known about the support systems for the nurses working in the A&E units, the experiences of the nurses and their coping strategies were not quantifiable, the nature of the problem was not fully understood as it was never formally reported, and therefore there was no tangible evidence. Finally, the researcher was of the opinion that the phenomenon needed to be re-examined. In the study, the information to be investigated was about the nurses' experiences, coping skills, and the support systems that needed to be enhanced to improve the situation in the A&E units of regional urban hospitals in KZN. The qualitative approach was relevant in exploring and describing the information from the nurses' own point of view. The research methods is summarized in Table 1.1 that follows. The detailed methods and data design quality are described and presented in chapter 3.

Table 1.1: Summary of study objectives, methods and data analysis

Objectives	Methodology	Sample	Sampling method	Data collection	Data analysis
Explore and describe the nurses' experiences in the A&E unit of a regional urban hospital at KZN	Qualitative	Nurses working in the A&E units	Purposive	In-depth interview	Transcription, categorizing, coding and theme-based
Describe the coping strategies used by nurses working in the A&E units	Qualitative	Nurses working in the A&E units	Purposive	In-depth interview	Transcription, categorizing, coding and theme-based

1.10 STRUCTURE OF THE THESIS

The components of the research study comprise the following:

Chapter 1: Orientation to the study
Chapter 2: Literature review
Chapter 3: Research design and methods
Chapter 4: Analysis, presentation and description of the research findings
Chapter 5: Presentation of the strategies
Chapter 6: Conclusions and recommendations

1.11 SUMMARY

This chapter serves as an introduction to the study in that it gives an overview of the aspects that will receive greater attention and details in the later parts of the text. Aspects introduced include background information about the research problem, research problem, aim and significance of the study, definition of terms, and theoretical foundation.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Rebar, Gersch, Macnee and McCabe (2011:206) describe literature review as a synthesis of the literature that describes what is known or has been studied regarding the particular research question or purpose. According to Kumar (2011:32) literature review used in a study can help in making the subject of investigation to be understood better, and shape the research problem so that it can be conceptualized clearly and precisely. This makes it more pertinent to the researcher's field of enquiry. It reveals the aspects of the subject of research that have been examined by others, what they have found out about these aspects, what gaps they have identified and what suggestions they have made for the future research. All these discoveries help to gain insight into one's own research questions and provide with clarity, which are central to a relevant and valid study.

The topic of research in this study is about strategies to enhance the support systems of the nurses in an accident and emergency unit of a regional urban hospital at KwaZulu-Natal. This chapter therefore involves the discussion of published information from various reliable sources regarding the A&E unit issues. It gives a summary of the arguments, ideas and conclusions of previous researchers based on these issues. These arguments have provided the researcher with a foundation for the research topic, which aims at improving the health of nurses and in turn patient care in the A&E units.

There is a close relationship between the researcher's topic of inquiry and the previous investigations based on A&E issues. Previous investigations traced mainly focus on the factors that have been noted to be the sources of high stress levels in that they are associated with critical incidents. The consideration of these previous investigations has helped the researcher to explore the information that is directly related to this study, making it important to credit those who have made such

information available and worth acknowledging. This information has shaped and directed the researcher's investigation to take place within its own context without having to duplicate other researchers' findings about A&E units. It explores administrative-environmental factors as well as characteristic specific A&E unit work factors that are associated with critical incidents. Most of the previous literature avails this information in the form of qualitative research studies, which coincides, with the researcher's planned qualitative approach of investigation that will ensure exploration of subjective views about the targeted A&E units.

Searching for the published information involved mainly the use of two engines, namely, the University of South Africa (UNISA) online library and the public online search, namely, the google scholarly search. The advantage of the UNISA online library is that it guides to the specific field of search such as 'Health Studies' and Nursing Research' in the case of this study. From the specific field it then provides a variety of resources/sites for information such as, among other things, the books, articles, and theses and dissertations. The researcher to reach the subject database with nursing articles commonly used the site for articles. The data base sites included the academic research premier, health resource and CINALL, which led to the EBSCO host search. In order to obtain the relevant information, the researcher entered the key words that form the backbone of the research topic such as 'emergency unit', 'nurse', 'support' and 'urgency'. The theoretical framework selected by the researcher for the study suggested more key words like 'coping' and 'stress'. The latest articles were retrieved by adjusting the period of publication to the latest years, namely 2008 - 2016. Less frequently, the public online search engine was used although the researcher had to be specific to request scholarly articles to ensure reliability of the information. For every article retrieved, references were checked for latest articles used as an additional source of information. The researcher's own experience in the A&E unit also guided the search.

Fifty-three (53) articles with the identified key words were retrieved for use in both Chapters 1 and Chapter 2 of the study. Countries associated with the accepted articles abound outside South Africa especially in the Middle East, Europe and United Sates of America (USA). Most of the articles discuss the overwhelming A&E conditions followed by a suggestion for support strategies for nurses as the way forward.

While many are based in the A&E units, a few are based in other hospital units such as psychiatric and paediatric units, which are also noted to have high stress levels. The researcher for comparison also used the later with the A&E units regarding the levels of stress and health outcomes. South Africa and Africa as a whole do not show many articles related to nurse support in the A&E units though much work has been done in relation to the state of emergency in the continent, triage and improving A&E units in many other ways other than supporting the nurses only.

2.2 DEVELOPMENT OF INTERVENTION STRATEGIES

Since stress in the form of physical, psychological, and emotional reactions is quite predictable in workplaces where critical incidents form part of daily activities, intervention strategies are becoming popular for protection of those exposed to workplace trauma. Intervention strategies aim at neutralizing the traumatizing effects of critical incidents by dealing hands on with people concerned during or following the occurrence of a critical incident (Davis 2013:68).

While on one hand it is important to understand how work issues/pressures act as predictors of workplace stress, it is, on the other hand, also relevant to take note of the contribution of other related variables that predict the perception of workplace stress. It is therefore appropriate that any attempts to investigate into workplace issues involving critical events with the aim of developing intervention strategies, should also explore into the influence of cognitive styles, personality dimensions and coping strategies of people concerned (Pino & Rossini 2012:2). This would lead to better decisions for development of sustainable intervention programs, which, according to Chou, Li and Hu (2014:2) should be feasible stress reducing programs in hospitals. Milutinovic, Golubovic and Prokes (2012:177) add that the understanding and recognizing of all risk factors is important in that it can also contribute in the prevention of work-related diseases.

Development of intervention strategies can be based on the interpretation given by those concerned about the work situation. Regarding the accident and emergency (A&E) work situation, it is noted that some of the A&E staff may not even identify and

interpret some of the A&E incidents as critical and stressful because of the frequency with which they take place; also that to certain staff, a certain amount of stress resulting from such incidents can act as a motivational factor, encouraging them to focus on tasks at hand (Healy & Tyrrel 2012:35). In another instance, it is noted that A&E staff do perceive workplace stress but show differences in the levels of their perception of stressfulness as indicated by the extent to which they develop physical and psychological symptoms (Milutinovic, Golubovic & Prokes 2012:177).

Studies that rank the A&E events according to their severity also show that staff concerned may differ in their opinions regarding the severity of stress, in that incidents identified by staff as ranking very high in determining the occurrence of stress in one study maybe identified as ranking low or very low in another or other studies and vice versa (Adriaaenssens, de Gucht & Maes 2012:1415; Healy & Tyrrel 2012:34; Milutinovic, Golubovic & Prokes 2012:177).

Thus, the need to carefully estimate the magnitude to which the A&E issues have had physical, psychological and emotional consequences regarding staff safety, health and performance, as well as assessing the coping abilities and the amount of support interventions that have been in place over years for the staff working in these units cannot be overemphasized. According to Healy and Tyrrell (2011:37), establishing a supportive culture for the situation, should value staff and demonstrate recognition of and concern for the effects of stress. Uren and Graham (2013: 5) believe that support is often a fundamental component in dealing with the daily stressful situations experienced by caregivers at work and that the absence of such structures allocates further responsibility to the caregiver to find on her/his own, the needed support.

2.3 PREDICTORS OF STRESS IN THE ACCIDENT AND EMERGENCY UNITS

In predicting the occurrence and consequences of occupational stress among health workers, certain studies have analysed and highlighted the relationship between certain identified stressors and health stress related outcomes (Adriaenssens, de Gucht & Maes 2015:347; Pino & Rossini 2012:2; Sterud, Hem, Lau & Ekeberg 2011:2).

Two main categories of stressors have been studied to determine the extent to which they can influence health outcomes.

These involve the administrative-organizational, and the job characteristic/specific factors. Among administrative-organizational factors, problems cited include, among others, the environmental conditions, workload, staff shortage, inadequate material resources, and little or lack of support from managers. Job specific factors include the type of events inherent in the job, the degree and frequency of exposure of staff to the related events, especially, high job demand, and low job control. For this reason, Sterud, Hem, Lau & Ekeberg 2011:2) raise the importance of assessing well the category of stressors that is more specific in a situation in order to determine health outcomes on staff concerned. For instance, administrative - organizational stressors may not be an issue in jobs like ambulance work, but job specific related factors such as high frequency in dealing with critical incidents may be the most important source of frustration and low job satisfaction.

2.3.1 Administrative-organizational factors

Carrus, Corbett and Khandelwal (2010:1) indicate that the issues that confront the hospital A&E units cannot be understood to be emanating only from the malfunctioning of the A&E units. To a certain extent, extra-departmental problems involving even the environment in general, contribute. There is therefore a reason to expect administrators to also evaluate the root causes of the A&E issues, and anticipate participation from all the relevant departments in solving them while A&E staff receives necessary support. House, Nyabera, Yusi and Rusyniak (2013: 2) suggest even going outside the hospital to the extent of knowing about the local patient population, which involves their demographics, volumes and patterns of their arrival in A&E units, as well as common complaints. This information is required to tailor the programs for staff, students, and patient support in these units. In terms of these observations, concentration on identifying local sources of issues affecting staff output and patient care outcomes in the A&E units can resolve A&E issues to a certain extent. However, a wider approach of investigating beyond these units can prove more profitable and add more value towards suggesting strategies that can enhance the support systems to staff working in them.

2.3.1.1 Environmental conditions

Attention is drawn to processes like hospital restructuring, undertaken with the aim of reducing expenditure, which may have resulted in the closure of certain units. Under these circumstances nurses are likely to destabilize psychologically and emotionally as these processes may be perceived as a threat to job security (Pino & Rossini 2012:1). Closely related to this fact is the unavailability of admission beds in the wards, resulting in patients being stuck in the A&E unit.

Tomajan (2012:29) is aware of external influences, advancing technology, looming workforce, and changes in population, which can adversely affect the working environment and administrative decisions on improvements. Hence, an indication that nurses involved in areas indirectly affected by challenges that specifically affect certain work areas, are also at an advantage of a greater voice in influencing local changes, input in health policies and enhancing the nurses' image and the profession. Nurses are believed to be the agents of change through self - advocacy, especially where it is clear that the work challenges face them directly.

Rainer (2013:1) observes that A&E issues are experienced worldwide. However, unique situations may arise depending on the country's unique situation. In this regard, House, Nyabera, Yusi and Rusyniak (2013:2) refer to the factors associated with the African continent where there are immense resource constraints leading to a surge in A&E attendance and thus overcrowding, overloading and the overburdening of the A&E units. South African A&E units are no exception to this problem (Aacharya, Gastmans & Denier 2011:1; Augustyn 2011:24; Rosedale, Smith, Davies & Wood 2011 537), a situation that has resulted in high stress levels for nurses working in these units.

2.3.1.2 Overcrowding in the A&E units

Regarding factors associated with overcrowding and work overload, Boyles, Beniuk, Hugginssons and Atkinson (2012:2) identify poor emergency unit design which prevents the flow of patients, delays with diagnostic imaging and results, and inadequate number of medical and nursing staff. Often there is lack of critical care

beds in the wards, which prevents the quick transfer of the high acuity patients to the wards. Major issues involve long waiting times for results such as radiology investigations and blood tests.

In South Africa, the situation of overcrowding especially in the A&E units of regional hospitals is exaggerated by the fact that these hospitals receive patients referred from surrounding district hospitals and clinics, which means that nurses attend to an extra share of work in addition to their own volume of patients. A number of studies conducted in South Africa confirm the excessively high volumes of patients accessing the A&E units of regional hospitals through referral (Cimona-Malua 2010:7; Rosedale, Smith, Davies & Wood 2011:537; Twomey, Wallis, Thompson & Myers 2011:4; Pillay, Ross & van der Linde 2012:140).

Further accounts for overcrowding in South African A&E units involve the situation whereby patients who could have attended at the Primary Health Care (PHC) clinics opt to present at the hospital A&E unit. Reasons extracted from patients are that medicine at the PHC clinic does not help, the hospital medicine is superior, there are no PHC services after hours and that the PHC clinics only see a specific number of patients. This suggests that the referral guidelines to regional hospitals are not very strict. For this reason, a great percentage of patients attending hospital A&E units are self - referrals (Becker, Dell, Jenkins & Sayed 2012:4).

2.3.1.3 Workload and inadequate human and material resources

Work overload in the A&E units results from the growing demands within the public to attend A&E units. The problem may be exaggerated by the organizational problems such as lack of human and material resources, which are required for adapting to the local needs. For this reason, staff shortage and financial constraints are highly associated with work overload in the A&E units. The fact that the daily time limits for the completion of tasks in the A&E units cannot be easily estimated, contributes to the perception of work as an overload. Various factors contribute to this problem. The most noticeable factor is the segmentation of the A&E units into various treatment areas such as shock, triage, resuscitation, injection and dressing rooms.

The treatment demands in these rooms differ in that each area has its own peculiarities, and thus, the estimated time limits for completion of tasks in these areas will differ. Certain tasks require simultaneous attendance by more than one nurse, which indicates that there is a doubling or tripling of the workload in the cases where attendance is provided by one or two professional nurses (Rosseti, Gaidzinski, & Fugulin 2013:9**).**

A study by Pillay et al (2012:1) conducted at King Edward V111 Hospital, Durban, KZN showed the overloading occurring as a result of many trauma- afflicted patients, which has a high rate in South Africa. Peaks in patient attendance was observed mid-month, month-end, between 08h00 and 12h00 daily and on Saturday and Sunday nights. It was noted that most of the patients sustained their injuries on roads, informal settlements and drinking bars, otherwise popularly called *shebeens*.

Work overload impacts on resource planning and organization in that as the work increases, the A&E structures are usually not very accommodative or material and human resources are scarce.

2.3.2 Accident and emergency job specific factors

Additional issues that confront the A&E units are job related or very specific to A&E work. While administrative factors that constitute issues in the place may sometimes be predicted because the nurses may be conditioned to them as time goes on, the A&E job related factors are not easy to predict. This is because they often involve a sudden change from one state of affairs to another without prior indication. For instance, violence, sudden death, sudden confrontation with mutilating injuries and threatening situations are some of the job related factors that rarely indicate before they present in the A&E unit.

2.3.2.1 Violence in the A&E units

Reasons identified for increased violence towards healthcare personnel, especially A&E nurses, include, among other things that, nurses come into contact with families

who are often under intense emotional charge due to severe trauma or bereavement. Sometimes patients' emotions are heightened by the long hours they wait before receiving attention in the A&E unit.

In a number of instances, nurses provide care in secluded areas like the diagnostic rooms, and perform procedures that bring them to closer physical contact with the patient. In addition, the fact that money and drugs are available over 24 hours in hospital makes staff a target for robbery (Stathopoulou 2014:2).

It has also been noted that patients who become violent are those under the influence of drugs or alcohol especially where they have been brought to hospital against their will (Gillespie, Gates and Berry 2013:4). Under these circumstances, the slightest provocation is enough to trigger unexpected reactions in the form of violence. Nurses may not be aware of these factors. Even if they may be well indicated prior to the traumatic incidence, the situation of urgency under which the A&E nurses work, may not give them the slightest opportunity to observe the relevant signs in advance in order to be ready for an appropriate response.

In South Africa, A&E violence is ascribed to the high levels of social interpersonal violence, which has spilled to and created negative effects on health services. There is a reason that it must be well understood and addressed in the sense that when the health services receive the victims of violence, they automatically become part of violence prevention. Further that, staff who attend to these victims are susceptible to post – traumatic stress, a situation that requires the strengthening of physical and psychological safety of personnel in health care centres (Ward, Artz, Berg, Boonzaier, Crawford-Browne, Dawes, Foster, Nicol, Seekings, Van As & Van der Spuy 2012:215). Accident and emergency as well as psychiatric units have been identified as hospital settings that are specifically infiltrated by violence. The types of violence experienced by nurses in these units include physical, verbal, and psychological or emotional abuse. Physical abuse refers to inflicting harm to the worker such as kicking, slapping or stabbing. In verbal abuse, there is intentional use of a language that is humiliating, decreasing or indicating lack of respect for the dignity and worth of the individual while in emotional abuse violent behaviour is used to humiliate or degrade the individual. In all these violent behaviours, there is use of threat or power.

Nurses tend to normalize workplace violence under the perception that it is part of the job to be subjected to violence. For this reason, they tend to under report this incidence. The result of this is the increasing levels of violence and the mounting evidence pointing to its adverse effects to care givers, health institutions and consumers of health care. The problem has therefore been overlooked until only recently that it has become regarded as a serious occupational burden and a public health issue.

Nurses have endured these conditions over a long time. In their desperation to cope with the situation, where little or no support availed itself from administrators, nurses have been surviving by using whatever available means of undocumented self – supporting systems on advice by colleagues, friends or family members. They have also tried the strategies that have been seen used by other nurses who have been confronted by violence. These strategies include using colleagues as sounding boards, helping out with duties, taking a smoke break, and using friends and family to take it out of their chests (Kennedy & Julie 2013:7).

2.3.2.2 Sudden death

A comprehensive understanding of the experience of a sudden death in an A&E unit was unfolded in Newton (2011: 42) in a study conducted in UK to explore the relatives' and nurses' experiences of sudden death in the A&E unit. The main concern for the nurses in the study is the context within which death takes place. According to the nurses, the ideal for the A&E tasks is that patients must be seen, treated, admitted or discharged within a targeted time. A sudden death and the need to care for the suddenly bereaved relatives is therefore interpreted to be taking place against a background which is already pressurized with imposed targets. Since the care of the suddenly bereaved relatives cannot be rushed in order to meet the time frames, this makes the situation very challenging. Moreover, the injuries that sometimes lead to the patient's death and the place within which the patient dies, remove the dignity with which any patient can be expected to die. For instance, patients are generally understood to die with dignity in their homes or perhaps in a stable situation such as the ward where families can surround them.

Naik (2013:1) makes a distinction between two instances of hospital death, namely, expected and sudden death. In the former instance, it is noted that relatives do expect death based on the serious nature of the illness. In the latter instance, relatives are unable to cope with the sudden release of the death news. Grief and violent reactions that differ with individuals among relatives may vary from silence to loud crying, bodily movements as well as bouts of anger directed to staff. Staff often feels inadequate to handle this situation, which may in turn result in conflict among them surrounding the death of the patient.

Shoenberger, Yeghiazarians, Rios and Henderson (2012:181) add that the words to be used in breaking the news to the survivors are usually not readily available, making the act very stressful to staff involved especially that in the A&E unit there is no well – established relationship between the caregiver and the patient or relatives. The situation is worse if the course of death is unknown.

Sudden deaths are not uncommon in the A&E units. A number of studies that have given attention to sudden deaths in the A&E units show that respondents commonly rank this problem high in the list of the frequency of occurrences among other critical events encountered by nurses in the A&E units (Adriaenssens, de Gucht & Maes 2012:1415; Healy & Tyrrel 2012:34). The situation is such that both doctors and nurses need to be addressed adequately on the subject of sudden death in an A&E unit and how to handle the situation when it occurs.

2.3.2.3 Dealing with severe to mutilating injuries and critical illnesses

South African Urban A&E units often suffer the consequences of rapid urbanization of the surrounding areas. This situation is accompanied by population surges, increase in the number of road users (vehicle owners, cyclists and pedestrians) which increases road traffic accidents in the form of blunt trauma (Parkinson, Kent, Aldous and Oosthuizen (2013:131). In addition, there is an increase in interpersonal violence, leading to penetrating injuries that include stabs and gunshot wounds (Moodley, Aldous, and Clarke (2014:104). The nature of these accidents is such that patients present in A&E units with different levels of acuity, ranging from mild to severe such as crush injuries.

The problem with mutilating injuries is the complications with which they are associated, which requires performance of different stabilizing procedures before the patient can be transferred elsewhere such as the ward or ward via operating theatre.

The encounter of such events is unfolded in Smith (2011:3) where a picture of one night's experience in an A&E resuscitation unit of Ngwelezane regional hospital at KZN is given. The scene involves, among other things, a young man with multiple gunshot wounds, unstable and presenting with bilateral pneumothorax, and haemoperitoneum; a patient with severe diabetic ketoacidosis; a woman in her 20's with end stage HIV, dying from tuberculous meningitis; a diabetic patient with wet gangrene, awaiting amputation; a boy with the depressed fracture of the skull awaiting transfer to the neurosurgical unit, and a man with a haemoglobin concentration of 3.6gd/L, awaiting blood transfusion.

