# PHENOMENOLOGICAL ANALYSIS OF THE EXPERIENCES OF NEWLY QUALIFIED NURSES DOING COMMUNITY SERVICE IN THE EASTERN CAPE

by

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## DEDICATION

*In memory of my late parents:*

*Alex, my father*

*and my mother*

*Caroline Songqushwa*

**Student No: 5008344**

## DECLARATION

**I declare that PHENOMENOLOGICAL ANALYSIS OF THE EXPERIENCES OF THE NEWLY QUALIFIED NURSES DOING COMMUNITY SERVICE IS IN THE EASTERN CAPE** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before in any other degree at any institution.

**SIGNATURE** **DATE**

**(ADELICIA NOMAWETHU MBATHA)**

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# ABSTRACT

The purpose of this study was to explore and obtain research-based information regarding the lived experiences of newly qualified nurses doing community service (CS) in the Eastern Cape Province and suggested improvements to the future implementation of community service for newly qualified nurses. The research question was: *How do newly qualified professional nurse's experience doing community service? p*osed to interviewees as: "*How do you (did you) experience doing community services?"* This question stemmed from an interest to understand newly qualified nurses' experience of their initial encounter as professional nurses to assist in supporting the newly qualified nurses.

The researcher embarked on a descriptive and interpretive phenomenological journey within the qualitative research paradigm. Purposive sampling yielded participants for in-depth interviewing. Six interviews with six participants who worked either in rural or urban hospitals and clinics lead to data saturation. Data analyses involved both the idiographic and nomothetic levels of analyses as proposed by Wertz (1983).

The findings of the study revealed the existential baseline of the newly qualified nurse, their conceptualisation of the topic of interest in experiential terms, positive experiences, negative experiences and the articulated needs to improve their competencies.



**KEYWORDS**:

Phenomenology, newly qualified nurses, community service, experiences, learning, transition, adaptation, confidence, competent, independent.

## ISISHWANKATHELO

Injongo yolu phando-nzulu yayikukufumana ulwazi oluphandisisiweyo ngamava okwenene abongikazi abasandul' ukuphumelela izifundo zoqeqesho lwabongikazi xa bebesenza umsebenzi woluntu (*Communityi Service*), nokwalatha iindlela ezintsha emazilandelwe ekumiselweni komsebenzi woluntu kwixa elizayo. Umbuzo ebekufanele uphendulwe luphando ngothi: Athini amava abongikazi abaziingcali abasandul'ukuphumelela izifundo zoqeqesho lwabo xa bebesenza umsebenzi woluntu? Lo mbuzo wawundululwa ngumdla wokuba kuqondwe ukuba athini na amava abongikazi abasandul'ukuphumelela izifundo zoqeqesho ngokuphathelele kwizinto abagagana nazo bengabongikazi abaziingcali, ukuxhasa abongikazi abasandul'ukuphumelela izifundo zabo.

Umphandi-lwazi (researcher) wafuna ukuba bawachaze la mava, andule ke yena ukuwaphicotha kwinkqubo yokuqwalasela ubume bawo, kumngxilo wophando ngokuxabiseka kwezinto. Inkqubo yokuqokelela ulwazi ngeenjongo ezingqalileyo yakhokelela kubathathi-nxaxheba ekwaqhutywa nabo udliwano-ndlebe olunzulu. Kwaqhutywa udliwano-ndlebe nabathathi-nxaxheba abathandathu ababesebenza kwizibhedlele neeklinikhi zasemaphandleni okanye ezidolophini olwathi lwabonakalisa ukuba akusekho zincukacha zintsha zinokubuya zifumaneke. Kwasetyenziswa uphicotho lwamava omntu ngamnye kwaza kwenziwa nolukuqwalaselwa kwamava abo bonke.

Iziphumo zolu phando zabonakalisa ubume obusisiseko bokuba mtsha kubongikazi, iindlela abathi abongikazi bayithathe ngayo engqondweni le ngongoma yomdla ngokwamava abo, amava ancomekayo, amava angemahle kwaneemfuno ezichazwayo zokuphucula izakhono zabo.