According to Adriaenssens et al (2012:1412) repetitive exposure to such scenes can be seen as a risk factor for development of psychological problems in A&E nurses. This means that nurses do not have to be necessarily exposed to large-scale events such as mass collision before they suffer the psychological consequences of working in an A& E unit.

2.3.2.4 Other life threatening conditions

Other life threatening conditions can arise as a result of the unstable social conditions. Under these problems, Davis (2013:70) mentions rape victims, suicide, and abused spouses and children as well as major incidents such as fire, earthquake, floods, industrial disaster and workplace violence.

Resuscitation is identified in Healy, Tyrrel (2012:35) as one of the measure life threatening conditions, and a major course of stress among A&E nurses especially the less experienced. Shoenberger, Yeghiazarians, Rios, & Henderson (2012:181) note that under these circumstances, emotional impact on nurses may involve being reminded of a death in one's own family or declining health of a family member.

2.4 EFFECTS OF EXPOSURE TO CRITICAL EVENTS

Several factors play a role in determining the severity of stress and thus the level of support required for personnel involved.

These include personal understanding or pre – existing knowledge about the incident, personal rating of the seriousness of the incident, length of exposure, pre – existing coping strategies, and available social support. These factors operate differently on different people concerned, which results in different and subjective interpretation of the events or life situations.

In many instances critical events cause significant and long – term effects on those involved. In the health care setting, the effects are demonstrated on patients and those who care for them. When they occur, a cascade of emotions may overwhelm an individual to the extent of disturbing his/her normal coping skills (American Association of Nurse Anaesthetists (AANA) (2014:1) Board of Directors.

When nurses and other health care givers become involved in the care of patients who have suffered adverse events or trauma, they also indirectly become victims of their patients' encounters. They in turn experience a unique traumatic response that triggers personal physical, psychological and emotional problems as well as concern or self – questioning about their competence in dealing with their patients' problems. For this reason, while patients as direct sufferers of critical incidents are referred to as first victims, caregivers are referred to as second victims to the critical incident (Scott, Hirschinger, Cox, McCoig, Brandt & Hall 2009:326; Seys, Scott, Wu, Gerven, Vleugels, Euwema, Panella, Conway, Sermeus & Vanhaecht 2012:2; Seys, Wu, Van Gerven, Vleugels, Euwema, Panella, Scott, Conway, Sermeus & Vanhaecht 2012:3).

According to Davis (2013:70), the effects of traumatic events on victims are predictable though Scott et al (2009:326) note that certain individual factors may intensify the experience and effects. Factors noted include the relationship between the patient and the caregiver, past clinical experience and patients the same age as a family member or other factors that make the caregiver feels somehow more personally associated with the incident.

Davis (2013:70) notes that personnel who have experienced a traumatic incident first go to a short-term crisis where they undergo many stages. These may include denial, anger, rage, sadness, confusion, terror, shame, sleep and eating disturbances, humiliation, hyper-vigilance, fear, guilt and self-blame.

These symptoms are expected from survivors of a critical incident and those who are helpers though there is a tendency that in certain victims they may be masked through excessive use of substances such as tobacco, drugs and alcohol. The problem noted is that some of these symptoms may show up quite early for detection and attention whereas others take time to surface, or keep on re – surfacing depending on the surrounding circumstances, leading to a long-term crisis reaction. Scott et al (2009: 326) describes this phenomenon as the re-living of the event when triggered by an external stimulus. The trigger could be a critical event that involves a different patient in the exact location as the original event, a similar name, similar diagnosis or similar clinical situation.

According to Ariapooran (2013:157) the long-term crisis reaction to stress can manifest in a syndrome of symptoms collectively known as secondary traumatic stress (STS) or in posttraumatic stress disorder (PTSD). Devilly, Wright and Varker (2009:3) note that STS and PTSD are nearly identical regarding the syndrome of symptoms they produce, except that PTSD affects those people who are affected by the trauma of other people, such as patients or family members. It therefore involves aspects like witnessing or hearing about the trauma of another individual. The syndrome of symptoms involved in both STS and PTSD include intrusive imagery, avoidance, and arousal symptoms.

People who suffer from intrusive imagery re – experience the traumatic event through recurrent memories, distressing dreams and feelings that the traumatic event is recurring. Avoidance involves avoiding almost all the situations that act as reminders about the event. People who suffer this aspect of STS or PTSD will therefore avoid thoughts, feelings, conversations, activities, places and even people that are associated with or remind them of the traumatic event. Eventually the person has a restricted range of affects. Where the person suffers from the arousal syndrome, these

will manifest in sleeping problems, extreme anger, vigilance, difficulty in concentrating and a startle response (Ariapooran 2013:157).

A study conducted by Adriaaensens, de Gucht and Maes (2012:1420) on the impact of traumatic events among Netherlands A&E nurses, revealed a strong relationship between a frequent exposure to traumatic events and PTSD.

This was based on the findings that almost one third of the respondents had already exceeded sub-clinical levels for psychological disorders associated with PTSD while one out of seven respondents already reached a clinical level.

In the same study, the influence of personal characteristics in reacting to stressful conditions was also mentioned. Characteristics noted include high levels of autonomy and independence, good multi-tasking, and a talent to remain calm among chaos. The question is whether more resilience to stressful conditions can be expected from such people. The study recommended a further exploration into this aspect with respect to emergency response. In subsequent studies (Adriaenssens et al 2015:353; Healy & Tyrrel 2012:34), a closer look into the matter is based on age and gender, and to determine a link between these personal characteristics and work stressors and/or stress outcomes among emergency nurses. In Adriaenssens et al (2015:353) in a study on causes and consequences of occupational stress in emergency nurses conducted in Netherlands, age and gender do not show any significant relationship with many stress outcomes such as emotional exhaustion, work engagement, and psychosomatic distress. In Healy and Tyrrell (2012:34), a link exists between these personal characteristics and certain stressors, for instance, where a significant result is noted with age and caring for a critically ill patient, which is less stressful to those more experienced in A&E work.

2.5 NURSES' COPING STRATEGIES WITH CRITICAL INCIDENTS

Lazarus and Folkman (1984) are credited with the proposal of the transactional model of coping, which identifies a link and an interactional process between man and the environment. The model describes coping as the constantly changing cognitive and

behavioural efforts to manage the taxing demands of man's internal and external environment (Kuo 2013:18).

Coping involves an ability to mediate stress and it is considered as a variable that may alter the action of stress on an outcome variable. Its mediating effect depends on the level to which the other variables such as problem solving skills that the individual possesses, and the available amount of support, contribute towards reducing stress.

The environment, whether internal or external to the individual, has precipitating events to stress. However, the determination whether the event is indeed stressful or not, depends on the individual's perception of the situation (Mwale 2012:4). This results in different people using different strategies for coping with different situations (Kasi, Nagvi, Afghan, Khawar, Khan, Khan, Khuwaja, Kiani & Khan (2012:1). In this way, coping displays individualism, cultural values, secularism, and spirituality (Kuo, Arnold and Rodriguez-Rubio (2013:3). In addition, a variety of elements influence the responses adopted. These include the generic influences, past experiences, and mental health.

Lazarus and Folkman (1984) identified two aspects of coping, namely, the cognitive and behavioural responses. Mwale (2012:4) describes the cognitive responses as consisting of the individual's appraisal of the events in primary and secondary stages. In the primary appraisal, the event is evaluated whether relevant, benign – positive (producing pleasure), threatening (associated with loss or harm) or challenging (associated with gain). In secondary appraisal, there is deciding regarding the options to choose in dealing with the situation. For this reason, the decision taken at primary appraisal and the choice of responses taken during secondary appraisal, determine the quality of responses displayed by the individual. Lazarus and Folkman (1984) further proposed that coping serves two measure functions by being problem - focused and/or emotion - focused in their approach. The former approach deals with direct management of the problem that is causing stress and which is perceived to be under control. The approach is positive. The latter approach deals with the regulation of emotions for a problem, which is beyond control. The approach is negative.

In the absence of social support, A&E nurses have engaged in the said approaches of coping strategies to deal with their work encounters. In Gholamzadeh, Sharif and Rad (2011:45) in a study to determine the sources of occupational stress and coping strategies among A&E nurses in Iran, the most common coping strategies used by the nurses were self-control, followed by positive appraisal. The strategy less used was accepting responsibility.

According to the study, exercising self-control is in line with the cultural practices of Asian nurses while positive re-appraisal has a religious dimension. The fact that accepting responsibility as a coping strategy was less used, indicates that the nurses did not feel that it was their responsibility to solve the A&E problems, and they did not blame themselves. In addition, nurses used emotion-focused coping strategy, probably because they felt that the problem was beyond them.

In Jannati, Mohammadi and Seyedfatem (2011:126) in a study conducted to investigate on coping skills for job stress among Iranian clinical nurses, a number of coping skills were identified. Under cognitive strategies, nurses indicated the belief that one's perspective on the stressors determines the way one can cope in the presence of such stressors. Coping under such circumstances would involve positive thinking and looking forward for the positive and trying to avoid anger. Regarding behavioural strategies, it was noted that under the self-control strategy, nurses had further sub-category approaches that they used to reduce stress. These included positive strategies such as preparing for work, resting sufficiently before starting work, listening to music, doing sports, reading books, shopping and referring the problem to the nurse manager. Avoidance, such as getting away from the stressful situation, though a negative strategy, was identified among nurses. Emotional reactions included aggressiveness, crying, laughing, smiling and keeping cool.

In their effort to cope with stressful situations, nurses have even gone beyond the work spheres to secure support. For instance, friends and families have been used to ventilate. Uren and Graham (2013:7) note that sometimes families have not been supportive. They have often focused on the importance of maintaining a job rather than the well-being of their member. These authors also warns that the habit of resorting to alternative support measures beyond the workplace has its own issues. It

utilizes the caregiver's own limited resources for coping, especially in the presence of additional personal stressors. It also means that the caregiver is capable of using anything that has the ability to occupy the mind and remove the possibility of ruminating over the workplace stressors. This refers to the use of either positive coping strategies that are effective and lasting or the negative coping strategies that are ineffective and offering temporary relief from stress (Uren & Graham 2013:9).

2.6 SOCIAL SUPPORT

Dealing with stress is a fundamental aspect of everyday life and the existence of work related stressors is inevitable in the nurses' work – place. It is also inevitable that nurses to cope with many work-related stressors (Jannati, Mohammadi & Seyedfatem 2011:123) use different kinds of strategies. While factors that constitute stress can adversely affect the working environment, they can also create opportunities whereby nurses can advocate for improvements in their workplace (Tomajan 2012:2).

Advocacy involves being aware of a need and finding a way to address it (Amidei 2010 in Tomajan 2012:2). Such advocacy should reasonable find a place in the A&E units where a positive balance should strike between the high work demands and the nurses' health outcomes. Acknowledging the existence only of these high work demands without suggesting a way forward is not sufficient. A difference can be brought about through taking into consideration the support strategies that need to be in place and enhancement of those that already exist. This can serve a complete advocacy duty for the nurses concerned, which is the purpose of this study.

Advocacy requires a set of skills that include among other things, communication, influence and collaboration (Tomajan 2012:6). This indicates a compelling need to engage with nurses concerned to identify the issues to be addressed through exploration of their experiences in the A&E units and how they cope under the circumstances. This approach encourages self – advocacy in that once they are aware of their own state of affairs at work, they are likely to be the ones who suggest better social support systems that are relevant to their own situation. They are an important source where little or no information is available about their workplace.

Despite the fact that some nurses find A&E units to be stressful while others find them to be motivating or inspiring, which are quite divergent views, collaboration with nurses representing both sides is necessary if relevant social support is to be achieved. The reason according to Johnston, Abraham, Greenslade, Thom, Carlston, Wallis and Crilly (2016:23) is that though views may be divergent about the situation, they still pivot around the central themes which involve work overload, impact of traumatic events and the need for support.

Among administrative – organizational factors identified, lack of social support has been labelled as a strong predictor of stress outcomes especially among A&E nurses (Adriaenssens, de Gucht & Maes 2011:1419 in Adriaenssens, de Gucht & Maes 2015:347). This factor seems to have no limits in its operation in the A&E units as it also applies in relation to job specific tasks, which is an indication that A&E nurses need complete support, that is, from the administrative point of view to task performance.

Social support refers to a feeling of being cared for and appreciated, and having director indirect help that one may need and be enabled to face life experiences positively. It is perceived to emanate from multiple sources such as supervisors, co-workers, families as well as employing organizations. When support is content specific, it relates to the special demands of the work area, and enables staff concerned to fulfil their roles positively (Kossek, Pichler, Bodner & Hammer (2012:3). According to Ariapooran (2013:158), social support is concerned with a number of social relations an individual has (structural support) and the quality of the resources that these relationships provide (functional support). Individuals with few support structures are more vulnerable to stressors and tend to suffer from physical and psychological health problems. Perceived social support from co – workers enhance the level of job performance and decreases job stress. In this way, it is negatively related to later problems such as STS and PTSD. For this reason, Pino and Rossini (2012:6), note that people who experience a kind of social support from supervisors and co-workers, and utilize the opportunities made available for such support, also experience a feeling of personal control and job satisfaction.

In a study conducted by Lavoire, Talbox & Mathieu (2010:1518) from January to May 2007 among A&E nurses in Quebec, nurses expressed in various ways the need for a kind of support at work. Things suggested for inclusion among gestures of social support, include a talk to a colleague so as to feel listened to, and a meeting held right after the critical incident, not weeks later but within the hours of the event to see what caregivers did right and what they did wrong and how others experienced it**.**

The latter view receives support from the guidelines for critical incident stress management AANA (2014:3) which recommends a critical incident stress debriefing session, which consists of a structured group discussion taking place within one to three days after the occurrence of a critical incident. In terms of these guidelines, all staff members from the same discipline or department, who were involved in the critical incident, should attend. The discussion should aim at alleviating acute signs of distress and identify the need for follow up for those who need it. The guidelines anticipate signs of improvement when this step has been taken and these include among other expectations, better mental health of the group, reduced symptoms and increased productivity.

Though in Healy and Tyrrel (2011:34) there is an identification of great inadequacy by employers to assist employees, there is an indication that some employees are aware of a few gestures of social support that some managers are capable of offering. These include deployment of extra staff, allocating workload among members more equally, ensuring the existence of an occupational health department or employer assistance programme (EAP) where employees can be referred with their consent to receive free and confidential counselling. Informal means of assistance include reflection and talking with colleagues.

Arriving at appropriate support interventions for A&E staff would therefore depend on the perspective from which those concerned, whether positive or negative, view exposure to critical events. For instance, while Healy and Tyrrel (2012:31) note a motivational role played by exposure to critical events to some nurses, Fjeldheim et al (2014:1) note a certain amount of depression occurring with some of the emergency workers after a traumatic event.

Since the cumulative effects of stress are often ill health, employers have an obligation to support staff towards better health by ensuring that that the workplace is free from health hazards that act as sources of stress (Health and Safety Authority 2010:3 in Healy & Tyrrel 2012:36). In South Africa, the need to support staff at work is encompassed in the Legislative instrument, namely, the Occupational Health and Safety Act (Act 95 of 1993). In terms of the Act, the employer must, where possible, provide and maintain a safe environment that is without risks to employers.

The Act is pro-active in that it requires prevention of unnecessary injury, illness and loss. At the same time, it is expected that employees co–operate by taking responsibility over their own health and safety. For instance, they have a right to report any work situation that is detrimental to their health and safety (Boshoff 2015:3).

The fact that the stress predictors change over time in terms of the extent to which they operate, and in turn influence changes in stress outcomes in a positive or negative way, should be regarded by employers as a factor that provides an opportunity to improve the relevant outcomes for nurses in the A&E unit. Based on this opinion, interventions should be targeted at the deterioration in specific predictors. For instance, it is important to fill vacancies as soon as possible, to ensure an adequate workload, to anticipate peak load, and to increase work efficiency wherever possible (Adriaenssens et al (2015:353).

Two levels of social support have been identified, namely, at the individual level and at the organizational level. At an individual level, many people such as supervisors, counsellors, therapists and colleagues can provide support. Support at this level should include being there and present for the person who is affected. However, it is noted that discussion with a colleague is interpreted differently by the potential victims and those already affected. Those who do not readily accept it, maintain that discussion of their adverse events with a colleague could pose a threat to their professional reputation and image and therefore they are scared of it. Those who accept it are of the opinion that support given by colleagues is very helpful and there is no need for a specially trained peer support. For this reason, a strong relationship of trust between the health care provider and the individual who is providing support is strongly recommended. At an organizational level, a support program that is part of

the comprehensive process is likely to be effective. The aim of this program should be to take actions not only to correct system failures and inadequacies, but also to render support in general to those who encounter adverse events (Seys et al 2012:3).

2.7 SUMMARY

Stress in the form of physical, psychological, and emotional reactions is quite predictable in workplaces where critical incidents form part of daily activities. On these grounds, intervention strategies are becoming popular for protection of those exposed to workplace trauma.

Two categories of stress predictors have been identified, namely, the administrative – organizational, and the job characteristic/specific factors. Among the sub – categories of these stress predictors, lack of support has been noted to feature under both aspects which indicates that support for A&E nurse is necessary and important in both instances. The administrative-organizational factors include environmental conditions, overcrowding and work overload while the job specific factors include experiences of violence, sudden death, attending to patients with severe injuries, suicide, rape cases, and many other measure incidents such as disasters and public riots.

In many instances, critical events cause significant and long-term effects on those involved. In the health care setting, the effects are demonstrated on patients and those who care for them. For this reason, those affected need social support from co – workers and supervisors to enhance the level of job performance and decreases job stress. Although there is an identification of great inadequacy by employers to assist employees, legislative instruments make it an obligation for the employer to provide some degree of support to employees. In South Africa, the need to support staff at work is encompassed in the Occupational Health and Safety Act (Act 95 of 1993). From this point of view, A&E nurses should be able to receive a kind of support at an individual and organizational level.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

The purpose of this chapter is to describe the research methodology adopted in the study to achieve its purpose, namely, the development of strategies to enhance the support systems of nurses working in the Accident and Emergency (A&E) units of the regional urban hospitals at KZN.

Methodology refers to the choice of methods used by the researcher to conduct the study depending on the problem and purpose of the study, the researcher's expertise in generating information, and whether or not a need exists to generalize information generated (Brink, van der Walt & van Rensburg 2009:53). According to Maltby, Williams, McGarry and Day (2010:263) methodology relates to the underlying philosophy that is applied when approaching/investigating a research problem. It informs a decision-making process regarding a systematic way of investigating that problem.

In this study, methodology guided the researcher towards answering the question about the A&E experiences of KZN nurses, a problem triggered by the existence of basic or general beliefs about the A&E daily life. Methodology directed the researcher towards the appropriate design, approach and the methods for finding the answers to this question to arrive at a proper decision regarding the designing of justifiable support systems for the nurses involved. In this sense, methodology in this study depicts the researcher's expertise in generating information, and indicating whether a need exists to generalize information generated.

The chapter therefore focuses on the description of rationale for selection of the research design and study methods about their relevance to the study. The design and methods selected are secured on a theoretical background, which guides the study towards the findings and their interpretation. The choice of selection exposes

the researcher's own philosophical orientation of worldviews regarding the existence of knowledge and how it can be acquired. According to Creswell (2009:6 in Botma, Greeff, Mulaudzi & Wright 2010:187), these views need to be exposed since it is not only empirical research data that can confirm the findings.as indicated in chapter 1, the study was conducted in two phases as indicated in table 3.1.

Table 3.1 Phases I and II of research process

Phase I	**Phase II**
Compilation of evidence in preparation for the development of strategies to enhance support systems for the nurses working in the A&E units	**Development of the strategies**
Explore and describe the nurses' experiences of working in the A&E unit of a regional urban hospital at KZN.E Describe the coping strategies used by nurses working in the A&E units	Develop strategies to to enhance support systems for the nurses working in the A&E units
Explore and describe other research studies regarding the experiences in the A&E units	

PHASE I

3.2 RESEARCH APPROACH FOR PHASE I

The study used the qualitative approach to explore and describe the experiences of the A&E nurses as well as their coping skills, which are the main objectives of the study. This approach was selected because of its acknowledgement of the subjective views of experiences based on Lazarus and Folkman's theory (1984) which was also selected to guide the researcher on the design. Despite the fact that most researchers concur in their findings that A&E units are overwhelming and nurses working in these units are exposed to high levels of stress (Gholamzadeh, Sharif & Rad, 2011:42; Healy

and Tyrrell, 2011:34; Adriaenssens, de Gucht & Maes, 2012:1412), the subjective views of the prospective participants remained the core of the study.

The approach was selected for its advantage highlighted in Creswell (2014:184), namely, that it insists on active participation by the researcher. For this reason, the researcher conducted the study personally in the natural setting, namely, the A&E unit where the participants undergo their experiences. The researcher became the key instrument from the beginning and throughout the whole research process in an attempt to extract the details of the phenomenon under study and in preparation for compiling a detailed report of the findings. The approach was employed for allowing flexibility in that it accommodates changes in the design where it becomes necessary. This was seen as appropriate for a study conducted in the A&E units because of their unstable nature.

3.2.1 Qualitative approach

According to this approach, reality is not a fixed entity, but rather dynamic especially where human beings are involved in a social context. Individuals concerned subjectively create and shape reality based on their experiences, that is, they develop and attach meaning to their own encounters, which results in many truths about phenomena (Polit & Beck 2012:13). For this reason, information about humans that is derived from the purely objective standpoint does not suffice according to qualitative approach. Researchers need to explore beyond the objective by delving into the subjective view about the phenomenon of inquiry (Streubert and Carpenter 2011:6).

In this study, the approach was selected because of its ability to guide towards understanding subjective reality, obtaining and analysing subjective knowledge about the topic at hand, as well as finding its place in the nursing profession. The fact that humans and not objects were the subject of investigation supported the reasons for selecting the approach. The researcher's desire was also to limit the investigation within the participants' A&E unit context and not to skip that boundary. This took into consideration the participants' own social and cultural background within which the investigation was going to take place and the type of health problems that are

commonly handled by the participants in their A&E units. The belief in many truths influenced the researcher to be committed to each participant's opinions with an understanding that divergent opinions about the A&E work life can be extracted from the participants despite the fact that they are exposed to the same environment and events. Streubert and Carpenter (2011:5) upholds this value of knowing in the subjective sense in that it represents the different views of human beings where the same objectively understood experiences may be interpreted differently by people concerned within a specific context.

3.3 RESEARCH DESIGN

The research design in this study outlines the systematic structure of inquiry followed by the researcher towards achieving the purpose of the study (Babie, Mouton, Vorster & Prozesky 2011:72). This consists of the exploratory and descriptive studies directed towards exploring and describing the experiences of nurses working in the A&E unit of a regional urban hospital at KZN. Exploring and describing the nurses' experiences as the primary objectives of the study, was conducted to establish an initial rough understanding of the phenomenon which was anticipated to provide a link towards the development of relevant strategies to support nurses working in the A&E units of hospitals selected for the study.

3.3.1 Exploratory research design

Polit and Beck (2012:18) concur with this view and state that exploratory research engages in investigating the phenomenon of interest in its full nature. This sheds light on how the phenomenon is manifested before it can be described. In this study, the researcher began by exploring through reading and accumulating literature from previous studies and their findings about A&E experiences in general. Since literature accumulated did not address the A&E experiences specifically within the prospective participants' context, the researcher resolved to engage personally with prospective participants for exploring their A&E experiences within their work context through individual unstructured interviews.

3.3.2 Descriptive research design

Descriptive research design aims at describing what is prevalent with regard to a situation or issue under study (Kumar 2011:10). This design was used in the study with an intention to apply a subjective approach of inquiry around each participant's description of A&E experiences, coping mechanisms, and the suggestion of the support systems that would be appreciated if provided. The researcher believed in the essence of the situation, namely, that there were some critical elements that could be discovered, understood and communicated in writing from the targeted hospital A&E unit nurses.

3.4 RESEARCH METHOD

While research methodology lays the philosophical foundation for directing the investigation of the research problem, the research method focuses on the implementation of the techniques or processes used to carry out the investigation and all the aspects surrounding their administration in the study (Maltby et al 2010:263).
This section of the study therefore provides a description of how the researcher managed technically, procedurally and administratively to proceed with the study towards the findings.

In the study, the research method was guided by the purpose of the study. Thus, the move from the identification of the relevant resources such as the population and setting for conducting the study, the development of a sound data collection method and consideration of the most valid way of answering it, as well as the practicality of conducting the research (Walter 2013:27). The whole process ensured that data collected were precise in order to depict the reality of the participants' situation of working in the A&E unit. For this reason, the information collected related to amongst others the A&E activities. the information for the study was requested from the A&E nurses of targeted hospitals and within the usual setting where the participants normally accumulate their daily work experiences. The data collection was based on a method that was likely to yield the reliable results.

3.4.1 Setting for the study

The study was conducted at the 4 accessible regional urban hospitals in KZN, South Africa. These hospitals had A&E units. All four hospitals are situated at the eThekwini District, in KZN. The hospitals as the settings for the study were based on the fact that this is where the problem was identified; and the accessibility was based on the permission granted by authorities to conduct the study in the specific hospitals.

3.4.2 Population

According to Guest, Namey and Mitchell (2013:42) the population of a research study refers to the entire group of elements or people that the researcher would like to study. The population in this study consisted of all nurses working at the A&E units of the regional urban hospitals in KZN. The target population consisted of all the nurses at the chosen and accessible hospitals, and who were likely to be sufficiently knowledgeable about the A&E experiences by virtue of being able to meet the selection and inclusion criteria set by the researcher. These nurses were likely to provide the researcher with the required information regarding the coping skills and strategies they used to deal with issues they encountered while working in the A&E units. The estimated target population from four targeted hospitals was 200 nurses.

3.4.3 Sample and sampling method

A sample is a subset of population elements, which are the most basic units about which data are collected (Polit & Beck 2012:275). In this study, non-probability purposive sampling method was used to select the nurses who would be able to provide the required information. Regarding the selection of hospitals, the researcher used the online KZN Department of Health (DoH) document to obtain and compile a list of all the regional urban hospitals of KZN which have A&E units and where it was likely to obtain nurses who are knowledgeable about the phenomenon under study**.**

Regarding the selection of nurses, the researcher targeted the nurses who conformed to the designated selection criteria in that they were accessible for the study by being

on duty at the time of the data collection and that they had worked in the A&E unit of the chosen regional urban hospitals in KZN for a year and above. For this reason, the researcher judged and selected those subjects who were most knowledgeable and likely to give first-hand information by articulating and giving sufficient explanation about the phenomenon under investigation (Brink, 2016:139). It was anticipated that the sampling method would be accommodative to all social categories of the targeted A&E nurses, namely, males, females, all categories of nurses, young and old in order to secure as much divergent views as possible for the full understanding of the A&E experiences. According to Guest et al 2013: 41) this ensures the accommodation of the diverse opinions, which may not be provided by only the most knowledgeable candidates.

3.4.4 Sample size

Brink (2016:143) states that the absolute size of the sample is more important than the sample size relative to the population size. In qualitative studies, particularly, large samples do not apply in that the larger the sample, the more the issues will be crowded. This will also increase the complexity of analysis. In this study the site sample was limited to 4 accessible regional urban hospitals with A&E units that met the inclusion criteria. The researcher recruited 16 nurses who met the inclusion criteria. This was based on the fact that out of the estimated target population of 200 nurses working in the A&E units of the 4 selected hospital, only those who were on day shift and present during the data collection would be interviewed. The researcher decided that the sample size would increase only if the data collected from the original sample did not yield any meaningful insights. In essence, all the 16 recruited participants were included in the study and data were collected till data saturation.

3.4.5 Recruitment method

Recruitment of participants was done in collaboration with the A&E unit managers because of their full position of being in charge of nurses working in the A&E units. The pre-determined selection method, namely, the purposive sampling was briefly discussed with the unit managers to ensure that they understood its ability to influence

the recruitment strategy. The number of participants required and the documents to be used for recruitment such as the information sheet and consent for participation were discussed with the unit managers.

The challenge of identifying the best time to address the nurses had to be decided well noting that there was barely, a quiet or stable period in the A&E units.
In order to ensure that all the questions related to the study were directed to the researcher to give them attention immediately, the researcher arranged with the unit manager to engage on a face-to-face contact with the prospective participants. This was aimed at creating an opportunity for interpersonal relationship based on the spirit of understanding between prospective participants and researcher as colleagues.

During the introduction with the participants, the objectives and the purpose of the study were discussed. The benefit of the study to nursing, the public, the participants and the researcher were highlighted without exaggeration. The researcher indicated her interest in the A&E units though the A&E working experience was not mentioned to ensure that the participants would discuss without reservations based on the understanding that the researcher understood their situation as A&E nurses.

3.4.6 Eligibility criteria

Prospective participants were eligible for inclusion in the study if they

- had worked for one year and above in the A&E unit of the targeted hospital. These nurses were thought to have accumulated reasonable experience in the A&E unit to be able to deliberate on A&E issues,
- had not interrupted the 1year period of exposure in the A&E unit,
- were working as full time employees of the hospital, working 40 hours per week,
- were on duty at the time of the conduction of the interview,
- were willing to give consent to participate in the study.

3.4.7 Data Collection

According to Streubert and Carpenter (2011:33), data collection happens during a dialogue between the researcher and the participants on a topic of direct interest to the phenomenon under study. The researcher used the qualitative approach to explore the experiences of the nurses in the A&E unit of the targeted hospitals. This involved the use of the individual unstructured interviews to allow the participants to elaborate on a broad research topic about the study phenomenon.

3.4.7.1 Data collection approach and method

An unstructured in-depth interview was used to collect data. This is a technique designed to elicit a clear picture of the participant's perspective on the research topic. The interviews were conducted face-to-face and involved the researcher as the interviewer, with one participant at a time. Interview data consisted of audio recordings, typed transcripts of audio recorded data and the researcher's notes (Mack, Woodsong, MacQueen, Guest and Namey 2005:29-30). A classical individual interview with one central question was utilized in this study. It was particularly useful for exploring a topic broadly, which was in this case, the experiences of working in an A&E unit of a regional hospital. Probing questions were used in response to the information given by the participants. This in-depth interview helped to understand details of services offered in the units, the types of patients, the environmental conditions as well as the conditions under which the nurses work. As a follow-up, a question about the coping strategies was asked. Field notes were kept as well.

The researcher arranged to collect data using a personally developed data collection form. The form had three sections, which included the collection of the participants' demographic information, followed by a topic related to the discussion by the participants of their own experiences of working in the A&E units and the last section with a question that relates to the coping strategies they use to deal with problems experienced in the A&E units. . Demographic information required was based on the participants' professional credentials such as the professional category and the length of the A&E experience.

The central topic for the study was as follows:

‘Describe your experiences of working in the Accident and Emergency unit’.

The topic afforded the participants freedom to describe their personal encounters regarding the A&E experiences from any angle and without limitations except for sticking to the time scheduled for the interview and focusing on the topic. The topic and its discussion was followed up with a probing question that was directed to ask the participants to describe the coping strategies that they used in the units (see Annexure 6).

Other probing questions aided the researcher in obtaining clarification in certain areas from the participants’ discussion while the participants had time to elaborate on the initial response. This method of interviewing participants was inspired by the researcher’s quest to understand the participants’ A&E unit experiences for the purpose of designing strategies to enhance the support systems related to their concerns. According to Brink (2016:158) these types of interviews are therefore free flowing, allowing a certain degree of flexibility between the interviewer and the interviewee. Probing and follow-up questions helped to increase detailed exploration. They enhanced rapport between the researcher and the participants as they indicated the genuine interest of the researcher in understanding the participants’ personal account of experiences.

In order to facilitate the interview process, an audio-record was was used for those participants who agreed to have their discussions with the researcher recorded. Essential, all the participants agreed to be audio recorded. The researcher envisaged to subsequently transcribe all the audio-recorded information verbatim after playing the audio-tape or reading the drafted notes back to the participant to verify the content recorded as a true reflection of what the participants shared during the interviews.

3.4.7.2 Data collection period

The data collection period extended over 8 weeks from December 2016 to January 2017. This period covers all hospitals that were targeted. The interviews took place at the respective hospitals where the participants worked. A private room or the unit managers' offices was used as a private place where the interviews took place. The interviews took 30-40 minutes each.

3.4.8 Data analysis method

Data were analysed following the steps of qualitative data analysis as explained by Creswell (2009:186). Data analysis steps are explained in details in chapter 4.

3.5 ETHICAL CONSIDERATIONS

Ethical considerations are concerned with what is fair, right and acceptable in terms of moral and legal obligations pertaining to the selection of and interacting with the participants for the study. In this study, the researcher conforms to the recommendations of 'Leary's (2010:41) which focussed on the sensitivity of the topic of inquiry and the nature of the working environment within which this information had to be unpacked. Certain ethical issues confronted the researcher even before the study was commenced.

3.5.1 Protecting the rights of institutions

The institutions that were targeted are government institutions established in terms of the government laws. They had to be respected in terms of their legal position in society by entering them with permission from relevant authorities. Permission to conduct the research at the KZN health facilities was obtained from the KZN Provincial Manager for health services through e-mail communication with the researcher (see Annexure 1). Such permission served as the main requirement for submitting the application online to the KZN provincial Department of Health (DoH). The online procedure of application further requested two documents, namely, the researcher's

protocol and the Ethics Committee Approval Document from the University of South Africa (see Annexure 2). The approval letter from the KZN DoH was obtained after a 2 weeks period following the online application (see Annexure 4).

Once the approval letter was obtained from the KZN DoH, its copies were submitted to the managers of targeted hospitals together with the application letters. Where more than 3 hospitals were targeted in 1 district, the district manager also received the application documents and gave approval. A sample copy of the consent form was included among the application documents to indicate to the managers that the prospective participants would be expected to express their voluntary willingness to participate in the study once entrance to the premises had been gained. In order to ensure complete transparency, the consent form also indicated the purpose of the study and how it linked to the main goal of the study, namely, developing strategies to enhance the support systems of nurses in an accident and emergency unit of a regional urban hospital at KZN.

3.5.2 Protecting participants

Permission to secure participation of the A&E nurses' was obtained from the managers in charge of these units. Securing the full participants' understanding and participation required that the researcher inform them fully about the nature of the research topic, the details of which appeared in the consent form. There were no foreseeable physical and psychological risks associated with the study.

However, the researcher explained that emotions were likely to be heightened out of either exciting or disturbing past experiences and that the researcher was prepared to accommodate that situation or the manager of the unit would be requested to help where necessary. The researcher ensured confidentiality and anonymity of the participants' identity by informing them that pseudo - names would be used instead of their proper names when recording information and that tape – recorded information for those who allowed would be erased/deleted once transcription had taken place Also, no harm was going to be done to the participants.

A consent form was provided whereby the prospective participants would express their voluntary willingness to participate. The content of this document included almost all the aspects of the investigation included in the formal application letter to the regional authorities and the hospital top management. No false promises such as incentives appeared in the consent form. In addition, the freedom to withdraw from participation was indicated. Although the researcher was aware of the bias of including, only the candidates with one year experience and above in the A&E unit, the quest for a variety of experiences using the minimum number of participants overthrew the need to consider candidates with a shorter and probably less varied experience. This limitation would also ensure that a reasonable time would be spent with each of the few willing candidates.

3.5.3 Scientific integrity

In this study, the researcher prevented the pollution of the study by avoiding plagiarism. It was ensured that all authors associated with research methodology and who are used in this study, were cited to acknowledge their contribution to existing knowledge. The researcher collected the data personally in the targeted A&E units to ensure their originality and that they were pure from the participants. No additional information of unknown origin was added. All the data collected were completely used for this study. No part of data were concealed or used against the participants for personal reasons of the researcher except where a need arose to protect the participant's reputation. The researcher adhered to the inclusion and exclusion criteria to ensure that data were obtained from candidates who met the criteria. In order to ensure that data were correctly presented, the researcher confirmed with the associated participants. Data were stored by the researcher's private places and were not shared with anyone else before the study was completed and published.

3.5.4 Processing and analysing of interview data

Analysis aimed at eventually being able to describe the participants' A&E experiences through following and integrating steps cited by Creswell (2009:186) in Botma Greeff, Mulaudzi& Wright (2010:224). The steps involve a search for significant expressions

from the participants' information, noting common patterns or essences of relationships between them, and assigning them a meaning. In following these steps, the researcher looked forward to eventually identifying themes, which constituted topics under which lived experiences of the participants were later described.

3.6 TRUSTWORTHINESS

Trustworthiness of the study was achieved through adhering to the requirements of credibility, dependability, confirmability and transferability (Polit& Beck 2012: 584).

3.6.1 Credibility

Credibility requires that findings are true interpretations of the lived experiences (Fain 2015: 249). In this study, this was achieved through various processes that involve prolonged engagement with the participants, ensuring the availability of reliable materials to document data, use of unstructured interviews, member checks, negative case analysis, and peer debriefing.

Prolonged engagement with the prospective participants involved spending a few hours with them a day or 1 week prior to commencement of the study. This depended on the availability of time that the A&E nurses were able to spend with the researcher. The period was used mainly for self-introduction of the researcher to the prospective participants, planning with them how the investigation should proceed, and responding to their questions about the study and the identity of the researcher. During this period, researcher-participant trust relationships were established, the prospective participants were ensured reasonable time to unease tensions while digesting the request of participating before the date of the formal study.

More short discussions were engaged in with the participants immediately prior to and after the interview to ensure the mutual understanding regarding the interview process and to summarize and thank the participant respectively. After data collection sessions at each targeted hospital, telephonic calls or visits became later means of contacting

participants for confirming certain areas of data, which further stabilized the researcher-participant relationships.

Ensuring the availability of reliable materials to document data was ensured through the pre-testing of the data collection process at 2 hospitals. Member checks were considered for verifying the participants' input and to correct any distorted interpretation by the researcher, which would make the participants unhappy.

Peer debriefing required the researcher to employ the advice of a peer/colleague for scholarly guidance to ensure credibility. This involved one professional within the same status as the researcher in terms of professional ranking and academic qualifications. In order to ease the task, the researcher targeted a peer member involved with a qualitative research study for own advancement. The first aim was to obtain a feedback of a critical review from a neutral opinion regarding the researcher's method selected to collect data and its relevance for use in the A&E unit to achieve the purpose of the study. The main concern was to know whether the method was seen as capable of accommodating the unpredictable situations in the A&E unit while the study continued. This matter was addressed verbally. The second aim was to have the transcripts checked if they did not contain obvious errors, and that codes matched well with the sections of data for which they were assigned.

3.6.2 Dependability

This refers to the stability of data over time and conditions (Polit& Beck 2012: 585). According to Streubert and Carpenter (2011:49), dependability is a criterion that is met once credibility has been demonstrated. Polit and Beck (2012: 585) agrees with this statement by arguing that credibility cannot be attained in the absence of dependability.

3.6.3 Confirmability

Confirmability involves the keeping of a record of findings that leaves the readers with no doubt that they are linked to the sources of information. According to Polit and Beck

(2012:585), the participants and not the researcher's inventions concern it with establishing that the data and its interpretation represent the information that was provided. Hence, Fain (2015:248) adds that the line of proceedings, which led to the findings, must be clear to follow. In this study, confirmability was established through identifying the relevant research approach and design, bracketing, maintaining an audit trail and keeping a reflexive journal.

Identifying the relevant research approach involved the researcher's understanding of the appropriateness of the approach in relation to the study. Bracketing was used as a means of establishing confirmability of the findings of the study. This involved the identification and suspension of all the foreknowledge about the A&E units based on the researcher's previous work experience and literature gathered prior to the study so that they would not influence the outcome. All the information was documented in the way the participants expressed themselves, that is, there were no modification of the words or phrases used by the participants. In accordance with the recommendations in Fain (2015:248), an audit was conducted. This involved obtaining a reader to study the research process followed by the researcher from data collection towards the findings.

3.6.4 Transferability

Transferability refers to the fact that the findings of the study probably have a meaning to others in similar settings (Streubert & Carpenter 2011:49). In the study, the researcher enhanced the reader's transferability judgement through providing a detailed description of the A&E units and their peculiarities in the literature review. The thick description of methodology indicated the context within which the study took place, namely, the A&E units of 6 regional urban hospitals of KZN, and how participants were recruited using purposive sampling. According to Babbie and Mouton (2011:277) purposive sampling in qualitative research is used to maximize the range of specific information that can be obtained from and about the context within which the study takes place.

PHASE II

3.7 RESEARCH METHODS FOR PHASE II

Phase II was the development of the strategies. The steps to compile the evidence for the development of the strategies included integrating and synthesising the findings from Phase I, both the experiences of working in the A&E units and the coping the strategies used by the nurses. Data collected were the evidence from Phase I, literature review and formulation of the preliminary strategies. The population or sample in this phase included a group of expert nurses who were recruited to validate the preliminary strategies formulated by the researcher based on evidence form Phase I. Data were analysed from the recommendations from experts using inductive and deductive reasoning, as well as integrating and synthesising information. Development of final strategies, the approach and methods for Phase II are explained in details in chapter 5.

3.8 SUMMARY

This chapter gave an overview of the research methodology followed in this study. Aspects outlined include the research design and the rationale for selecting the design. The research methods used in the study as justified by the selected design were discussed. These included how and who was recruited for participation, how the information was obtained from participants and how the information was studied for interpretation. In order to ensure quality of the study, the researcher adhered to the requirements of trustworthiness of a research study. the findings for Phase I are presented in details in chapter 4, in preparation for phase II which is presented in chapter 5.