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**LIST OF ABBREVIATIONS**

| | |
|---|---|
| BCMM | Buffalo City Metropolitan Municipality |
| CSNP | Community service nurse practitioner |
| DA | Democratic Alliance |
| DENOSA | Democratic Nurses Organisation of South Africa |
| EBSCO | Elton B Stephen Company (Collection of data bases for) research |
| EC | Eastern Cape Province |
| EDL | Essential Drug List |
| CBE | Community Based Education |
| CINAHL | Cumulative Index to Nursing and Health Literature |
| CS | Community service |
| CSNP | Community Service Nurse Practitioner |
| ECSECC: | Eastern Cape Socio-Economic Consultative Council |
| EPPR | Empirical Phenomenological Psychological reflection |
| GSPD | General Structural Phenomenological Description |
| GPS | General Psychological Structure |
| HRD | Human resource department |
| IFP | Inkatha Freedom Party |
| IPD | Individual Phenomenal Description |
| IPBS | Individual Psychological Baseline Structure |
| MDG | Millennium Developmental Goal |
| MEC | Member of Executive Committee |
| NDoH | National Department of Health |
| NEHAWU | National Education and Health Allied Workers Union |
| HIV/AIDS | Immune Deficiency Virus/Acquired Immune Deficiency Syndrome |
| NGO | Non-Governmental Organisation |
| NHI | National Health Insurance |
| NQPN | Newly qualified professional nurses |

| | |
|---|---|
| PBL | Problem- Based Learning |
| PHC | Primary Health Care |
| SADA | South African Democratic Alliance |
| SANC | South African Nursing Council |
| SAPA | South African Press Association |
| SASCO | South African Student Congress |
| SDG | Sustainable Developmental Goals |
| SAMMA | System for Automated migration of media Archives |
| SANTA | South African Tuberculosis association |
| SSA | Statistics South Africa |
| SASA | South African Student Association: |
| TB | Tuberculosis |
| UFH | University of Fort Hare |
| UK | United Kingdom |
| UNISA | University of South Africa |
| USA | United States of America |
| WHO | World Health Organisation |
| WSU | Walter Sisulu University |

# CHAPTER 1

OVERVIEW AND INTRODUCTION TO THE STUDY

## 1.1 INTRODUCTION

This qualitative phenomenological research study on the lived experiences of NQPNs' community service (CS) was conducted in the Eastern Cape Province of South Africa. The study addressed the NQPN's experience of their placement in the clinical facilities to fulfil their community service obligation. The study focused on discovering the lived experiences of the participants (newly qualified professional nurses) while doing CS. The study provided an understanding of the extent to which the objectives of CS have been accomplished and could assist in improving its implementation and improve its quality. The existential baseline of the participants comprised their experiences as student nurses.

The overall research question for the study was, *"What are your experiences of doing community service?"* Alternatively*, "How was it like doing CS?"* In-depth phenomenological interviews, on participants' lived experiences as newly qualified professional nurses doing CS, provided the answer to the research question. Clear explanations of such lived experiences emanated from the clues, cues hints, and intimations the participants provided.

The newly qualified professional nurses referred to in this study, were nurses who had been educated and trained in a four-year integrated diploma or basic degree courses leading to registration as a Nurse (general, psychiatric, community) and Midwife according to Regulation R425 of 22 February 1985, as amended (SANC 1985).

## 1.2 BACKGROUND INFORMATION ON THE EASTERN CAPE PROVINCE (ECP)

The Eastern Cape Province (ECP) covers about 169,580 square kilometres, which is 13.8 % of the land area of the Republic of South Africa. It has a population of

7,130,480 of which 88% are black of whom the majority live in the former homelands of the Transkei and Ciskei. Fifty percent (50%) of the population resides in less than a third of the province's land. The province is mostly underdeveloped and close to 70% of its population lives below the poverty line (ECSECC, 2012). According to Hoffman and Todd (2012:46), the ECP is characterised by a high incidence of teenage pregnancies, a soaring disease profile including communicable diseases, (e.g., HIV/AIDS, TB), non-communicable disorders (e.g., metabolic syndrome, and mental illness) as well as childhood illness (e.g., measles, mumps, diarrhoea, late diagnosis of diseases and disabilities), and family violence resulting in high death rates. The Eastern Cape provides health care through health care facilities, as shown in table 1.2 to a diverse population, as depicted in table 1.1.