CHAPTER 4

ANALYSIS, PRESENTATION, AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

The purpose of this chapter is to present the data analysis and the findings following the research processes described in Chapter 3. Throughout the presentation, the researcher was guided by the objectives of the study to ensure that the responses presented lead to the findings**.** The purpose of the study was to develop strategies to enhance the support systems for nurses in an accident and emergency unit at a regional urban hospital in KZN, South Africa. Therefore, this chapter presents the outcome of phase I which was aimed at compilation of evidence in preparation for the development of strategies. The objectives of the study for Phase I as were to explore and describe the nurses' experiences in the accident an emergency (A&E) unit of a regional urban hospital at KZN; and describe the coping strategies used by nurses working in the A&E units.

4.2 DATA MANAGEMENT

Data management refers to the preparation efforts engaged in by the researcher in this study to ensure the smooth running of the data collection process as well as the safekeeping of data on completion of each unit of work. The documents that were prepared for managing and filing the details of each unit of work included the notebook for drafting the information from the participants, an audio-tape for obtaining a clear information from the participants who were comfortable with its use, the consent form and the, data collection form. Key words for tracing the most important texts of the interview notes from the draft were made available throughout the stages of data collection.

4.3 DATA COLLECTION PROCESS

Data collection process began with a pre-test study, which was conducted in the A&E units of 2 hospitals. Six nurses that met the criteria participated in the pre-test study. The purpose of the pre-test was to ascertain if the proposed data collection method, namely, the use of unstructured interviews was applicable. Furthermore, the aim was to gather information using the unstructured interviews for the purposes of introducing improvements where it became necessary (Polit & Beck 2012:196). The researcher concentrated on looking for aspects of ambiguity or unclear phrases in the interview question (Botma, Greeff, Mulaudzi & Wright 2010: 275). Further problems that needed noting with a view to modifying the data collection procedures where it was deemed necessary, included threats, limitations, vagueness of the interview question, and the timing of the interview sessions. The timing of the sessions was also monitored.

There were no problems experienced with the data collection tool, the understanding of questions and responses from participants, and the time frame for each interview. Therefore, no modifications were introduced before the main study data collection. The main study was conducted in the A&E units of 4 regional hospitals of KZN. Fourteen nurses who met the inclusion criteria participated in the study. The smooth running of the data collection process was achieved through working with the operational managers of the units. The aim was to arrange for a 10 minutes' discussion meeting between the interviewer and the prospective participants who were prepared to sign the consent. The purpose of these short meetings was to decide on how participants were to take turns in the interview process in order to ensure continuity of the data collection process without disturbance in the unit functions. During the meetings, the research question was re – introduced. The prospective participants were thanked in advance for their volunteering to be part of the study. The time limit for discussion was mentioned. The researcher then proceeded to collect data in 2 stages. The first stage involved the collection of the participant's demographic information while the second stage involved the discussion by each participant of his/her own A&E experiences.

The interviews were carried out in sessions of 3 to 5 participants per week over the period from December 2016 to January 2017.Each participant was given a participant

number in order to ensure anonymity. Data collected were about the experiences in the A&E unit. The participants whose level of knowledge was based on having spent a year or more in the A&E unit were targeted. Data were collected using a central topic to elicit a conversation as follows:

'Please describe to me your experiences of working in the accident and emergency unit'

A follow-up question was asked that related to the coping strategies used by the nurses. Probes by the researcher followed the responses from the participants where it was necessary. The duration of the interviews was 30-40 minutes. The information was captured using the audio-recorder and notes were drafted in a notebook to obtain a clear information log.

4.4 DATA ANALYSIS

Data analysis was done manually. The process took place concurrently with data collection. After repeatedly listening to the participants' description of their experiences, the researcher transcribed the audio-recorded participants' verbal responses verbatim. This was done 5 hours following each interview in order to have a good follow-through with the interviews. The listening and transcription allowed the researcher to pick up points for follow-up with the next interviewee, where necessary. Of the 16 recruited participants, 14 were included in the interviews till data saturation. The results are thus based on a total of 14 transcripts, saved as electronic versions. The transcripts indicated who was speaking in each turn of the interview process by using 'Interviewer' when the interviewer was talking and participant number ('Interviewee' with identification number attached) when the participant was talking. The time that lapsed during the times of silence that created gaps in the continuity of the interview was noted with dots. Non-linguistic utterances such as laughter, emphasis of words and demonstrations were noted.

All the completed transcripts were then read to obtain the overall sense, reflect on the meaning, and to obtain clues regarding the existence of segments of the data in the

form of words, phrases or paragraphs of interest that were outstanding as informative or could be assigned certain meanings/labels/terms or descriptive words referred to as codes. The codes identified during this preliminary reading were listed in a separate sheet of paper for noting how frequently they appeared later during the detailed analysis. Noting that the list of codes identified during the preliminary reading was not likely to be comprehensive enough to give a full interpretation of A&E experiences, the researcher aimed to continue discovering new codes during the detailed analysis.

Detailed data analysis involved reading of each transcript according to the arrangement from the simplest to the complicated version. The transcripts were read with the aim of matching the newly identified segments of data with the pre-identified codes from the prepared list or to identify new codes that arose later.

This resulted in each identified segment being assigned an appropriate code or left as originally expressed as a code. The identified segments or assigned matching codes were written next to the original segments in the adjacent column. Unless a new code was assigned, most identified segments were written in the adjacent column as the participant had expressed them originally.

The examples of quotes from the participants' description of the experiences and assigned codes are as follows in Table 4.1

Table 4.1: Quotes from the participants and assigned codes

Codes	Quotes
security for staff not tight not safe enough	'What I will say I do not like and I am still scared of is security for staff. This still needs to be worked out. We are not at all safe from patients and relatives'
sudden change	'When you come to the department you may first be experiencing a good day but it may suddenly feel like a bomb is exploded. It may take 1, 2 to 3 patients to change the whole climate depending on the acuity of their condition'
paediatric resuscitation, not easy loss of paediatric patient tough	'That paediatric resus...you know...isn't easy for anybody. If you lose a paediatric patient, it's tough...'

During the subsequent phase, the researcher explored the pattern of codes identified, and the relationships with each other. Related codes or the codes that conveyed similar messages whenever they appeared were developed into categories. The process was facilitated by the fact that many codes had been identified from the text in the way they had been expressed by the participants. The codes that existed in isolation were closely examined to detect any particularly peculiar type of message or experience. The last step involved concluding that most of the common codes identified conveyed similar message for the participants. Since some of the categories were related, they were in turn grouped together to form themes.

4.5 RESEARCH RESULTS

The research results presented address the sample characteristics, the themes, and the nurses' coping skills.

4.5.1 Sample characteristics

The tabular presentation of the participants' characteristics is as follows in table 4.2.

Table 4.2: Demographic data/Description of participants

Participant	Professional category	Length of experience in years in the A&E unit
Participant 1	Enrolled Nurse	1 year 2 months
Participant 2	Enrolled Nurse	4 years
Participant 3	Professional Nurse	2 years
Participant 4	Professional Nurse	17 years
Participant 5	Professional Nurse	17 years
Participant 6	Professional Nurse	20 years
Participant 7	Professional Nurse	15 years
Participant 8	Professional Nurse	1 year 5 months
Participant 9	Professional Nurse	4 years
Participant 10	Professional Nurse	11 years
Participant 11	Professional Nurse	2 years 6 months
Participant 12	Enrolled Nurse	3 years
Participant 13	Enrolled Nursing Assistant	7 years
Participant 14	Professional Nurse	1 year 4 months

4.5.2 Themes

Data extracted from the participants culminated in 6 themes based on the nurses' description of their experiences in the A&E unit. The themes were constituted out of 13 categories of information discussed by participants. Data were organized into 2 main sections of information, namely, the positive aspects, and the challenges of working in the A&E unit based on the participants' description of the situation.

The themes that emerged under each section and categories involved appear in the relevant tables to follow:

4.5.2.1 The positive aspects of working in the accident and emergency unit

The participants revealed that working in the A&E unit was enjoyable despite the challenges that nurses are faced with. The activities that were highlighted in this regard were noted as the benefits of being an A&E nurse, which keeps the nurses in the unit. The tabular presentation of the themes on the positive aspects is as follows in table 4.3.

Table 4:3 The positive aspects of working in the accident and emergency unit

Theme	Category
1. Notable benefits	1.1 Diverse nursing care with immediate rewards
	1.2 Teamwork
	1.3 Learning opportunities

Theme 1: Notable benefits

According to the participants, the benefits of working in the A&E unit were noticeable to them especially that most of them were still young and looking forward to progress.

Category 1.1 Diverse nursing care with immediate rewards

The participants highlighted the element of diversity in the A&E care as a rewarding experience. Since the patients' conditions cannot be predicted ahead of their arrival, the nurses stayed prepared for any type of patient. The nurses were also convinced that they were making a big difference in the lives of the patients who entered the A&E unit. The stated facts were expressed as follows:

> **Participant 3:** 'On the positive side, it makes you to be able to nurse multi – disciplinary. I mean you are able to nurse all types of patients.'

Participant 4: 'But I like this place. I always wanted to be a nurse. I am able to make a difference in somebody's life though holistic nursing is not possible in the A&E unit while one may wish to be nursing as far as counselling the patient.'

Participant 11: 'It is one of the rewarding experiences. I feel when you work here you are a life saver and you are a game changer because whoever comes through the door, you never know what you expect. So, by doing your job properly you end up saving lives and you can change the outcome of a patient. A lot of patients come in critical. By your help patients walk out to their relatives… Here, whoever comes, you are not sure what is going to come through, whether the patient will need intubation or will need CPR. Always you have to be prepared which is a good thing, and patients do not stay long. You do whatever needs to be done and you send them home or to the wards...or....'

Category 1.2 Teamwork

The participants mentioned the existence of a team spirit during work. An expression indicating the consultation of the existing unit guidelines/protocols was uttered to confirm that the nurses were still confined within their scope of practice over and above teamwork:

Participant 2: 'My experience of working here is that since I started in 2013, the first thing I notice we are working as a team although the department is busy. I said we are working as a team...sometimes you also do PN's job...like...eh...if the PN is busy… Sometimes the PN can give you permission.'

Participant 9: 'You report to doctors, saying 'Please understand, there is staff shortage'…so that when they do not see a nurse, they know. They are so nice. They can help where they can. Then they tell you that you can bring the patient across because they have helped you here and there. You inform them so that they do not assume there is so much staff and they are looking for staff but there is hardly staff.'

Category 1.3 Learning opportunities

The learning opportunities for self - advancement were described as abundant for professional nurses. The EN's and ENA's benefited from the unit in-service

programmes and the daily experiences. Through experience, the operational managers improved their problem solving skills.

> **Participant 5:** 'I love working in the A&E unit. I have passion for it. More than that, I am about to do the trauma course….'
>
> **Participant 12:** 'I have been taught a lot of things here because as a student I went to casualty but I was never exposed to major procedures like suturing, resuscitation, giving the drugs through the registered nurse, and Lodox X-Ray, where instead of sending patients to X-Ray Department, X-Ray people are called to do X-Rays here in the unit.'
>
> **Participant 13:** 'I experienced a lot here in casualty, since I came here. Firstly, I know how to triage patients. When I came in here I didn't know anything about how to triage a patient...Must I continue? ...to do the statistics and to channel patients to other departments and to various clinics which I didn't know. I know how to use the monitor. I can say equipment such as monitors, ECG machine, suction, BP machine. I can say.... equipment, I know how to use it.'
>
> **Participant 14:** 'Another good thing about this department or hospital is that they encourage you to learn. They'll send you for...for like trauma course. People are encouraged to study, which is nice…But they do motivate the staff here to do Midwifery, to apply for courses...ja...which is nice. We continually do in service, which is nice. So, we are constantly being updated...which is nice...not just sticking with all the old stuff.'

4.5.2.2 The challenges of working in the accident and emergency unit

The discussions with the participants revealed that the A&E units are burdened with the challenges that impose a risk to the health and safety of the nurses. Although the nurses knew that they were not immune to the A&E health risks, they still preferred to stay in the unit. Accordingly, the unit was acceptable because the participants were already too used to it. There was no wish to experience what takes place beyond the unit since there was no assurance that things could be better somewhere else.

The tabular presentation of the themes regarding challenges is as follows in table 4.4.

Table 4:4 The challenges of working in the accident and emergency unit

Theme	Category
2. Working under pressure and stressful conditions	2.1 High patient demands and expectations 2.2 Inability to exercise control over the flow of work
3. The need for safety and security	3.1 Emotional disturbance 3.2 Exposure to danger
4. Limited resources	4.1 Human resources 4.2 Material resources
5. Psychological and emotional problems	5.1 The handling of deaths 5.2 Lack of support 5.3 Interpersonal relationships

Theme 2: Working under pressure and stressful conditions

Working in the A&E unit was described as stressful because of its association with extreme levels of pressure. Based on this observation, the participants felt that they were not meeting their goals in terms of time frames and provision of quality care. The main sources of pressure that were noted related to high patient demands and expectations, and inability to control the workflow.

Category 2.1 High patient demands and expectations

The participants highlighted the pressure imposed on them by the patients and their relatives through their excessive demands for attention. The participants indicated that the patients and the relatives often insisted on their expectations being met within a short period of arrival within the unit. If not so, the patients and relatives insisted on explanations; and their expressions of dissatisfaction and anger were directed at the nurses. Pressure from the patients was indicated from the following participants' comments:

Participant 2: 'If the doctor is busy and you are talking to them...you rather keep quiet about the time it will take because if you tell them that it will take 5min... once 5 min is over they will ask you, "…but, you said 5min" So, you see...' Sometimes they come with a letter from the private doctor...and... "Can you help me, I'm from the private doctor...I come for admission" If you hear that, you don't have to waste their time. According to their knowledge, the only thing that they can expect from you is those vitals, and then...ward. If you tell them about other things, you are wasting your time.'

Participant 8: 'Yes, and sometimes you know these patients who come in now and want to be seen now...even if it's busy...even if you explain to them. They just cause a drama in front of you… They do not want to wait.'

Participant 11: 'They (relatives) will come...and every now and then they frequent our resus area or shouting at nurses, swearing...and... which becomes a bit of a problem.'

Category 2.2 Inability to exercise control over the flow of work

Inability to exercise control over the flow of work was noted by some participants as another source of pressure leading to stress. The participants noted the unpredictability of the events and sudden changes in the situation. Often there was a need for urgent decision making which in turn caused disturbances in the duty allocation. The levels of acuity of patients ranged from mild to severe. The influx was high on a daily basis, leading to overcrowding and work overload. Due to constant pressure, the findings indicate that there was a growing tendency towards absenteeism by colleagues, whereby the remaining nurses carried the work overload. Since the factors contributing to overcrowding and work overload operated from outside the unit, the A&E nurses had no control over them. The participants said:

Participant 3: 'On a negative note, it makes us jump from one patient to another. It becomes more difficult because we are short – staffed. Whilst we are busy with a critically ill patient, a psychotic patient comes... and you leave resus and go there...so at the end it becomes ...ya....so, at the end of the day you become very stressed.... .'

Participant 4: 'Generally, this place is very stressful, very challenging, tiring and at the same time rewarding. I say it is stressful because we nurse many categories of patients. We switch from medical to surgical patients or from 1 patient to another. It is

tiring because there is shortage of staff against many treatment areas such as the triage area, asthma room, resus room and treatment room.'

Participant 6: 'All this leads to overcrowding. There is a short –stay ward on the other side of the resus. The aim of that ward was to decongest casualty. Now, the crisis of beds in the wards causes wards to send patients to this short – stay ward in A&E. This includes stable patients and those discharged. Wards do that so that they can take new patients from A&E. Now it's vice versa.'

Participant 9: 'When you come to the department you may first be experiencing a good day but it may suddenly feel like a bom is exploded. It may take 1, 2 – 3 patients to change the whole climate depending on the acuity of their condition. So, you become stressed out of running trying to help patients. By the time you leave, it is like you have been carrying 100 patients. So, in as much as people can look and say but it is not busy because they have about 5 patients, it is the amount of work that you need to do for those patients which involves many activities which are time consuming. It could be stressful and challenging to get each particular patient better. It can take 1 hour to complete 1 patient. At times you feel burnt out but if you are meant to be an emergency nurse you do not want to leave here because the pastures are not always green on the other side (laughing).

Theme 3: The need for safety and security

The participants expressed a desperate need to see the safety measures given attention in the A&E units. According to the findings, the environment was unsafe for both nurses and patients in that the security measures were not very tight. The participants mentioned emotional disturbance from patient aggression and exposure to danger as their concerns under safety and security.

Category 3.1 Emotional disturbance

The participants reported the behavior of patients and relatives as sometimes very much unmanageable. This ranges from mild acts involving non – tolerance for the nurse and treatment to violent acts such as insult, aggression and intimidation. For this reason, nurses were operating under threat in many instances and end up being emotionally disturbed.

A high degree of non–compliance on the side of the patients was noted in many instances during treatment. This includes refusal of treatment and lack of interest in the nurses' explanation. There was a tendency of preference to report health problems to the doctor rather than reporting to the nurse, deciding which treatment they must have and rejecting other forms of treatment. Regarding these situations participants remarked as follows:

> **Participant 5:** 'Now and then patients are also very uncooperative. You put a bandage, they take it off. You put a drip, they pull it off. Sometimes you cannot even tell whether they are drunk or psychotic.'
>
> **Participant 9:** "It's like a burden. Those are days when you run around and you just feel 'It's not worth it. I'm going to die of hypertension or some stress related disease. Some days you feel you better be at home rather than die of hypertension, but you still come...just I was brought up where my matron said 'Your job is your bread and butter.'
>
> **Participant 12: '**Sometimes they do not want to tell the nurse anything. "I will not tell you...I will only tell the doctor...not you. You are not a doctor. Who do you think you are?" Some will tell you what drug they want eg Pethidine and not Tremadol because they think Tremadol will not help them.'

Acts of serious aggression were noted to present when the patients screamed to nurses as a result of dissatisfaction with certain hospital procedures. Occasions were noted where the patients insulted the nurses verbally as a result of the psychological state during that particular moment. This was noted commonly from drunken patients especially the young ones. Some unpleasant statements were uttered by walking patients who cannot tolerate waiting for nurses while they are still committed with other very sick patients. The participants mentioned the following:

> **Participant 11:** 'Now that's why I'm worried about our safety, especially with these ones who are insulting... because you get affected somehow, and if you don't have any way of expressing it, your anger, your disappointment or your depression remains… .'
>
> **Participant 13:** 'It affects me emotionally...A young person calling me names...as old as I am! (Frowns)...It affects me really. I don't like it.'

Category 3.2 Exposure to danger

Nurses felt that working in the A&E unit amounted to exposure to dangerous situations, and they feared for their lives. Several threatening incidences that either involve their lives or that of their patients took place in their presence. Conflicts and fights among patients themselves were noted and reported to be responsible for a certain amount of disorder and threat. Some of the patients escaped security scanning procedures and presented with dangerous weapons inside the unit. Psychiatric patients often charged suddenly and attacked when least expected. In some instances, nurses had to hide themselves or where possible, call the security to clear the situation.

Thoroughfare in the unit was reported as one of the major concerns. Everybody including patients, patients' relatives, paramedics, hospital workers and ordinary hospital visitors used the same entrance of the unit, which is also the first line of entrance in the hospital. Security guards were not evenly distributed to sufficiently provide protection to the A&E unit. The participants said the following:

> **Participant 8:** 'What I will say I do not like and I am still scared of is security for staff. This still needs to be worked out. We are not at all safe from patients and relatives. Yes, we do have security but I do not think it's safe enough whereas you get more specially drunk people. They will come in. I do not think they search them when they come in because I remember one day there was an incident. A patient came in with a knife. Anything could have happened there.'
>
> **Participant 11:** 'Sometimes they get shot somewhere and they are brought here without...you know...the police knowing about them or maybe the people at the scene have not reported...and if a gunshot patient comes, we screen the gunshot patient… but then we don't know...you find…Aw, he's got a gun!'
>
> **Participant 14:** 'I don't think walking patients should be allowed at this gate (pointing towards the direction of the A&E entrance). This is an emergency department. You know what I'm saying. If you come in an ambulance...fair enough...but anybody comes in through trauma. They are not even coming to trauma but they are going to other places in hospital. I think they should pre – fab the security gate here so that only ambulances can come in. Any other case should go through the main gate…So, I think

security (pointing in the direction of the gate) … it doesn't help sitting outside and something happens here. It will be too late by the time they come.'

Participant 3: 'Mostly drunk patients will come and intimidate the staff. Also, psych patients will come, and because they are very violent…At one stage one of the nurses had spectacles on. The patient kicked him on the face...and ...broken…The spectacles fell. The nurse was trying to handle him, and bending. While he was like this (bending slightly), the patient just kicked her.'

Theme 4. Limited resources

Limited resources, namely, human and material resources were indicated with reference to the negative impact they have in the running of the A&E unit. Errors and negligence were noted by the participants who attributed this problem mainly to shortage of staff and material resources. The participants noted that sometimes nurses failed to update the records properly for each treatment room because they keep on being called to take over where there is staff shortage. Regarding staff allocation for duties and running of various departments within the unit, the findings revealed that this was sometimes only a formality. The participants said:

Participant 6: 'Nurses fail to enter statistics properly, for example the number of patients sutured because they move from one treatment room to another, thus they are not accurate. This is common during the night when one nurse runs many areas.'

Participant 9: 'You've got the form where you do allocations for formality in case there is a question…but in reality you are like 'because you want that form, let everyone have a task'. You end up allocating 1 person in 3 areas which is not practical. How is that person going to manage…?'

Category 4.1 Human resources

Regarding shortage of staff, the participants cited restrictive administrative procedures, circulars or policies such as the freezing of the posts so that there is no advertising on resignation of a nurse unless it is a critical post. Another cause mentioned was the repeated sick leave by the staff. Shortage of staff was also noted

in relation to the workload, namely that it is evitable to have staff shortage when the workload increases.

The negative impacts of staff shortages were noted to be including insufficient staffing of the treatment areas such as the triage area, resuscitation rooms, treatment rooms, dressing rooms, and stay-in rooms, all of which form parts of the A&E units. Also, the taking of sick leave by staff was increasing because of overworking. The allocation of the remaining nurses took place beyond their coping capabilities. The participants said:

> **Participant 4:** '…there is shortage of staff against many treatment areas such as the triage area, asthma room, resus room and treatment room. The unit may have assigned a certain number of staff to work in a particular area such as 3 professional nurses in the resus room, 2 staff nurses in the treatment room etc; however, one of them may go off sick or may go on leave which creates a big problem.'
>
> **Participant 5:** 'So, when we experience shortage, we end up having only 2 nurses at the resus room whereas there should be 4 nurses...2 professional nurses and 2 enrolled nurses. We therefore end up borrowing nurses from that short stay ward back to emergency side.'
>
> **Participant 9:** 'Staff shortage, it is so bad. It's really heavy. It's like a burden. I feel we've been neglected somewhere. There are days when you work with half-staff. Patients are more than staff.....'

Category 4.2 Material resources

Shortage of equipment was noted as a serious problem associated with policies that delay the ordering processes, staff negligence and repeated use of equipment. Among perishable equipment, gauze, protective material for wounds and masks were reported to be out of stock very often. This resulted in improvising and failure to adhere to the sterility principles thus compromising patient care. The participants noted with regret that there was no contingency plan to deal with the issue of shortage of perishable stock under emergencies. There was no alternative source of supplies during the times of urgent need. Concerns about the situation culminated in the following comments:

Participant 5: ‘Regarding equipment, there’s shortage of gauze, cotton wool and strapping. Sometimes we have to leave the wounds open and borrow from other departments. Even if things are ordered in time, ordering needs compliance with ordering policies and this courses delays.’

Participant 14: ‘I find the lack of resources a problem here. One minute you have so much stock, the next minute you’ve got nothing… Like your dressing material**,** face masks...There was a time ...you know...in the emergency unit, when we had no paediatric oxygen masks… Ya...so, how do you nurse your patient properly? When I work in an environment like this, every day...It’s putting ourselves out of the line...putting ourselves at risk.’

Regarding non-perishable equipment, statements presented by the participants showed differences in the levels of stocking by different A&E units. Some units were not in a serious state of shortage. This was associated with latest renovations of the department which was aligned with the upgrading of equipment. In these units the participants reassured about the presence of good monitors and ventilators. The only problems that were encountered were related to the instances when there was a need for new equipment or repair of the existing one. This involved delays because a protocol must be followed:

Participant 6: ‘The resources are a big issue. Equipment is limited. If you need it, it must be in the plan. You cannot get it immediately. Only items that are below R5, 000 can be issued immediately.’

Participant 11: ‘The other thing is about procurement. You want something now and you can’t get it. You have to make an order long time with the stores, and it takes time. It goes to the bidding committee, awarding committee...Ey! By the time things come, it’s six months! And you wanted it yesterday.’

Where the participants complained about the shortage of non-perishable equipment, the A&E units concerned seemed to be too desperate regarding this issue. One of the contributory factors was linked with insufficient staff updating on the use of equipment. The participants mentioned the following:

Participant 5: ‘Other equipment needs replacement because it is not working. Just now we have only 1 dynamap. Air – conditioners are not functioning. Perspiration runs down your face and you can’t even wipe it because you have gloves on.’

Participant 6: ‘Things break easily because they are used now and then. Some are just fragile eg glucometers, Hb meters and auto – saturation probes. There are no computers. The contingency plan does not exist especially when there is shortage of equipment so that we can borrow from another hospital. Everything comes from stores.’

Participant 10: ‘Staff is negligent with equipment. I think we must have an in - service about equipment and you must sign. Then, the question must be “Why are you negligent?’

Theme 5: Psychological and emotional problems

Under the incidents that impact negatively on the psychological and emotional feelings, participants cited the handling of deaths and lack of support from the management.

Category 5.1 Handling of deaths

Death in the accident and emergency unit was reported to be a common incident but dealing with it still gives nurses psychological and emotional problems. One of the problems cited was that in some instances there was no indication of imminent death. These are incidents of sudden death which result in a state of shock to both nurses and relatives. Under such circumstances it was common to see relatives demanding answers from the nurse. Anger and frustration took place in both parties in that while relatives expect the nurse to provide better answers, the nurse cannot help in this respect. Relatives end up fighting if they receive no explanation. If they do not fight they still, obviously under disbelief, expect the nurse to help even if the patient is dead. The participants remarked as follows:

Participant 6: ‘There is DOA (death on arrival and DIC (death in casualty). Whichever death, sometimes it is difficult to announce it because the relatives are watching for

every mistake. They have their waiting room but they keep on coming out and peeping in the resus room.'

Participant 11: 'Whether he is sick or critically injured ...the moment they rush in here, we rush to the person and feel whether the person has got pulse or...Once you tell them 'Guys, he is no longer alive...' all what they are thinking is you should be running and helping...but we know there is no pulse. It's gone.'

The participants who discussed the scenes of death were emphasizing the problem of long lasting memories of such scenes. The participants noted that the feelings of disbelief also affected the nurses especially when children die. The nurses were reported to be seriously affected by these incidences to the extent that some of them would even refuse to handle the next coming child. They would simple cry. The witnessing of those scenes whereby all efforts directed at reversing the condition fail, left the nurses with psychological and emotional scars that do not heal. The situation was described as follows:

Participant 7: 'Also, we've had experiences where we have lost patients, both young and old, some before they got here and some after they had been here, and some after we had helped them, and that was totally heart breaking...and there are a lot of incidents that stand out but there are few that still bother me because in an A&E unit you tend to feel responsible because you are the one attending. You feel you could have done something. Things tend to live with you for a long time.'

Participant 11: 'Sometimes it is babies who I've realized they affect staff...you know...brought in dead. A baby comes...or child is brought following a car accident. We rush, and the child ends up dying. You find nurses crying ... Ey, nurses tend to cry. At least with others they may say "This one is big" but with babies, nurses really cry, and they'll end up definitely saying "I'm not touching this one" and they will go out and cry.'

Participant 14: That paediatric resus...you know...isn't easy for anybody. If you lose a paediatric patient, it's tough...and, I just think if they had debriefing afterwards where staff involved could sit down, talk about it, re – assure each other that everything possible was done, it will be a lot easier to deal with it...you know.'

Category 5.2 Lack of support

The participants stated that they were working under demanding and dangerous situations but they received very little or no support for their physical, psychological and emotional well-being. There were no incentives from the employer. There were rarely words of gratitude from the patients and relatives.

The nurses seldom ventilated their problems to family members. Since the family members did not clearly understand the situation, they offered very little or no support. The nurses were therefore looking forward for strong support mainly from the hospital management. They expected the management to pay attention to the problems they encountered at work physically, psychologically, and emotionally. Such expectations were high especially after exposure to critical incidents. The participants indicated the following:

> **Participant 5:** '...and there are no incentives. No extra day off, no overtime allowance, no words of encouragement...in – fact I've never heard. Suppose we are so used to it...but not to the extent of not expecting it...I mean that "Thank you" … At home, family members do not want to hear. My husband says to me "Leave accident and emergency unit stories at work.'
>
> **Participant 7:** 'Sister...my husband picks me up. From the time he picks me up I tell, I say, I talk, I complain...By the time I reach home I'm ready for my kids. Whether or not he is listening, I don't know...but I say what I have to say.'
>
> **Participant 11:** 'The other challenge is the staff...the well - being of the staff. It's one of those challenges because we do our best but other than the salary we are getting, we are not getting any moral boosting or something to assist us in emotional being or being looked after, especially the things that you see. You find that a patient will be brought here, and he will be missing a limb. It's traumatic to us. It affects your emotional being, whether the limb belongs to you or it belongs to someone else. At the end of the day it affects you' … and the negative part is that in spite of running, and doing the best you can, you hardly get a thank you, neither from the patients nor the relatives.'
>
> **Participant 13:** "...but from the management nothing is happening. They do not do anything about that but we report each and every time…Sometimes they do come.'

> **Participant 14:** 'It is a tough environment... it is a tough environment. I think there is very little support for nurses especially when it comes to debriefing...very little. Actually there is no support. That to me is the biggest thing. We do not have debriefing sessions, and you are expected to just cope with everything and deal with everything.'

Support came as a rare occasion. Moreover, it was insufficient or there was no consistent follow up. Single or isolated episodes of support sessions had no effect on the traumatized psychological or emotional state of the nurse. Instead they created resistance to further invitations to them.

> **Participant 4:** 'The problem is...there is no formal ventilation of stress here. Once we were advised to go to sick bay...only if you felt like. I did not go… I did not go. I am not immune...I just did not feel like.'

> **Participant 11:** I think 3 or 4 sessions where the EAP did the counselling as a group but we've never had the individual counselling, perhaps where he will say 'You and you were involved, I'll perhaps call you on this day...' So, it's just a blanket counselling for whoever is available on the day...but then you never know...because you may never know the extent to which the accident affected me as an individual. So it becomes one of those things. We end up having apathy and a lot of absenteeism among staff. A lot of absenteeism ends up happening.'

Category 5.3 Interpersonal relationships

Different working relationships were reported. The participants indicated satisfaction regarding the doctor nurse relationships whereby both parties appreciate each other's interests for the benefit of the patient. The participants, however, noted odd times during which the doctors' moods were not a bit accommodative following overworking:

> **Participant 3:** 'Some of them don't even take lunch because they are on call from 16h00 the previous day to 08h00 the following morning. So, you can imagine if you have been working the whole night without any break.'

Doctors' emotions under those circumstances were described as follows:

Participant 3: 'Very high, and it also affects us. Maybe they had a resus at 04h00. It's very difficult to work with that doctor.'

The doctor patient relationships were described as fair. Nurses however reported more negative than positive experiences with patients because the patients' moods change depending on the situation. This is worse when they do not receive attention according to their expectations:

Participant 2: 'You can talk but assess first. Most of the time you can see… You can see that I can give health education to this one...but you can also see on the face that I can only do the vitals with this one...write...and tell her...'Ok, wait there'...because if I talk more...the answers that I will get...!'

The nurse to nurse relationships were described as good. Nurses reported that they worked as a team although some people were not easy to get along with in respect of work:

Participant 1: 'Let's talk about colleague - wise. Everybody is not the same. You tend to find a few go getters and a few that need you to tug them along, and a little bit annoying… I guess it's work related. Somebody...like...can take initiation on their own to go and look what needs to be done...but the other one you've got to ask why a particular thing was not done...or you've got to look...where are you? Where are you? (imitating looking around), and (both interviewer and interviewee laugh).'

4.5.3 The nurses coping strategies during the challenges

The interviews revealed that the A&E nurses were using various strategies to cope with the stressful situations. The major concerns involved avoiding conflicts with the patients and relatives, and maintaining stronger relationships among themselves as colleagues. Conflicts with the patients were avoided through controlling the emotions while stronger relationships among the nurses were maintained through good interpersonal relationships. Further strategies depended on the situation. They included requesting help from the nursing managers, announcing problems to the patients, and maintaining vigilance where the situation was suspicious.

4.5.3.1 Control of emotions

The participants noted that there were no benefits from arguing with the highly emotional patients and relatives. The act could worsen the situation. The nurses therefore exercise caution when dealing with emotional patients and relatives. The following were said by the participants:

> **Participant 2**: **'**Most of the time you talk to them politely. If you go up, the patient will go more up. You end up fighting now. You try as much as you can to explain to them though some of them don't even listen, but you try.'

> **Participant 9:** 'There are some…I do not know whether it's due to their prior experiences or it is their nature. Sometimes they come here already fighting and if you try and answer they chow you up, so you work around it and you say nothing – you hold your mouth or direct them to the person they want.'

4.5.3.2 Maintaining good interpersonal relationships

Maintaining good interpersonal relationships helped the nurses to neutralize the consequences of working under pressure. The nurse to nurse relationships were described as good. There was unity among nurses and mutual understanding between the nurses and the doctors. The participants reported that sometimes nurses and doctors co-operated to minimize the stress from work pressure. The aim was to ensure that both nurses and doctors fulfil their roles without conflicts. The nurses therefore felt free to communicate with the doctors where there was a problem that prevented the flow of work. Some of the doctors were noted to be highly appreciative for the nurses' functional role in the unit. The participants described the stated relationships as follows:

> **Participant 6:** 'Sometimes the doctors are the ones who refuse to release certain nurses from certain treatment points or to allow them to go to the wards because those nurses have skills.'

Participant 9: ‘Staff is like a close net…we are like a unit. No time to fight with each other…we are like a family. We can only question about something that is past (How it was done). Support is so good among nurses themselves....’

4.5.3.3 Summoning assistance from the hospital managers and security

The participants reported that they often summoned the hospital managers’ assistance when they encountered problems regarding the workload and safety. Assistance would be made available but sometimes it made no difference. The reason stated was that sometimes the people who responded to the call as rescuers, did not match the situation. This could be due to the level of experience or the incident beyond easy control. Despite the gestures of assistance, the participants stated that they were mainly concerned about the scarcity of the management visits to the A&E unit especially after an extraordinary incident. The participants expressed the stated experiences as follows:

Participant 9: Sometimes we do try and phone the matron to say please assist us. They try but sometimes it is not possible because it may be the whole hospital experiencing shortage. They may send us a junior nurse or student nurse to do observations.’

Participant 11: ‘It becomes a problem because when we tell our security, they just stand there. They don’t have a gun. They are not carrying anything...and they (patients) will just swear at the security. You know, there’s this element about people that if you are a security, you are nothing, and if you are a nurse, you are nothing.’

4.5.3.4 Prioritizing the tasks

According to the participants, working in the order of priority also helps the nurses to achieve objectives of patient care to a certain extent. The participants viewed this approach as a kind of informal triaging to manage ones’ scope of work. Although it led to dissatisfaction to other patients, it is time saving during mass attendance in the A&E unit. The statements from the participants revealed the following efforts by the nurses in respect of prioritizing:

Participant 9: ‘Sometimes in order to cover for deficits we do triage in the sense that we prioritize the urgent cases because we cannot do observations on all cases. Urgent cases…you do them more frequently and the non – urgent cases… you estimate and do them 4 hourly. You scan the patients and you decide ‘These are the ones ‘I’m going to do frequently. The ones with abscesses or stable…you can do them 4 hourly.’

Participant 11: ‘So, those minor cases...if they are drunk, even if you explain to them that ‘No, we are looking after people who are badly injured first. We’ll come back to you ...they will be shouting ’Hey...! We pay...This is our government…!’

4.5.3.5 Explaining problems to patients

The discussion with the participants revealed the fact that it is better to be honest with the patients about the A&E situation in order to secure an amount of co – operation. Otherwise, their expectations keep on increasing. The situation was described as follows:

Participant 8: ‘Now, I just explain before. I just tell them, ‘You are going to wait for about 4 – 5 hours. I am just preparing you’. That’s what I do now. Some, they understand. It is the relatives who don’t understand but if you tell the patients, they understand.’

Participant 9: ‘You’ve got to be realistic. You announce and explain to them. You can’t hide these things. You will tell them “We will see you but we are still sorting things here and there.” It actually works because sometimes they have a pre – estimation of the situation. “I must not expect so much” If you don’t tell them they come to you and they will assume like there is 100 nurse “But…where are they? I want a Sister.’

4.5.3.6 Social coping strategies

The study revealed that there are times during which measures were tried to strengthen social support among staff. The aim was to help with relaxation and to provide time for ventilation, which was hardly possible at work. Social trips were mentioned though it was not clear when last they were organized. According to the participants, the moments for social support were important because the services of

the hospital psychologist were not sufficient. The sessions with the psychologist were limited. Besides the social trips other staff members engaged in relaxation methods at home.

> **Participant 11:** 'I've tried it on my own...you know...try and attempt exercises where we went out with the whole team to enjoy ourselves and talk about things you know...trying to build that team spirit. I've tried that. I've also organized an EAP to come and speak to the staff but the psychologist should be per appointment for 3 or 4 sessions. I don't think it's a helping.'

> **Participant 13:** 'I (at home) bath, eat, watch TV, and sleep. I do not tell them (relatives)...it's embarrassing...especially I have grown children. My first born is 23 years old. So, how do I tell that?.'

Another form of support for coping was advocating for each other. The nurses advocated for each other whenever one of their colleagues was confronted, for instance, where relatives demanded answers.

> **Participant 5:** 'For instance, one day we were very busy. One man came in complaining of chest pain. He was on the wheelchair. ECG was done and it was found normal. He was taken to wait in the ambulance area. He demised immediately on arrival at the ambulance area. Relatives came straight to me. They wanted to fight with me because I was the one who did the ECG. Somebody (colleague) explained to them, and they left me.'

4.6 DISCUSSION OF THE FINDINGS

This study identifies the main challenge as the existence of stressful situations experienced by the nurses in the A&E units that formed part of the study. Also, the study observes lack of continuous support for the nurses from the hospital management. The insistence is on the hospital management to pay attention and engage on deliberate efforts to assist the nurses in dealing with the stressful situations. Based on literature review, most of the stressors identified are common in the A&E units. The differences in their magnitude may be dependent on the predictors or circumstances surrounding the area of concern.

In this study, the predictors that are likely to produce a great change in the magnitude of stressors may be associated with the functional level of the hospital as well as the geographical area within which it operates. The regional hospitals possess a potential for increasing the magnitude of stressors because of their ability to accommodate large volumes of patients. Further, the urban areas within which the hospitals whose A&E units were studied are situated, add to the exaggeration of the stress conducive situations. The urban areas have a great prevalence of traumatic incidents. Pillay et al (2012:1) estimate an annual trauma workload of 17, 500 within the South African regional urban hospitals.

The findings also show that the nurses in the studied A&E units were already utilizing their own self – designed coping strategies to deal with the work stressors. Although these coping strategies benefited them in most instances, they seem to have emerged instantly and out of desperation for immediate relief from a problem. For this reason, their sustainability, among other elements of quality in a support strategy, cannot be guaranteed. Based on the findings, the researcher developed the strategies to support the A&E nurses.

The nurses in this study were already using the control of their tempers as one of the coping strategies when they were confronted by the angry patients. The reason stated for this response was that it prevented the escalation of the patients' anger. The strategy seemed to achieve its purpose, although it is emotion focused, and does not provide a future solution to the problem. It raises a question of sustainability considering the frequency with which the anger outbursts occur among the patients in the A&E unit. The other concern is the extent of negative health impact that can be expected where emotions are continuously suppressed. However, Arik, Anat and Arie (2012:2) in trying to understand what guides the staff's responses to anger encounters, finds that staff evaluates 2 questions as one of the decision making processes: 'Am I under danger?' and Who is to blame for anger: is it the staff or the patient?' Where danger is sensed, the staff is likely to be influenced to end up giving in to the patients' wishes.

Since the nurses are highly likely to succumb to the patients' wishes in fear of danger, the anger outbursts are not likely to stop. The findings of this study therefore suggest that the EAP can play a major role in assisting the nurses with the process of the restoration of their normal emotions despite the continuation of the anger outburst scenes. In addition, the created image that may negatively paint one's professional reputation during the exchange of words with the patient or relative, can be prevented.

The advantage of the EAP is that its services are confidential. It provides an opportunity to openly discuss the problems with the expert professionals in the counselling procedures. It is not restricted in its services in that a wide scope of problems including the physical, psychological, and emotional aspects can be attended to. In Houck (2014:454) in a study to help the nurses cope with grief and compassion fatigue in the Northeastern United states, the EAP services were highlighted as relevant in the instances of cumulative grief. Rajin (2012:1V) in the investigation of the relevance of an EAP in one of the Soweto police stations, South Africa, noted the importance of this service at the police station investigated. The service was highlighted as relevant in that the employees of the police station were exposed to daily traumatic events since their duties required them to attend to overwhelming incidences. Crime scenes involving murder, collisions of varying seriousness, and often witnessing the murder of their colleagues were cited among the critical incidents.

More advantages of the EAP can be expected depending on the model utilized by the institution. In Singh (2015:1), the advantages of the in-house versus out-sourced EAP were noted. The in-house model was noted for its easy accessibility over 24 hours. In this study, the in-house model is identified as the best model to operate in the A&E units studied in that critical incidences follow each other within a short space of time. Under such circumstances, it may be very difficult to keep on travelling to the outsourced EAP. For this reason, it would be an advantage to receive immediate and easily accessible help during the times of need.