**TABLE: 1.1 Eastern Cape Province population distribution and economic profile (2011)**

| **Population by Race** | | |
|---|---|---|
| | **N** | **%** |
| Africans: Black | 5,448,495 | 86% |
| Coloureds | 468,532 | 7.4% |
| Indians | 19,356 | .3 % |
| Whites | 330,294 | 6% |
| **Population Distribution** | | |
| | Urban | 36.6% |
| | Rural | 63.4% |
| **Economy** | | |
| Poverty rate: Mostly in the rural area | | 64.4% |
| Unemployment rate based on the country's statistics | | 48% |

## 1.3 MAGISTERIAL DISTRICTS OF THE EASTERN CAPE PROVINCE

While South Africa constitutes 367 magisterial districts, 78 of those belong to the ECP. The researcher conducted the study in the Amathole District of the ECP, according to the national system of districts and municipalities. The Amathole District

covers an area that includes land from the Apartheid (before 1994) South African Republic, namely the former homelands of the Transkei and Ciskei.

The study was conducted specifically in the Buffalo City Metropolitan Municipality (BCMM) within the Amathole District. This municipality covers about 2,750 square kilometres. It has a population of 834,997 and a population density of 303.6 per square kilometre. The BCMM ascends from East-London at sea level to about 1,200 meters at Dimbaza in the west. It includes Bisho (formerly King William's Town) the Eastern Cape Province's capital, Mdantsane, the second largest South African township and the industrial hub of Berlin. East London hosts headquarters of the Amatole District.

Further, East London has attractive and expansive landscapes and coastal planes, which form a valuable base for a quality life. It acts as a centre for trade, commerce, and industry. Unfortunately, East London is densely populated and constitutes many disadvantaged communities and underdeveloped rural areas. Two universities; Walter Sisulu (WSU Campuses) and the University of Fort Hare (UFH), are in East London as well as other tertiary institutions and primary and secondary schools.

The students (interviewees) were mostly from the University of Fort Hare and the local Campus of the Nursing College of the ECP, including five main campuses and 21 satellite campuses distributed throughout the province. Table 1.2 shows the names of potential CS allocation sites for NQPNs in the ECP.

**TABLE: 1.2 Amathole District: Number of public healthcare facilities**

| **FACILITY:** | **N** |
|---|---|
| Regional/ Provincial | 10 |
| Psychiatric Hospitals | 5 |
| District Hospital | 47 |
| Lifecare Managed Hospitals | 4 |
| SANTA | 8 |
| **Sub-total** | **74** |
| CHC | 28 |
| Clinics | 711 |
| **Total Public healthcare facilities** | **813** |

## 1.4 THE BACKGROUND TO THE RESEARCH PROBLEM

The World Health Organisation (WHO 2003:110) declares “the most critical issue facing health care systems is the shortage of people to make them work.” The shortage of human resources has disastrous effects on health care systems. Limited numbers of staff rendering health care, leave them burdened by an increased workload and increased responsibilities, which lead to burnout. The latter manifests in stress, high levels of emotional exhaustion, energy depletion, social instability, and reduced work satisfaction and efficiency (Konis, Giannou & Saridi 2015:[Sa]) . Thus, workers become de-motivated and work less effectively (Thu, Wilson & Mc Donald 2015:1). While health care providers fall short in rendering the required healthcare services; healthcare consumers experience difficulties, and even an inability, to access available health care systems. The ensuing subsections discuss this matter further.

### 1.4.1 Concern about accessibility to health care

Access to, and equity in health care are fundamental human rights of every citizen, especially in a democracy hailing transparency and equity as the South African Constitution does (South Africa 1996:12; Scheffler, Visagie, Schneider 2015:[Sa]). Katterl (2011:1) also emphasises that available health services should be accessible to all citizens irrespective of their level of need. The inability to access the health care delivery system, particularly by people who live in the rural and urban underserved communities, is a significant concern.