Concerning the provision of extra staff through overtime or agency work, the rate of staff absenteeism has not indicated this need in the past. Absenteeism has not been an alarming issue in the studies quoted earlier in this study. It has hardly received

attention as one of the main causes of stress in the A&E units. Where it has received attention, it has been associated with burnout, as one of the results of stress.

In this study, the increase in absenteeism is one of the issues. The issue is that absenteeism seems to be linking negatively with the old chronic problems of the A&E units, namely, poor resources, overcrowding, and constant pressure of work overload. The problems are noted to occur in a vicious cycle in that work overload and pressure lead to absenteeism and in turn absenteeism increases the work overload and pressure. From the data obtained during the interviews, absenteeism seemed to have a greater prevalence in the A&E units that were reported to be experiencing more problems with material resources. The interpretation is that burnout manifesting in absenteeism can be associated with stress from working with inadequate material resources.

The findings regarding the negative link between staff absenteeism and the chronic A&E are in line with the literature by Fakih, Tanaka and Carmagnani (2012:3). The workers who remain on duty were noted to have to perform the absent workers' tasks, which amounts to an overload. This overload may result in health problems that warrant the need to grant seek leave, causing more staff reduction. Thus, a need to consider and direct more focus on reducing absenteeism with a hope to further curb the perpetuation of chronic challenges.

Since the staff strengths is the most important resource of any organization, any reduction in the staff numbers through absenteeism amounts to a serious hindrance of progress in respect of productivity. Organizations prevent this problem by engaging in efforts to formalize leave of absence to control staff attendance at work. During leave of absence by some staff members, the remaining staff are capable of adjusting physically and psychologically because absence occurs when they expect it. Without a well planned leave arrangement, unplanned absenteeism is a threat to the remaining nurses' physical and psychological health.

This study suggests the engagement on means of providing extra staff through the allowance of overtime or agency work. The advantages of utilizing the staff agencies for recruitment of staff is that the staff agencies have a broad network of candidates,

which makes the recruitment procedure easy. The broad network of candidates increases the chances of obtaining the right recruits in terms of expertise. In the A&E units, the need for staff with high expertise in emergency nursing is high because of the need for fast decisions related to patient care.

In this study, the participants stated that time for orientating the helpers who were sent by the managers during major crisis also posed problems because helpers kept on asking. The interpretation is that if staff keeps on answering questions or orientating helpers instead of continuing with work, the state amounts to the same situation as posed by absenteeism. Thus, the suggestion to obtain nurses with A&E expertise through the agency. These nurses need a short time for orientation.

Overtime is also possible, but managers need to be conversant with the rules applying to the utilization of the overtime strategy to curb absenteeism. For instance, the fact that working overtime is voluntary, and that the number of hours cannot be more than the stipulated time according to the Labour Act applying. Unless the precautions are taken to understand the status of the overtime worker, further incidents in the A&E unit may emanate from the fights with the managers over the remuneration processes. Angry employees are likely to absent themselves causing further reduction in staff numbers.

Organized plans to control absenteeism could be another reason for strengthening the EAP. As many nurses as possible can be retained on duty while they receive appropriate care. It can also pave the way for openly acknowledging excellence in work attendance. Staff members with a good record of attendance can receive incentives including awards with certificates per year or floating half-days.

Whereas this study indicates the frequent experiences associated with the emotion triggering situations in the A&E units, the findings reveal that the nurses were not afforded an opportunity to reflect on these experiences. The debriefing sessions were reported to be scanty or non – existent. There was no sharing of the emotional experiences among the colleagues because of lack of time to do so or probably lack of knowledge about the alternative strategies to deal with emotions. In the instance of the death of the child, the problem was more complicated. Having to face the relatives

or another same kind of experience was tough. The whole situation was difficult to handle. As a result, the nurses embarked on the strategy of avoidance.

The nurses' dilemma in the situation confirms that many people who have been traumatized by a critical event have often been caught off guard and therefore ill – equipped to handle the consequences (Davis 2013: 68).

According to Harrison and Wu (2017:1) the mechanisms for supporting staff under these circumstances have been existing for a long time but not routinely utilized by the institutions. Among the available programs that promote resilience and recovery, they identify the long existing Critical Incident Stress Debriefing (CISD). With the utilization of this program the affected staff can be assured of professional attention and care for weeks, months and possible years to come (Davis 2013:68). This recommendation takes into consideration that accumulation of emotions resulting from high levels of stress have detrimental effects on the health of the affected individuals. For this reason, when a traumatic incident befalls the nurses, steps should be taken to prevent its ill-effects on health.

Further, according to Davis (2013:70), a CISD is a specific technique designed to assist others deal with the physical or psychological symptoms associated with trauma exposure. It allows those involved with the incident to process the event and reflect on its impact. The results are that individuals who are provided with CISD within a 24 - 72 hours period after the incident, experience less short- and long-term crisis reactions. As the length of time increases between the time of the incident and exposure to CISD, the debriefing becomes less effective.

The important activity during the debriefing sessions is the sharing of the feelings following the critical incident. In this study, the participants pointed out the absence of the debriefing sessions as a hindrance to their emotional healing because they were not sharing their traumatic experiences. There were no grieving sessions, especially after the death of a child, which was the most traumatic experience to most of the nurses. Support for the nurses' assertion in this study regarding the need for the grieving sessions after the death of a patient is found in Keene, Hall and Rushton (2010: 1). In the mentioned study, a strategy was designed to offer bereavement

sessions after all unexpected patient deaths or death of long-term patients. Although the sessions were offered to many health disciplines, the nurses were the ones whose attendance was often. The health report forms revealed that the health professionals found the sessions very helpful.

The mention of physical insecurity is noted with reference to its negative consequences on work performance. The participants were concerned about the fact that they were working under threat.

There was the interruption of the nursing activities with each violent scene. This concern is implied from the participants' statements that the nurses had to suddenly embark on measures to secure help during violence. In certain instances, they had to identify hiding places within the unit instead of continuing with their duties. The interpretation is that the line of concentration was disturbed when the nurses had to respond to violent scenes.

Besides the observations made in this study, the findings about the state of physical insecurity in the form of violence traces back from the previous A&E studies. In Talas, Kocaöz and Akgül (2011:197) in a survey of violence against staff working in the emergency department in Turkey, verbal abuse, verbal threats, physical abuse and sexual harassment were mentioned. Aluyemni & Alhudaith (2016:35) in a study of workplace violence against the nurses in an emergency unit conducted in Saudi Arabia, concur with Talas et al (2011: 197) on verbal and physical abuse. Ramaciatti, Ceccagnoli, Addey, Lumini and Rasero (2016:17) note that violent scenes have been identified worldwide as epidemics in the A&E units, and staff see them as inevitable.

The focus of this study regarding interventions for physical insecurity is therefore the improvement of security services. The aim is to lessen the threats and ensure the continuity of the nursing activities with less or no interruption. This is more important in the A&E units because of their being adjacent to hospital entrances. Security needs to be tight from the hospital entrance to ensure that everybody within the hospital is safe.

The responsibilities of a hospital security officer imply that peace should prevail within the hospital premises while the other hospital employees perform their tasks. In addition, that whoever is within the hospital walls, and including the hospital property should be protected from any kind of harm. Their responsibilities take into consideration that hospital staff, patients, and visitors are vulnerable to exploitation through violence and theft of their property. Hospital property, including drugs and some types of furniture may find attraction to certain groups of people especially those who leave by theft.

According to Hospital Security Guard (2013:1) the hospital security officers are expected to patrol hospital grounds and buildings to prevent fire, theft and vandalism. They have to ensure that only authorized people enter the hospital premises. They have to respond to emergency calls by the hospital staff, visitors, physicians or the patients. They have to investigate the incidences of unusual circumstances and write incidence reports. They are trained and licenced to perform the mentioned duties.

The A&E state of working under the threat of violence and physical insecurity in this study indicates a need for increase in the numbers of the security officers if their duties are to be performed well. An increase in their numbers can ensure that they are well distributed all over the hospital entrances thus preventing unauthorised entry to the hospital. The unauthorised groups of people include those who are armed and those who are under the influence of alcohol or drugs. The thoroughfare state described by the participants in the study showed that armed and drunken people easily entered the A&E units. According to their description, the state was inevitable because of the A&E units being adjacent to the hospital entrances. It is for this reason that the cameras and alarm systems are required to enhance the functions of the security officers. The adequate performance of the security job can be expected to result in the reduction of the A&E threats and an unbroken line of concentration in the nurses.

According to the findings of this study, little or no support from the hospital managers as reported by the participants did not mean that the managers were very insensitive about the nurses' needs. Further discussions with the participants showed that the managers were able to provide immediate support during the times of need. For instance, they were able to provide extra staff when the unit was overflowing with the

patients. The problem according to the findings of the study was that continuity of support was not guaranteed. The cause of this problem is noted as lack of formalized or well stabilized procedures that need to be followed in attempting to address the stress causing situations. When taking into consideration the unpredictability of the situations and work overload in the A&E units, time for making urgent requests every time there is a need, is very limited. Thus, the nurses should be assured about the continued availability of the support services. In addition, it is important to instil the feeling to the nurses that they are welcome to the liberal use of the available services.

Further, due to high pressure from work, the A&E nurses may not have time to report the problems as they arise. In addition, the nurses may find it challenging to communicate with the managers on a formal platform because of the personal nature of some of their problems or fear of opposition from the colleagues.

At the same time, visiting the manager's office for private ventilation may invite unnecessary labels from the colleagues who may misinterpret the aim of the visit. As a result, communication about many work related issues may be suppressed. Many problems may be left unattended for a long time, leading to complications. As a result, the managers may not be aware of them because they do not work closely with the patients and the nurses.

Being able to utilize an existing strategy after experiencing a critical incident can help to alleviate the negative effects of the incident while the reports are processed to the managers. Khamisa, Oldenburg, Peltzer and Ilic (2015:661) stress the need for management programs that provide support for the nurses dealing with stress related outcomes. These programs should include education and training on coping with stress.

In this study there was no mention of any readily available structure that the nurses could utilize immediately after every exposure to the incident and continuously thereafter. As a result, the nurses utilized their own coping skills which, according to Scott (2012:7) indicate that they have little control over the situation. The provision of continuous support structures can be predicted to improve the nurses' cognitive

appraisal of the incidents. The nurses can see them as problems to be solved, and not to be avoided or distanced from.

4.7 SUMMARY

This chapter presented the data analysis and the findings of this study. Participants engaged in an in-depth discussion with the interviewer. By virtue of their long experience in the A&E unit, participants were able to deliberate on experiences of crucial importance in the A&E unit.

Participants discussed their experiences under 6 themes where they indicated passion for the A&E unit though they were experiencing many negative challenges with little or no support mainly from the administration. Challenges include working under pressure and overwhelming conditions, the need for safety, environmental problems, the problem of administrative procedures, and psychological and emotional problems. The next chapter will be on the presentation of strategies.

CHAPTER 5

PRESENTATION OF THE STRATEGIES

5.1 INTRODUCTION

This chapter presents the strategies developed to enhance the support systems of nurses in the accident and emergency (A&E) units of the regional urban hospitals of KZN. To ensure relevance, the strategies were developed from the findings of the interviews. The aim of this chapter is present Phase II of the study.

5.2 THE PURPOSE OF THE STRATEGIES

The purpose of designing the strategies was to address the situations that were highlighted by the participants in the study as stressful, as indicated in chapter 4. The coping and intervention techniques that are suggested were aimed at equipping and enabling the A&E nurses to deal effectively with the highlighted stressors.

5.3 THEORETICAL FRAMEWORK

In Chapter 1 of this study, the transactional theory of stress and coping by Lazarus and Folkman (1984) was introduced with the aim of providing support for the study. The significance of the theory in the development of the support strategies is acknowledged in this section of this chapter.

The presence of stress in an interaction environment as noted in the A&E units, and a series of processes that follow once a stressful situation is noted, are aligned to the focus of the transactional theory. The theory describes the evaluation processes that man engages in with an intent to interpret the significance of the stressful situation in relation to his own survival. The series of the evaluation processes referred to as the cognitive appraisal of the situation, determine what seems to be the best responses for the person involved.

Based on the purpose of this study, and the need to develop the support strategies that are the most appropriate responses, the selected stress theory was used to understand the nurses' cognitive appraisal of the A&E situation.

The appropriateness of the theory for this study is founded on the premise that it suggests that transaction (interaction) occurs between man and the environment. Stress occurs when the demands (pressures of the environment) exceed the available resources (ability to cope) to the extent of endangering man's own well-being. The theory adequately defines stress in relation to its origins and the other elements associated with it, namely, the cognitive appraisal of the situation, and the concept of coping.

The observation that stress manifests only where a person and his or her environment are in an interaction process, suggests that the appraisal of the interaction experiences lies in the persons involved. According to the theory, the cognitive appraisal of the situation occurs at the primary and secondary level. At the primary level, the appraisal involves the determination by a person involved whether or not a particular person-environment relationship is stressful. At the secondary level, the individual engages on how best the situation can be worked out or how the individual can cope if the personal goals are threatened or thwarted.

The identification of the element of coping is one of the measure strengths of the transactional theory of stress. Additionally, within the mist of the dynamics involving stressful encounters, the theory identifies a link between stress and health outcomes. The physical, psychological, and emotional problems that are experienced during and after stressful encounters are within the theory's scope of the definition of the stress outcomes. Thus, contrary to other theories that deal with stress but dismiss the other components that accompany stress, the theory of Lazarus and Folkman (1984) identifies a clear relationship between stress, health outcomes, and coping mechanisms. In this manner, this theory is the one that best expresses stress and its outcomes in a way that opens a pathway for suggesting support systems for those affected. Lyon (2012:11) concurs with the assertions of the theory by identifying stress, coping and health outcomes as aspects that should be encompassed in a theory.

Furthermore, the establishment of this link provides the basis to suggesting strategies to enhance support systems for the nurses.

According to Lazarus and Folkman (1984) theory, the concept of coping is explicitly a cognitive and a behavioural effort to manage the situations that are appraised as too demanding. Either the coping measures will fall on the emotion or problem, that is, focused solution approaches. The emotion- focused approach aims at regulating the emotions while the problem-focused approach aims at managing the encounter. It may help to be aligned to both approaches because situations differ. One situation may require suppression of emotions to regain the reasoning processes before a response. Other situations may require careful planning of sustainable approaches. Although the unpredictable situations occur as much as the recurring scenes occur in the A&E unit, this study alluded to the problem-focused strategies.

5.4 METHODOLOGY FOR DEVELOPMENT OF STRATEGIES

The support strategies were formulated in relation to the findings from the interviews (evidence from Phase I). The findings from the interviews revealed that the A&E nurses experienced the following stressors:

- Anger directed to the nurses by the patients and relatives
- Constant pressure of work overload to the nurses remaining on duty resulting from the high rate of absenteeism
- Emotional disturbance from incidences relating to death of children and uncooperativeness of the patients and relatives
- Lack of physical security
- Little or no support from the hospital management

The identified stressors were problematized with support by a summary of the findings, and for each of them a support strategy was formulated and the rationale stated. Some of the coping strategies that were already in operation were also noted for reinforcement because of their relevance in practice. The foreseeable harmful effects

of stress that were likely to present where no support strategy was in operation were highlighted where it became specifically necessary.

5.5 SUPPORT STRATEGIES

The strategies are presented in this section. A summary of each finding that explains a problem related to the stressor to the nurses precedes the suggested strategy.

5.5.1 Stressor: Anger directed to the nurses by the patients and relatives

The nurses stated that the patients and relatives often insisted on their expectations being met within a short period of arrival within the unit. If this expectation was not met, the patients and relatives directed their anger to the nurses. The nurses reported this kind of incident to managers but nothing was done immediately about it.

Strategy 1: Develop or strengthen an existing employee assistant program (EAP) specifically for counselling and providing support for the nurses within the unit

Rationale

The aim is to ensure that assistance with the counselling programs for the nurses is within reach. The use of EAP will also ensure the formal recording of the incidents as there will be referral reports and this will make managers conscious of the magnitude of the problem and the impact of the stressor to the nurses and their performance on duty. The program can assist the nurses with the support to counter-effect the negative impact of anger or frustrating statements directed at them by the patients and relatives. Furthermore, the EAP can conduct continuous anger management as well as other relevant support programs. The existence of an EAP can ensure that there are enough counselling sessions immediately after exposure to anger statements. It can also justify the involvement of the other relevant professionals including the psychologist or the social worker who can help identify and deal with the chronic unresolved problems.

During the counselling sessions, the nurses should be taught control of temper through refraining from retaliating when faced with anger fuelled statements. Refraining from retaliating right at the face of the negative and anger fuelled statements that amount to accusations, has benefits. It provides enough time for the brain to rationalize the thoughts regarding the next appropriate response. This will in turn support the nurses to manage their own anger.

5.5.2 Stressor: Constant pressure of work overload to the nurses remaining on duty following the high rate of absenteeism

The nurses indicated that there was a growing tendency towards absenteeism by colleagues, whereby the remaining nurses carried the work overload. Staff absenteeism made meeting the increased demands brought about by overcrowding and unpredictability of the A&E events unbearable on the few nurses who remained on duty. The result was work overload resulting in fatigue. The problem with absenteeism was that it was either due to other causes, which were personal or involving social life other than those related to work pressure. When the work environment is also loaded with challenges, the situation may add to the impact of problems experienced at an individual level. The result is poor performance and poor standards of care. The nurses were aware of and appreciated the supply of extra nurses during the times of need. The problem was that the helper nurses could also add further stress to the A&E nurses if they were still students who needed supervision.

Strategy 2: Address staff absenteeism through the provision of extra staff through overtime or agency work.

Rationale

Providing extra staff will supplement the remaining nurses on duty and therefore relieve off the burden of work. Extra nurses will also assist to provide quality care as the nurses will not be pressurised to finish the work. However, this strategy may not be immediately possible as it has financial implications for the institutions. Additionally,

there is a global shortage of nurses, and thus it may be difficult to obtain adequate agency or overtime nurses.

5.5.3 Stressor: Emotional disturbance from incidences relating to death of children and lack of cooperation of the patients and relatives

The nurses were exposed to a number of emotionally disturbing situations. The death of children and the uncooperativeness of the patients and their relatives were the main causes of emotional disturbance. However, debriefing sessions were neither formalized nor made liberally available as a strategy for assisting the nurses to deal with their disturbed emotions. In some units, the nurses were asked to consult the EAP if they wished to do so. As a result, the irregular permissions to attend the EAP services were ignored by some of the nurses.

Strategy 3: Enforce attendance of monthly debriefing sessions

Rationale

The normal emotional states of the affected individuals need to be restored as soon as possible after an emotion disturbing experience. Where an EAP programme for the nurses has been formally developed, its existence can also be formally recognized for utilization to handle debriefing sessions. The debriefing sessions ensure that the requirement of emotional restoration is fulfilled especially when the procedures are formalised. The procedures can be timely with adequate follow up sessions for healing to take place.

5.5.4 Stressor: Lack of physical security

Physical safety was not guaranteed for several reasons. Thoroughfare was a problem in that everybody including the patients, the patients' relatives, paramedics, hospital workers and ordinary hospital visitors were using the same entrance of the unit to enter the hospital. The security officers were not evenly distributed all over the hospital entrances to ensure adequate control of patient movement and safety. Instead, they

crowded at one entrance of the hospital. As such, people had easy access to the A&E unit, and the safety of the nurses was thus compromised.

Strategy 4: Strengthen the security system through increasing and evenly distributing the security staff

Rationale

The aim is to provide safety. The security officers could be adequately populated at all the entry points, and improve the scanning procedures. The A&E patients can be separately channelled to the correct areas where they can receive attention. Conflicts that arise between the nurses and the patients, and between the A&E attendants themselves can cause tensions and fear. For this reason, the cameras and alarm systems can be an advantage in preserving evidence and boosting quick communication means, respectively. Alarms should have a sound that is easily distinguishable from any other sounds that may be used in hospital. They can be installed in discrete areas known by the nurses only and tested regularly for functioning.

5.5.5 Stressor: Lack of continuous support from the hospital managers

The participants stated that they were working under demanding and dangerous situations. However, they received very little or no support for their physical, psychological and emotional well-being. Incidents were reported to the managers but in most instances, nothing happened although the relevant managers visited the unit as expected.

Strategy 5: Give attention to all the problems and provide a quick response

Rationale

Attention to all the problems may not mean being able to provide relevant solutions at all the times. While some of the challenges are chronic, some may be newly experienced and thus no readily available strategy to solve them. Providing continuous

support can provide means of reducing the immediate impact of a critical incident. For instance, the provision of continuous debriefing sessions may provide the stabilization of emotions while the relevant solution to the specific problem encountered is under discussion. The hospital managers can update themselves about the latest problems by increasing the visiting times to the unit. The latest information can be helpful in updating the already existing and continuous support strategies. There is ample time to evaluate their sustainability.

5.6 VALIDATION OF THE STRATEGIES

A list of the recommended strategies was compiled and sent by email for presentation to a nominal group of experts in emergency care for scoring and comments. The targeted experts were holders of positions, and others having accumulated years of experience in the emergency services of the hospitals where they were rendering services. The qualifications, occupation and the work experience of the experts was a requirement for recording. The purpose of validation was to ensure that the strategies were, among other criteria, feasible, practical and acceptable.

Five experts were recruited for validation. The researcher ensured that the experts were well orientated to the purpose of the study before they could validate the strategies. This was achieved through addressing the request for validation in a letter form, and supplying the experts with the research protocol. Five (5) forms, each bearing a strategy to be validated were given to each expert. The experts were requested to return their responses to the researcher by e-mail.

5.6.1 List of strategies

The list consisted of five (5) recommended strategies as follows:

Strategy 1: Develop or strengthen an existing employee assistant program (EAP) specifically for counselling and support of the nurses within the unit

Strategy 2: Address staff absenteeism through the provision of extra staff through overtime or agency work.

Strategy 3: Enforce attendance of monthly debriefing sessions

Strategy 4: Strengthen the security system through increasing and evenly distributing the security staff

Strategy 5: Give attention to all the problems and provide a quick response

5.6.2 Instructions regarding the validation of each strategy

Each strategy had to be validated using the identified criteria. Desai (2013:1) identifies acceptability, feasibility, and sustainability as the most important criteria in a strategy. However, the list provided in this study includes additional criteria from Quain (2018:1), and Autism speaks Inc. (2012:39). The definitions of the criteria were provided to enable the experts to make informed decisions about the worthiness of each strategy. All the described information together with the rating scale (agree or disagree) were accommodated in the table of criteria.

The developed strategies, and criteria for validation of individual strategies are as follows in Table 5.1.

Table 5.1 Criteria for validation of individual strategies

Instruction: Kindly validate the stated strategy below according to the given criteria. Enter your response in the appropriate column by using a tick. If your response is ‘disagree’ in respect of a particular criterion, kindly comment in the adjacent space provided under the column of comments.

Strategy 1: Develop or strengthen an existing employee assistant program (EAP) specifically for counselling and support of the nurses within the unit.

Table 5.1 Criteria for validation of individual strategies

Criteria	Agree 1	Disagree 0	Comments
Acceptability: The strategy is acceptable in terms of the physical, psychological and emotional support needs of the nurses in the accident and emergency (A&E) units studied			
Applicability: The usefulness of the strategy as part of a support system for the A&E nurses studied can be predicted			
Clarity: The strategy is simple for understanding for the purposes of application as a support means			
Effectiveness: The strategy is able to achieve its objective as support means for the nurses within the context of the study			
Feasibility: The implementation of the strategy is possible in terms of the available hospital resources, namely, human and material			
Relevance: The strategy is ideal for application in relation to the handling the A&E experiences			
Sustainability: The ability of the strategy to address the present and future psychological emotional needs of the A&E nurses can be predicted			
Validity: The strategy is justifiable in that it is evidence based			

Signature……. Qualification…….....

Occupation……. Work experience……

5.6.3 Results of the validation of the strategies

Five experts had been recruited for validation of the strategies. Four experts returned the results by e-mail after 2 weeks. One expert did not respond. The experts who responded had spent most of their working experience in the A&E unit.

The biographic information of experts who responded is as follows in table 5.2.

Table 5.2 Biographic information of experts

No.	Qualification	Occupation	Work experience
1.	Professional Nurse	Nursing (Emergency)	16 Years
2.	Professional Nurse	Nursing (Emergency)	7 Years
3.	Professional Nurse	Nursing (Emergency)	25 Years
4.	Family Medicine	HOD (A&E Department)	48 Years

5.6.4 Calculation of validation scores

A validation score was calculated in respect of each strategy for each expert. The average score for each strategy was calculated out of the total score of results contributed by each of the 4 validating experts. An average score of eight was expected from each strategy following validation by 4 experts. A score lesser than eight was accepted only if it did not fall below six to ensure that the acceptable results for each strategy remained at 75% and above.

A sample of results from an individual validating expert is as follows in Table 5.3.

Table 5.3 Sample of the validation results from an individual validation officer

Criteria	Strategy 1	Strategy 2	Strategy 3	Strategy 4	Strategy 5
Acceptability	**1**	**1**	**1**	**1**	**1**
Applicability	**1**	**1**	**1**	**1**	**1**
Clarity	1	1	1	1	1
Effectiveness	1	1	1	1	1
Feasibility	1	0	1	1	1
Relevance	1	1	1	1	1
Sustainability	1	1	1	1	1
Validity	1	1	1	1	1
Totals	8	7	8	8	8

The condensed record of the validation results is as follows in Table 5.4.

Table 5.4 Condensed record of the validation results and scores

Criteria	Validation Results 1	Validation Results 2	Validation Results 3	Validation Results 4	Average Score
Strategy 1	8	8	8	8	8
Strategy 2	7	8	7	8	7.5
Strategy 3	8	8	8	8	8
Strategy 4	8	8	8	8	8
Strategy 5	8	8	8	8	8
Strategy 7	8	8	8	8	8
Strategy 8	8	8	8	8	8
Strategy 9	8	8	8	8	8

5.7.5 Evaluators' comments on low rated strategy (disagree)

Strategy 2

Two evaluators rated the strategy 2 at zero (disagree) in relation to feasibility. The comment from one validating expert was that there was a critical shortage of human resources in the facility. Although the expert did not state the facts around his comments expressly, the deduction is that since the hospital as a whole is running short of human resources, overtime may not be possible. The other expert simple stated that recruitment from the agency does not take place when there is critical shortage. The interpretation could be that the strategy is not affordable.

5.7 SUMMARY

This chapter presented the strategies developed to enhance the support systems of nurses in the accident and emergency (A&E) units of the regional urban hospitals of KwaZulu – Natal (KZN). The stressful situations that were identified by this study include anger directed to the nurses by the patients and relatives, constant pressure of work overload to the nurses remaining on duty resulting from the high rate of absenteeism, emotional disturbance, lack of physical security, and little or no support from the hospital management. Strategies that were developed based on the identified stressful situations.

The strategies include the development or strengthening of an existing employee assistant program (EAP) specifically for counselling and support of the nurses within the unit, addressing staff absenteeism through the provision of extra staff through overtime or agency work, enforcing attendance of monthly debriefing sessions, strengthening the security system through increasing and evenly distributing the security staff, and attending to all problems through ensuring continuous support systems.

The next chapter will discuss the conclusions and recommendations.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The purpose of this chapter is to present the conclusions and recommendations for the future. The contributions and limitations of the study are also presented.

6.2 THE PURPOSE OF THE STUDY

The purpose of the study was to develop the strategies to enhance the support systems of nurses in the A&E units of the regional urban hospitals of KZN.

6.3 RESEARCH DESIGN AND METHODS

The researcher used an exploratory and descriptive design to proceed with the investigation. The design and methods that were selected are those secured on a theoretical background, which guided the study towards the findings and their interpretation. The choice of the design selection was based on the researcher's own philosophical orientation of worldviews regarding the existence of knowledge and how it can be acquired.

A non-probability purposive sampling was used to obtain the list of hospitals which, and candidates who would be able to provide the required information. Fourteen participants were interviewed in the A&E units of four (4) hospitals following a pilot study in two (2) hospitals. The participants had to describe their experiences of working in the A&E unit of a regional urban hospital at KZN. Data analysis showed challenges than positive experiences for nurses working in the said units.

6.4 CONCLUSIONS FROM THE STUDY

The conclusions were drawn from the specific objectives that were set from the beginning of the study. The first objective involved the exploration and description of the nurses' experiences in the A&E unit of a regional urban hospital at KZN. The second objective involved the description of the coping skills used by the nurses working in the A&E units.

6.4.1 Exploration and description of the nurses' experiences in the A&E unit

Conclusions about the exploration and description of the nurses' experiences in the A&E units were drawn from both literature review and interviews conducted by the researcher on the targeted nurses.

6.4.1.1 Conclusions based on literature review

The existing literature helped to establish the information that has already been uncovered about the functioning of the A&E units. There is some light thrown into the researcher's topic of inquiry based on the A&E issues examined by the previous researchers. Their arguments, ideas, conclusions and suggestions contributed in formulating the background for the study. They also helped to shape the problem statement for better understanding and directing the researcher's investigation within its own context.

Literature reveals the A&E units as hospital areas of high stress levels in that they are associated with critical incidents (Healy & Tyrrell 2011:34; Gholamzadeh et al 2011:45). The problem unfolds as a global issue with reliable information sources in the form of publications commonly from the Middle East, Europe and USA. Noticeable, is that very little is mentioned about the problem in South Africa. According to the literature, the nurses who constantly work in the A&E units are perceived to be frequently exposed to critical incidents. The result is high levels of stress. Frequent exposure to critical incidents is noted to increase their susceptibility to psychiatric, physical, psychological, and emotional reaction. As a result, intervention strategies are noted as becoming popular for support and protection of those affected.

Aslam (2011:1) identifies the stress causing factors in the A&E units and their linkage with the health related outcomes. The nurses respond to the situation by using certain self – developed coping strategies due to lack of support from the hospital management. Some of the coping strategies are effective whereas some have negative health outcomes.

Regarding little or absence of support for the A&E nurses, literature reveals concern by the previous investigators. There is emphasis that the hospital managers also treat the matter as a subject for concern. This is a crucial matter despite the fact that the nurses may have, as individuals, their private extra – organizational support structures consisting of families and friends. Literature also insists that work – related issues that have a physiological, psychological, and emotional impact on the nurses' health need to receive special attention. The nurses affected have been noted to be reluctant in reporting their experiences because of lack of support from hospital management. Thus, the need to sensitize the hospital management into the existence of issues in the A&E units.

6.4.1.2 Conclusions based on interviews

The interviews led to the description of the nurses' experiences in the A&E units. A close association is noted to exist between the literature findings and the data that was collected during the interviews. This observation is based on the emergence of 4 stress related themes out of 5 themes that were identified. The stress related themes involve working under pressure and stressful conditions, the need for safety and security, limited resources and psychological and emotional problems. Among the problems discussed within the themes, there is anger that is directed by patients and relatives to the nurses, absenteeism that contributes to an increase in work pressure, emotional disturbance, lack of physical security, and lack of continuous support from the hospital management.

Regarding the awareness of the need for support from the hospital management, the findings revealed that the nurses were not totally quiet about the issue. They reported to the hospital managers when the problem was estimated to be beyond their coping

skills. In the same way as it has been discovered in literature, poor or lack of responses discouraged them so that reporting was becoming less frequent.

Single or isolated episodes of support sessions had no effect on the traumatized psychological or emotional state of the nurse. Instead, they created resistance to further invitations for support. The findings therefore finally concluded that the A&E nurses were in desperate need for support from hospital management. A joint effort between the hospital managers and the A&E staff to deal with the issues that generate stress needed to be established and sustained.

6.4.2 Description of coping strategies

Again, conclusions were drawn from both literature and interviews conducted by the researcher on the targeted nurses.

6.4.2.1 Conclusions based on literature review

The nurses' coping abilities in the A&E units are also noted as a subject for concern for the hospital managers. Literature reveals that the nurses, in response to the stress related situations, use their own coping strategies to survive. The nurses are noted to be coping to a certain extent, given certain conditions and personal strengths. These personal strengths are associated with certain demographic characteristics including among other things age, and experience (Healy and Tyrrell (2011:34). When the situation becomes uncontrollable, and the psychological and physical problems intensify, a variety of coping skills, ranging from negative to positive, feature.

The fact that the A&E units are perceived to be overwhelming as a result of very high levels of job stress, suggests that ordinary personal strengths and minimal support to enable the nurses to cope with the situation are not sufficient. Deliberate efforts to assist the nurses overcome the situation need to be in place and constantly revised. At the same time, the efforts to assist the nurses should enhance the coping and supportive strategies, which are already in place. If there are no planned support

intervention strategies, the nurses feel obliged to respond to the A&E incidents according to what they think constitutes work culture expectations.

These include keeping calm or staying in control, keeping going through emotions, carrying out the duties in a manner they were trained to do, listening to everybody around or stepping back to keep oneself intact (Betchel 2009:52). Eventually it becomes rare that their feelings and opinions about the situation are known.

6.4.2.2 Conclusions based on interviews

The interviews revealed a number of coping skills that the nurses were using to cope with various stressful situations. The major concerns involved avoiding conflicts with the patients and relatives, and maintaining stronger relationships among themselves as colleagues. Conflicts with the patients were avoided through controlling the emotions while stronger relationships among the nurses were maintained through good interpersonal relationships. Further strategies depended on the situation. They included requesting help from the nursing managers, prioritizing the tasks, explaining the problems to the patients, and maintaining vigilance where the situation was suspicious.

Control of emotions was used instead of arguing with the patients and the relatives. The nurses realized that argument further heightened the patients' emotions and the nurse did not benefit anything from it. The nurses were therefore exercising caution when dealing with highly emotional patients and relatives. Maintaining good interpersonal relationships helped the nurses to neutralize the consequences of working under pressure. The nurse to nurse as well as the nurse to doctor relationships were described as good. The participants reported that they often summoned the hospital managers' assistance when they encountered problems regarding the workload and safety. Assistance would be made available but sometimes it made no difference.

According to the participants, working in the order of priority also helped the nurses to achieve objectives of patient care to a certain extent. The participants viewed this approach as a kind of informal triaging to manage ones' scope of work. Although it led

to dissatisfaction to other patients, it was noted to be time saving during mass attendance in the A&E unit. In order to gain the patients' co – operation, the nurses would be honest about the situation and explain it to the patients.

The social coping strategies to help with relaxation and to provide time for ventilation were few or non – existent. It was hardly possible to organize them at work though they were very important because of the scarcity of the services of a social worker. However, the nurses advocated for each other when they were confronted.

In summary the nurses were using both the problem and the emotion focused strategies to cope. More emotion focused than the problem solving strategies were used. The use of both these strategies shows that the nurses were not passive when they were confronted by stressful situations. They responded according to what they estimated to be the appropriate response. The problem was that they received little or no support from the hospital managers. In addition, the emotion focused strategies did not remove the problem in that they did not generate any alternative means to change the situation. Instead, the problem stayed unresolved for as long as the nurses' emotions were in order.

6.5 RECOMMENDATIONS

Recommendations are directed towards the future and long-term plans for identification and management of the A&E challenges.

6.5.1 Sensitizing hospital managers about the A&E unit challenges

There is a need to sensitize the hospital managers regarding the existence of the challenges in the A&E units studied and the need to aim for improvements. The participants' discussion during the interviews shows that the nurses will appreciate if the hospital managers are sensitive to the A&E situation.

The hospital managers have a major role to play in addressing the A&E challenges. This role is possible through proper planning for material and psychological needs for

the nurses. For instance, better and sustainable physical and psychological safety measures should be in the plan. Sensitizing the managers should also consist of arrangements to equip them with the necessary skills to handle some of the issues. Undergoing counselling courses for upgrading their knowledge in counselling can enhance their ability to intervene appropriately in times of need. Attending counselling sessions conducted by qualified counsellors for nurses can be expected to expand their skills.

6.5.2 Reviewing and improving the communication system for announcing changes in the A&E unit.

The challenges mentioned by the participants in the study are often associated with the fluctuating situations in the A&E units. For instance, with the surge in the attendance figures, more patient demands, emotional disturbance, and more physical and psychological insecurity can be expected. The future plans should therefore consider designing a method that ensures a continuous feedback to the relevant hospital stakeholders about the A&E situation. The aim should be to enable them to co – operate in decongesting the A&E unit when it overflows with the patients. The figures can be broadcasted. On receiving the message, the doctors can consider discharging better patients, and the laboratory and all other diagnostic departments can fast track their procedures.

6.5.3 Future research

KZN has 13 regional hospitals dispersed over the urban and rural areas of this province. The study was conducted in only 4 regional urban hospitals. Since the findings are not generalizable, the recommendation is that the same study be conducted in the A&E units of the remaining regional hospitals of KZN whether urban or rural. The aim is to establish the possible generalizability of the findings so that the developed strategies can be applied generally.

6.6 CONTRIBUTIONS OF THE STUDY

The study has contributed by giving the nurses of the A&E units studied an opportunity to develop awareness and analysis skills of the work experiences that impact on their well-being. The opportunity has incorporated a skill of deliberating professionally on matters of crucial importance for noting and designing a way forward for survival or better management of the situation.

The investigations conducted have culminated in the development of the strategies that will remain a permanent record for reference should there be a need to revise the A&E working conditions at any particular time in the hospitals studied. In addition, the findings of this study will act as a point of reference for the researchers who wish to take the matter forward by investigating similar situations in the A&E units that did not form part of this study. In this way, a point of transferability of the findings may be reached.

The study has also contributed to the general world of knowledge regarding the factors that affect the well-being of a nurse at work thus compromising the delivery of health services. Thus, the study has drawn focus towards the need to improve the well-being of the A&E nurses, and in turn maintain the work morale of the A&E units and the hospitals concerned.

6.7 LIMITATIONS OF THE STUDY

This study has several limitations. Only 4 regional urban hospitals situated in the Durban and Pietermaritzburg districts of KZN were targeted for the study because of their accessibility to the researcher. The other regional hospitals fell off the target because of their distance for accessibility considering the period that was stipulated for data collection. The inclusion criteria limited the participation to interviews of only those individuals who had accumulated an experience of 1 year or more in the A&E unit. The researcher counted on reach information accumulated over a long period.

During the interview, 2 participants spent 10 minutes less than the stipulated time of 30 minutes interview although they confirmed that they had deliberated as much as they could. The content also looked sufficient to the interviewer. However, it is common course to think that more data could have been accumulated in the 10 minutes lost if the said participants had more information than they had contributed. On the other hand, 2 other participants extended the interview by 10 minutes. The extension impacted on time management although it added bulks of valuable data that was still manageable. The fact that a qualitative study was conducted, limits the application of the findings within the hospital A&E units that were studied. The generalization principle falls off. However, the findings are transferable to institutions with similar problems.

6.8 SUMMARY

The study identified the coping strategies that were used by the nurses to cope with the situation, and further that the hospital managers had no strategy provided for continuous support of the nurses. Strategies were developed to generate a support system of the nurses whose hospital A&E units formed part of the study. The developed strategies were trusted to remain as a record of reference whenever a need arose to revise the working conditions of the nurses in the A&E units that formed part of the study.

6.9 CONCLUDING REMARKS

The implication for the study is for other stakeholders such as hospital nursing management to be aware of the challenges experienced by the nurses working in the A&E units, as well as the strategies the nurses used to cope with daily activities in the units. This would assist with provision of support in the form of employee assistant programmes. Again, this would highlight the importance of holding meetings to indicate the challenges ad design ways to attend to them. This study contributes to the literature about stress in the A&E units, as it explains the experiences with regard to the provision of nursing workforce and the type of activities in the A&E units. Little has been explored regarding these in the South African context. The problems in the A&E

units have always been a debate for nurses in South Africa. However, it was always debated in the form of sharing untold stories of the A&E units rather than presenting concerns. The study emphasizes the importance of nurses' accountability and responsibility regarding their well-being.

LIST OF REFERENCES

Aacharya, RP, Gastmans, C & Denier, Y. 2011. Emergency department triage: an ethical analysis. *BMC Emergency Medicine* 11(16): 1-11.

Adbalrahim, AA. 2013. Stress and coping among psychiatric nurses. *Middle East Journal of Nursing* 7 (2): 1-20.

Adriaenssens, J, de Gucht, V & Maes S. 2012. The impact of traumatic events on emergency room nurses: Findings from a questionnaire survey. *Journal of Nursing Management* 49:1411- 1422.

Adriaenssens, J. de Gucht, V & Maes. 2015. Courses and consequences of occupational stress in emergency nurses, a longitudinal study. *Journal of Nursing Management 51:* 346 – 358.

Aluyemni, A & Alhudaith, H. 2016. Workplace violence against nurses in the emergency department of three hospitals in Ryadh, Saudi Arabia: A cross – sectional survey. *Nursing Plus Open 2: 35 – 41.*

Arik, C., Anat, R & Arie, E. 2012. Encountering anger in the emergency department: Identification, evaluation and responses of staff members to anger displays. *Emergency Medicine International 60315:2.*

Atakro, CA., Ninnoni, SP., Adatara, P., Gross, J & Abravor, M. 2016. Qualitative inquiry into challenges experienced by registered general nurses in the emergency department: A study of selected hospitals in the Volta region of Ghana. *Emergency Medicine International Volume 602105: 1-7.*

Ariapooran, S. 2013. The prevalence of secondary traumatic stress among nurses in Iran, Malayer: The predicting role of mindfulness and social support. sariapooran@malayeru.ac.ir.

Aslam, N. 2011. Need for revision of psychological support services to nurses working in emergency sections of government hospitals. *Editorial* 23 (4): 1-4.

Autism speaks Inc. 2012. What are the positive strategies for supporting behaviour improvement?

Babbie, E., & Mouton, J., Vorster, P & Prozesky, B. 2011. The practice of social research. South African edition. Oxford.

Borré, D, Tan, M & Figley, C. 2011. Compassion satisfaction, burnout, and compassion fatigue among emergency department nurses: A quantitative descriptive study. Cr Figley.