In South Africa, this is a serious health care problem, and is associated with a range of factors, for instance, socio-economics, geographical locations, availability of health care professionals and facilities to provide health care Scheffler et al 2015 [Sa], and it ( inaccessibility) denies individuals their rights to health care, further marginalising them and their communities. Disparities in health status and inadequate coverage of communities urged the South African National Department of Health, to come up with strategies to address the problem. The South African Government thus introduced compulsory Community Service (CS) for all health professionals in 1998 to ensure the fair distribution of health professionals to rural

communities, further develop the skills of newly qualified health professionals and thus curbing the problem of healthcare accessibility and delivery, especially in underserved areas.

#### 1.4.1.1 Demographics and health care accessibility

Disparities in health status by income, gender, age, ethnicity, and geographical residence occur in both developed and underdeveloped countries (Boelen & Heck 2017:8). Notwithstanding, all governments have the responsibility to respond to the health needs of communities, to be vigilant and prepared to mobilise means to assist communities at risk of their social rights to health care being jeopardised.The maldistribution of health care workers and inadequate coverage of communities with health care services are national concerns that need rectification as they impact negatively on health care delivery (Maphumulo & Bengu 2015:[Sa]. Motsoaledi (2017:1) corroborates the idea of access to health care by all South Africans with a vision of a single seamless Department of Health that would ensure pulling together all medical funds of South Africans, irrespective of their economic status, into a National Health Insurance (NHI) System. Such a system would enhance access for all citizens to decent quality healthcare services, irrespective of status, and income according to Motsoaledi (2017:1) (South African Minister for Health 2011). Harris, Goudge Ataguba and McIntyre 2011:[Sa]) assert that inequalities of communities presents a barrier to access health care , especially in rural and urban underserved communities, and this is a serious health care problem. This undermines the rights of marginalised communities to access mainstream health services. Furthermore, it deters the implementation of the minimum standards set for health services to ensure a vibrant and productive life for all communities. Boelen (2017:12) urges that health care values should be maintained and upheld to ensure that people's health needs are better considered and met.

#### 1.4.1.2 Socio-economic factors affecting the accessibility of health care

Education, income, and employment determine a person's socio-economic status (Katterl 2011:1). It relates positively to how people engage in and utilise available health care services. In this regard, Grut, Braathen, and Ingstad (2012:2) assert that poverty, mostly emanating from unemployment and deprivation of income, poses a significant barrier to rural communities to access health care facilities. Over and above that, high rates of illiteracy within the deep rural areas contribute to a lack of knowledge on health issues and healthy lifestyles, as well as ignorance about the kinds of services available in the community. Montevecchi (2012:18) also highlights socio-cultural and political factors as barriers to the access and delivery of health care.

#### 1.4.1.3 Geographic factors affecting the accessibility of health care

Literature indicates that geographical factors often create barriers that prohibit healthcare consumers from accessing health care services. The geographical challenges that deter health care consumers from accessing healthcare services include distance to the health care facilities, harsh weather conditions, and mountainous landscapes (Luis, and Pedro 2016:2; Montevecchi 2012:19).

In the Eastern Cape Province, most of the areas where people reside, especially the former Transkei, are rural and not easy to access. Vergunst, Swartz, Mji, and Mac Chachlant's (2015: [Sa]) study conducted at Madwaleni discusses the barriers and geographic topography concerning the infrastructure and access to health care services. Rugged hills, valleys, forests, and unpaved gravel roads characterise the Madwaleni area. Rain causes roads to become muddy and slippery, and valley beds form rapid running streams, making it unsafe for people to travel to health care facilities. Households sporadically scatter the hills, making it difficult for health professionals to access these communities. Partially apportioned small and isolated communities also make it challenging to provide health care facilities to those in need of it. Varela, Young and Viste (2019:[Sa]) also assert that scarcity of the mode of transport as well as unaffordability of transport constitutes a barrier to low in-

come groups to accessing health care facilities for any health care. Most people are unemployed and faced with abject poverty (Dyantyi 2014/2015:43; MEC for Health's Annual Report). The scarcity of transport and resources, including money, leave people unable to travel long distances to access health care systems. This discourages many from visiting health care facilities.