Botma, Y, Greeff, M, Mulaudzi, FM & Wright, SCD. 2010. Research in Health Sciences. Heinemann.

Brink, H, van der Walt, C & Van Rensberg, G. 2016. Fundamentals of research methodology. Cape Town: Juta.

Bulbulia, A. 2015. Childhood pedestrian mortality in Johannesburg, South Africa: Magnitude, determinants and neighbourhood characteristics.

Carrus, B., Corbett, S & Khandelwal D. 2010. A hospital-wide strategy for fixing emergency-department overcrowding. Insights & Publications. Los Angeles.

Chou, LP, Li, CY & Hu SC. 2014. Job stress and burnout in hospital employees: Comparisons of different medical professions in a regional hospital in Taiwan. *BMJ Open* (4):1-10.

Cicognani, E, Pietrantoni, L, Palestini, L & Prati, G. 2009. Emergency workers' quality of life: The protective role of the sense of community, efficacy beliefs and coping strategies. *Springer Science and Business Media* 94: 449 – 463.

Creswell, JW. 2014. Research design – Qualitative, quantitative, and mixed methods approaches. Fourth edition. Los Angeles: Sage. Los Angeles.

Creswell, JW. 2009. Research design: Qualitative, quantitative, and mixed methods approaches 3rd ed. Thousand Oaks, CA: Sage.

Da Silva, LG., Matsuda, LM & Wadman. 2012. The structure of a public emergency care service, from the workers' view: perspectives on quality. *Scielo* 21 (2) 320 – 328.

Davis, JA. 2013. Critical incident stress debriefing from a traumatic event. Psychology today.

Desai, A. 2013. What are the three success criteria for strategy evaluation? Sri Lanka, Hohenstein, India Pty, Ltd.

Devilly, GJ, Wright, R & Varker, T. 2009. Vicarious trauma, secondary traumatic stressor simple burnout. Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry* 43: 375 – 387.

Dörnyei, Z. 2015. Research methods in applied linguistics: Quantitative, qualitative and mixed methodologies. Oxford University press. UK.

Edmunds, MW. 2010. Caring too much: Compassion fatigue in nursing. From http://www.medscape.com.

Erasmus, J. 2014. Victims in KZN sex crime capital 'starting to put their foot down'. The Witness, 29 September 2014 00h00.

Fain, JA. 2015. Reading, understanding, and applying nursing research. 4thedition. FA Davis Company. Philadelphia.

Fakih, FT, Tanaka, LH & Carmagnani, MIS. 2012. Nursing staff absences in the emergency room of a university hospital. *Scielo Analytics 25(3): 1-7.*

Faridaalaee, G., Nikzad, F & Rahmani. 2015. Cause of death in emergency department. *Iranian Journal of Medicine 2(1) 45 - 48* Dolezal, L., Lyons, B. 2017. Health – related shame: An affective determinant of Health? *Medical Humanities 43(4) 257 – 263.*

Filha, MMT., de Souza Costa, MA& Guilam, MCR. 2013.Occupational stress and self-related health among nurses. *Revista Latimo – Americana Enfermagem* 21 (2) 475 – 483.

Fjeidheim, CB, Nöthling, J, Pretorius, K, Basson, M, Ganasen, K, Heneke, R, Cloete, KJ &Seedat, S. 2014. Trauma exposure, posttraumatic stress disorder and the effect of explanatory variables in paramedic trainees. *BMC Emergency Medicine* 14:1-11.

Gacki-Smith J, Juarez, AM, Homeyer, Boyett, L., Homeyer, C, Robinson, L & Maclean, SL. 2009. Violence against nurses working in US emergency departments. *Lippincotts Nursing Center.com*.

Gholamzadeh, S, Sharif, F & Rad, FD. 2011. Sources of occupational stress and coping strategies among nurses who are working in Admission and Emergency Department in Hospitals affiliated to Shiraz University of Medical Sciences, Iran. *Iranian Journal of Nursing and Midwifery Research* 16 (1): 42 – 47.

Guest, C., Namey, ER & Mitchell, ML. 2015.Collecting qualitative data: A field manual for applied research. Sage. Los Angeles.

Healy, S & Tyrrell, M. 2011. Stress in emergency departments: experiences of nurses and doctors. *Emergency Nurse* 19 (4): 31 – 38.

Holloway, I & Wheeler, S. 2010. Qualitative research in nursing and healthcare.3rd edition. Wiley – Blackwell.

Hospital security Guard. 2013. KZN. Department of Health.

Houck, D. 2014. Helping nurses cope with grief and compassion fatigue: An educational intervention. *Clinical Journal of Oncology Nursing* 18 (4): 454.

Johnston, A., Abraham, L., Greenslade, J., Thom, O., Carlstrom, E., Wallis, M &Crilly, J. 2016. Review article: Staff perception of the emergency department working environment: Integrative review of the literature *Emergency Medicine Australasia* 28 (16): 7-26.

Keene, EA, Hutton, N., Hall, B & Rushton, C. 2010. Bereavement debriefing sessions: an intervention to support health care professionals in managing their grief after the death of the patient. *NCBI.*

Kennedy, M & Julie, H. 2013. Nurses' experiences and understanding of workplace violence in a trauma and emergency department in South Africa. *Health SA Gesondheid Journal of Interdisciplinary Health Sciences* 18 (1): 1- 8.

Khamisa, N., Oldenburg, B., Peltzer, K & Ilic, D. 2015. Work related stress, burnout, job satisfaction and general health of nurses. *International Journal of Environmental Research and Public Health* 12 652 – 666.

Kossek, EE, Pichler, S., Bodner, T & Hammer, L. 2012. *Pers Psychol*. 64 (2): 289 – 313.

Kumar, R. 2011. Research methodology: a step-by-step guide for beginners 3rd edition. Sage. Los Angeles.

Kuo, BCH, Arnold, R & Rodriguez-Rubio, B. 2013. Mediating effect of coping in the link between spirituality and psychological distress in a culturally diverse undergraduate sample. Online http://www.tandfonline.com/loi/rhpb20 1-7.

Kuo, CH. 2013. Coping, acculturation and psychological adaptation among migrants: A theoretical and empirical review and synthesis of the literature. *Health Psychology and behavioural medicine* online http://www.tandfonline.com/loi/rhpb20.

KwaZulu-Natal Department of Community Safety and Liason. 2010. Preventing sexual violence in KZN. South Africa.

Lavoie, S, Talbot, LR & Mathieu L. 2011. Post-traumatic stress disorder symptoms among emergency nurses: their perspective and tailor – made solution. *Journal of Advanced Nursing* 67 (7) 1514 – 1522.

Lazarus, RS & Folkman, S. 1984. Stress, appraisal and coping. Springer Publishing Company.

Lyon, BL. 2012. Stress, coping, and health: A conceptual overview. *Semantic Scholar.*

Magnavita, N & Heponiemi, T. Violence towards heath care workers in a Public Health Care Facility in Italy: a repeated cross-sectional study. *BMJ open* 7:1-15.

Maloney, C. 2012. Critical incident stress debriefing and paediatric nurses. Paediatric Nursing 38(2) 110 – 113.

Maltby, J., Williams, G., McGarry, J & Day, L. 2010. Research methods for nursing and healthcare. Springer.

Masia, RT., Basson WJ & Ogubanjo, GA. 2015. Emotional reactions of medical doctors and students following the loss of their patients at the Dr George Mukhari Hospital, emergency unit, South Africa. *South African Family Practice* 52 (4) 356 – 363.

McKay, B & McKay, K. 2015. How to develop the situational awareness of Jason Bourne.

Mazzotta, C. 2015. Paying attention to compassion fatigue in emergency nurses. *AJN* 115 (12): 1-13.

Moodley, NB., Aldous, C & Clarke, DL.2014. An Audit of trauma – related mortality in a provincial capital in South Africa. *South African Journal of Surgery* 52 (4)101 – 104.

Mwale, OG. 2013. Reactions to Socio – environmental stress. From: http://www-Slideshare.net. Accessed 27 July 2013.

Newton, SA. 2011. Relatives' and nurses' experiences of sudden death in accident and emergency departments: A qualitative study. University of Huddersfield. UK.

O' Leary, Z. 2010.The essential guide to doing your research project. Sage. Los Angeles.

O' Reilly, M & Kiyimba, N. 2015. Advanced qualitative research: A guide to using theory. Sage. Los Angeles.

Pascasie, K & Mtshali, NG. 2013. A descriptive analysis of Emergency Department overcrowding in a selected hospital in Kigali, Rwanda. *African Journal of Emergency Medicine 13:* 1- 6.

Pillay, KK, Ross, A & van der Linde, S. 2012. Trauma unit workload at King Edward V111 Hospital, Durban, KwaZulu-Natal. *SAMJ: South African Medical Journal 102(5): 1-10.*

Pino and Rossini. 2012. Perceived organizational stressors and interpersonal relationships as predictors of job satisfaction and well – being among hospital nurses. *International Journal of Psychology and Behavioural Science2* (6) 196 – 207.

Polit, F & Beck, CT. 2012. Nursing research: Generating and assessing evidence for nursing practice. London: Lippincott& Wilkins.

Quain, S. 2018. How to do a Rumelt evaluation method. azcentral. USA.

Qureshi, NA. 2010. Triage Systems: A review of the literature with reference to Saudi Arabia. *Eastern Mediterranean Health Journal* 16 (6): 690 – 698.

Rajin, J. 2012. Employee assistance programme in the South African Police Services: a case study of Moroka Police Station. University of South Africa. Pretoria.

Ray, SL, Wong, C, White, D &Heaslip, K. 2013. Compassion satisfaction, compassion fatigue, work life conditions and burnout among frontline mental heal care professionals. *Sage* 19 (4) 255 – 267.

Rebar, CR., Gersch, CJ. Macnee, CL & McCabe, S. 2012.Understanding nursing research in evidence - based practice. 3rd edition. Wolters Kluwer.

Rebar, CR., Gersch, CJ, Macnee, CL & McCabe, S. 2011. Understanding nursing research: Using research in evidence-based practice. Wolters Kluwer.

Robinson, KS, Jagim, MM & Ray, CE. 2011. Nursing workforce issues and trends affecting emergency departments.

Rosedale, K. Smith ZA. Davies, H & Wood, D. 2011.The effectiveness of the South African Triage Score (SATS) in a rural emergency department. *South African Medical Journal 101 (8): 537 – 540.*

Rossetti, AC., Gaidzinski, RR & Fugulin, FMT. 2013. Nursing work- load in emergency department. *Rev. Latimo-AM Enfermagem* 21 (2)475 – 483.

Sacco, TLC, Yurzynski, SM, Harvey, ME & Ingersoll GL. 2015. Compassion satisfaction and compassion fatigue among critical care nurses. *Critical care Nurse* 35 (4): 1-35.

Sanders, K, Patison, S & Hurwitz, B. 2011.Tracking shame and humiliation in Accident and Emergency. *Blackwell publishing Ltd Nursing Philosophy 12: 83 – 93.*

Scott, SD., Hirschinger, LE, Cox, KR., McCoig, M., Brandt, J & Hall. 2009. The natural history of recovery for the health care provider 'second victim' after adverse patient events. *Quality Safety Health Care* 18: 325 – 330.

Seys, D, Scott, SD., Wu, A, Van Gerven, E, Vleugels, A, Euwema, M, Panella, M, Conway, J., Sermeus, W & Vanhaecht, K. 2012. Supporting involved health care

professionals (second victims) following an adverse health event: A literature review. *International Journal of Nursing Studies* 7(6): 1-20.

Seys, D., Wu, A., Van Gerven, E., Vleugels, A., Euwema, M., Panella, M., Scott, SD., Conway, J., Sermeus, W & Vanhaecht, K. 2012. Health care professionals as 'second victims' after adverse events: A systematic review. Evaluation and the Health Professions 00 (0) 1 – 28.

Shoenberger, MD., Yeghiazarians, S., Rios, C & Henderson, SO. 2012: 181. Death notification in the emergency department: Survivors and physicians. *Western Journal of Emergency Medicine* 14 (2) 181 – 185.

Singh, GP. 2013. Job stress among emergency nursing staff: A preliminary study. *Indian J Psychiatry* 55 (4): 407 – 408.

Singh, UA. 2015. In – house vs outsourced EAP*. OPTUM – Pioneer in EAP services.* Utkarsh.singh@optum.com.

Sterud, T., Hem, E., Lau, B & Ekeberg O. 2011. A comparison of general and ambulance specific stressors; Predictors of job satisfaction and health problems in a nationwide one-year follow-up study of Norwegian Ambulance personnel. *Journal of occupational medicine and toxicology* 6:10 http://www.Occup-med.com/content/6/1/10.

Streubert, SJ& Carpenter, DR. 2011. Qualitative research in nursing: Advancing the humanistic imperative. Wolters Kluwer/Lippincott, Williams & Wilkins.

Tomajan, K. 2012. Advocating for nurses and nursing. *American Nursing Journal (The Online Journal of Issues in Nursing* 17: 1-29.

Uren, SA & Graham TM. 2013. Subjective experiences of coping among caregivers in palliative care. The Online Journal of Issues in Nursing 19 (2): 1-20.

Walliman, N. 2011. Your research project: Designing and planning your work.3rd edition. Sage. Los Angeles.

Wallis LA, Garach SR. & Kropman A. 2008. *State of emergency medicine in South Africa International Journal of Emergency Medicine in South Africa 1 (2):1.*

Ward, C. 2012. Violence, violence prevention, and safety: A research agenda for South Africa. The South African Medical Journal 102 (4): 215.

Ward, CL, Artz, L., Berg, J., Boonzaier, F, Crawford-Brownne, S, Dawes, A, Foster, D., Matzopoulos, R, Nocol, A, Seekings, J, Van As, AB & Van der Spuy, E. 2012. Violence, violence prevention, and safety: A Research agenda for South Africa.

ANNEXURES

ANNEXURE 1

REGIONAL HOSPITALS AT KZN

HOSPITAL	DISTRICT	URBAN/RURAL	A&E UNIT
Addington	EThekwini	Urban	√
Edendale	uMgungundlovu	Semi - rural	√
King Edward	EThekwini	Urban	√
Ladysmith	UThukela	Urban	√
Madadeni	Amajuba	Rural	√
Mahatma Gandhi	EThekwini	Semi - rural	√
Newcastle	Amajuba	Urban	N/A (Maternity Hospital)
Ngwelezane	UThungulu	Rural	√
Port Shepstone	UGu	Semi - rural	√
Prince Mshiyeni	EThekwini	Rural	√
R. K. Khan	EThekwini	Urban	√
St Aidans	EThekwini	Urban	√
Stanger	ILembe	Rural	√
King Dinuzulu	EThekwini	Urban	√

KwaZulu-Natal Department of Health {Sa}: 1)

ANNEXURE 2

ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA

Health Studies Higher Degrees Committee

College of Human Sciences

ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/328/2014

Date:	11 June 2014	Student No: 457-501-6
Project Title:	Strategies to enhance the support systems of nurses in an Accident and Emergency Unit of a Regional Urban Hospital at KwaZulu-Natal	
Researcher:	Chinisile Albertina Mbokazi	
Degree:	D Litt et Phil	Code: DPCHS04
Supervisor:	Prof MC Matlakala	
Qualification:	M Cur	
Joint Supervisor:	-	

DECISION OF COMMITTEE

Approved ☒ Conditionally Approved ☐

Prof L Roets

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

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

ANNEXURE 3

REQUEST TO CONDUCT RESEARCH

Z 581
Umlazi Township
P.O. Umlazi
4031
2 February 2016

The Head of Department
Department of Health (KZN)
PIETERMARITZBURG
3200

Dear Sir/ Madam

REQUEST TO CONDUCT RESEARCH

I am a student at the University of South Africa, doing a Doctoral Degree in Health Sciences. My research topic is about '**Enhancing the support systems of nurses in an accident and emergency unit of a regional urban hospital at KwaZulu-Natal'.**

The purpose is to explore and describe the nurses' experiences of working in the accident and emergency (A&E) unit of a regional urban hospital at KwaZulu-Natal, how nurses cope, and their suggestions regarding the support systems that they would appreciate if provided for them. The information obtained will be used to develop the support systems for A&E nurses within the working environment.

An A&E unit of one of the three regional urban hospitals within your sector, namely, RK Khan, Addington, and King Edward VIII Hospital, would be an appropriate place for conducting the study because of their accessibility to the researcher, and the fact that they have nurses who have worked for a reasonable period of one year and above in the A&E unit.

I would like to approach the said nurses for the study. The student nurses will be excluded because of their routinely limited exposure within each hospital nursing unit due to their training needs. The number of participants recruited will therefore depend on the number of nurses who meet the criteria stated. Prospective participants will be requested to give consent, and this will be explained in English. Confidentiality of information will be assured to participants. Liberty to withdraw from participation at any point will be assured.

It is envisaged that the results of the study will provide an amount of information regarding nurses' encounters/experiences associated with working in the accident and emergency unit, how they cope with the situation, and how they would like to be supported. Recommendations will depend on the type of information yielded. The results will be made available to participants through the manager of the hospital. Also, they will be published to ensure that information is available to the community.

Yours faithfully

CA Mbokazi (Miss)

ANNEXURE 4

APPROVAL LETTER – DEPARTMENT OF HEALTH OF KWAZULU-NATAL

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
Health Research & Knowledge Management

Physical Address: 330 Langalibalele Street, Pietermaritburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

HRKM Ref: 221/16
NHRD Ref: KZ_2016RP31_570

Date: 26 July 2016
Dear Ms CA Mbokazi
UNISA

Approval of research

1. The research proposal titled **'Strategies to enhance the support systems of nurses in an Accident and Emergency Unit of a Regional Hospital in KwaZulu Natal'** was reviewed by the KwaZulu-Natal Department of Health.

   The proposal is hereby **approved** for research to be undertaken at Addinton, King Edward VIII, King Dinuzulu, Mahatma Gandhi, RK Khan, St Aidan's and Grey's Hospital.

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

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

For any additional information please contact Mr X. Xaba on 033 395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 27/07/16

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE 5
CONSENT FORM

TITLE: Enhancing the support systems of nurses in an accident and emergency unit of a regional urban hospital at KwaZulu-Natal.

RESEARCHER: CA Mbokazi (RN, RM)

You are invited to participate in a research study under the above mentioned title.

The purpose of the study is to explore and describe the experiences of nurses working in the accident and emergency (A&E) unit of a regional urban hospital at KwaZulu-Natal (KZN). The information obtained will be used to develop the support systems for A&E nurses within the working environment.

You will be requested to participate in an interview.

The study will benefit you in that it will allow you an opportunity to consider the encounters/experiences associated with your working in the A&E unit, which may suggest the relevant support systems that can be developed for KZN nurses working in these units. You will be able to describe and relate freely, your experiences, feelings, opinions and/or views.

No risks are anticipated in the study. During the interview, you will be with the researcher for ±30 minutes where you will relate freely as much as you can. A record will be kept regarding your participation though your name will not appear in the record. This is to ensure that data collected is not linked with your name. Data will be stored in a safe place for confidentiality. Your identity will not be revealed when the study is reported or published.

If you have any questions about the study, contact me at 076 9444 028 (mobile). If you have questions about your rights as a research participant, you are allowed to contact the Higher Degrees Committee of the Department of Health Studies, University of South Africa, PO Box 392, 0003, South Africa.

Your participation in this study is voluntary. You will be permitted to use your own language where there is a need for clarification. You reserve the right to withdraw from the study at any time if you feel so without penalty.

The Higher Degrees Committee of the Department of Health Studies, University of South Africa, has approved the study and its procedures.

……

I have discussed the above points with the prospective participants. In my opinion, the prospective participants understand the topic, benefits of participation, and their rights.

Researcher Date……

I understand that my participation is voluntary, and that I may withdraw my consent at any time without penalty.

I hereby consent to take part in the research project

Signature of participant Date……..

Signature of witness Date……..

ANNEXURE 6

DATA COLLECTION FORM

ENHANCING THE SUPPORT SYSTEMS OF NURSES IN AN ACCIDENT AND EMERGENCY UNIT OF A REGIONAL URBAN HOSPITAL AT KWAZULU-NATAL

Pseudo name of interviewee	
Professional category	
Length of A&E experience	
Interviewer	
Date and time of interview	
Question	'Describe your experiences of working in the accident and emergency unit'
Follow-up question	Please share the strategies you use to deal with the challenges you experience in the A&E units.

Thank the participant

ANNEXURE 7
TURNITIN ORIGINALITY REPORT

The support systems of nurses in the accident and emergency unit of regional urban hospital at KwaZulu-Natal

by Chinisile Mbokazi

Submission date: 16-Nov-2018 02:07PM (UTC+0200)
Submission ID: 1040255021
File name: All_Chapters_4_3.docx (947.77K)
Word count: 43501
Character count: 242206

Enhancing the support systems of nurses in the accident and emergency unit of regional urban hospital at KwaZulu-Natal

ORIGINALITY REPORT

10% SIMILARIT Y INDEX
8% INT ERNET SOURCES
3% PUBLICATIONS
4% STUDENT PAPERS