### 1.4.2 FACTORS ASSOCIATED WITH THE SHORTAGE OF HEALTH CARE PROFESSIONALS.

The researcher identified various factors in the literature associated with the shortage of health professionals. The next section discusses these.

#### 1.4.2.1 Factors associated with shortage of health care professionals

Arguments emanating from studies hold different views about the factors that lead to shortages of health care workers. These factors can occur independently from one another while, at the same time, they can influence each other's occurrence. It is also conclusive from some studies that retention is minimal or does not occur at all in rural underserved South African communities in comparison to rural underserved communities of United States, for instance (WHO 2010:[Sa]). This is because even if the rural areas of developed countries are underserviced, the USA has better support for the health care workers, for example, there are better infrastructure, economic structures, and education and training opportunities (WHO 2010: [Sa].

#### 1.4.2.2 Shortage of health care professionals in South Africa

The literature suggests that the health care delivery system in South Africa has been tailored to respond to the needs of all citizens. However, adequate implementation of the health care system in the country is grossly crippled by a shortage of health care personnel to render health care to all communities. The South African Medical Association estimates that at least 5,000 South African doctors emigrated in 2000. By 2013, the vacancy rate for doctors had reached 48% while that of nurses reached

68%. This necessitates the recruitment of doctors from abroad to work in South Africa.

The experienced shortage has been caused by migration of health professionals to overseas countries for instance in 2000 the migration rate of migrated doctors was at 44, 000. According to Seeth (2016: [Sa]), this figure did not accelerate much as it stood at 44,780 by 2010. Nonetheless, instead of the situation improving, it progressively worsened as the number of nurse shortages reached 88,000 by 2016.

The highlighted shortage of these health professionals is marked both at national and provincial levels (Spotlight and Maverick Citizen 2020: [Sa]). Nonetheless, the shortage is also marked across provinces and has led to disparities in provision of health care to needy communities. This shortage has in turn been affected by the fast growing number of the population against the number of health care professionals being produced in the country. Adding up to the shortage is poor management of health care facilities evidenced by that in 2006 there was a 30% of unfilled posts of doctors and in 2016 for this cohort surged to 49%. Similarly, that of nurses was at 31% and 46% respectively.

It is therefore, postulated that by 2025 there will be a need of 97,000 additional health care professionals to respond to the health care needs of South African population. Communities residing in rural communities have been hard hit by shortage of health care workers, due to lower supply of health care professionals to these areas. It is a concern that this problem is ongoing, without having adequate strategies to address it, is predicted that there is limited hope that it could be handled satisfactorily in the near future, especially so that there is a projected demand of additional 14, 000- 17,600 physicians specifically required to enhance access of underserved population to health care.

#### 1.4.2.3 The shortage of health care professionals in African Countries

African countries are also not immune to the problem of shortages of health care personnel with ensuing issues of poor accessibility of community members to available hard-pressed health services. Haseeb (2018:[Sa] assert that 65% to 70% doctors from African countries work internationally. The shortage of health

professionals, in these countries is influenced by the exodus of health professionals moving in numbers to other countries. About fifty seven (57) of these countries had a deficit of 2.4 million doctors against the developed countries which experience a ratio of 24.8 workers per 1000 people whilst the ratio for African countries was at the rate of 2.3 per 1000 population (Naicker et.al 2009 :[Sa]; Tulenko 2016:[Sa]. The professionals leave their countries in pursuit of better working conditions, better salaries, and opportunities of career advancement and for family needs. he push factors generally responsible for the emigration of African nurses are also those of low salaries, poor working conditions, low job satisfaction, little opportunities for professional development and career progression, inadequate security, political problems, civil strife, and ethnic issues. Poor governance of health services, lack of technology, and equipment also count among these factors (Haseeb 2018:[Sa].

#### 1.4.2.4 Shortage of health care professionals globally

Currently, there is global shortage of health care professionals which is sitting at 7.2 million. It is estimated to escalate to 12.9 to 13million by year 2030- 2035 respectively (WHO 2013, 2019:[Sa].

The increase in these numbers is associated with the following factors; aging of people who retire and leave services, staff leaving for countries that have lucrative salaries, deficit in numbers of young people who take up medical aligned professions, deaths through fatal conditions like Ebola and the fact that there is a growing population against the decreasing population accessing medical education (Etienne 2019), a regional Director for American medical institutions).

The United States, much as it is a developed country, also experience a shortage of health care professionals, especially doctors (WHO 2010: [Sa]). The USA is, however, not the only developed country that experiences a shortage of health care professionals. Developed countries like the United Kingdom and Australia to mention a few also experience this globally spreading problem (Dovlo 2005 cited by Ogilvie, Mill, Asle, Fanning & Opare 2007:116) This is a menace to the implementation of available health care systems, especially in rural communities, the communities hardest hit by this problem. The inability to recruit and retain doctors ( and other

health care professionals) appear to be a contributory factor to the scarcity of health care professionals and attempts to remedy the situation appears to be ineffective (WHO 2010:[Sa].

### 1.4.3 NURSES AS THE BACKBONE OF HEALTH CARE DELIVERY

Communities in rural areas, especially in developing countries, are often underserved and experience widespread shortages of health care professionals such as doctors, pharmacists, laboratory assistants, radiologists, dentists, midwives, medical assistants, supportive administrative staff and nurses ( Strasser, Kam & Reegalado 2016:396). However, nurses, as the backbone of health care delivery to the public at large, have the prerogative to render health services equitably to all citizens of the country. It is within this context that Motsoaledi (South African Minister for Health 2011) in addressing an audience at the International Nurses' Day (2011) emphasised the importance of nurses as the backbone of the health care delivery system. He acclaimed that without nurses, no health care delivery system could effectively, and successfully attain its mandate of service. In the same vein, Harney (2010:1) resonates that nurses are central to the success of emerging patient-centred care delivery models. It is essential, therefore, that governments worldwide provide communities with the number of nurses necessary to structure comprehensive and efficient health care systems in line with these governments' capabilities and resources and their community's needs. The shortage of health care providers inevitably leads to inadequate deliverance, non-accessibility, and in some areas, even non-existence of health care delivery services.

### 1.4. 4 THE SHORTAGE OF NURSES

Globally the nursing profession experiences an alarming shortage of nurses. According to WHO's (2013), the shortage of healthcare workers reached 7.2 million and is estimated to reach 12 million by the year 2030. The shortage of nurses is twofold, namely, a general shortage in the number of nurses and a specific shortage

of nurses willing to work in community and primary health care settings in rural areas.

#### 1.4.4.1 General nurse shortages

According to Pienaar (2015: [Sa]), nurses make up the largest group of health care providers in South Africa. However, the country currently, experiences a gross shortage of nurses as revealed by Rispel and Bruce (2015:1). These authors assert that according to the reports given in South African Health Review, although the South African Nursing Council has registered 133, 127 professional nurses, only slightly more than 68,105, nurses work in public hospitals. Reports also reveal that in 2010, the Department of Health estimated South Africa short 44,700 nurses, and yet there were about only 3,700 nurses in training. Klopper (2016) in reading a paper at a gathering of FUNDISA, commented that whereas there is a general shortage of nurses in South Africa, it hit the public sector hardest. This sector delivers services to 80-84% of the country's population, therefore, supplementing the number of nurses through such low numbers of nurses in training paints a gloomy picture, especially for public health institutions in the country.

Rispel and Bruce (2015:1) further cite the critical reasons for the shortage of nurses as the decline in interest in the profession, lack of a caring ethos and an apparent disjuncture between nurses' needs and those of the community they serve. As the younger generations appear not interested in nursing, this potential source would probably not solve the problem of the dwindling numbers of nurses in the public sector. Further, nursing in South Africa has an ageing population of professional nurses of which 48% of a total of 22,756 registered nurses/midwives are over 50 years of age, with an age distribution of 29% between 50-59 year, 16% between 60-69 and 3% over age 69 (SANC 20/12/31 (2017)) statistics. These are about to retire soon. Furthermore, Rispel and Bruce (2015:1) assert that the South African Nursing Council (SANC) is mostly dysfunctional as a regulatory body and provides "sub-optimal leadership in policy development and the implementation thereof, therefore, does not help the plight of the nurses". It is quite understandable that under such conditions, some nurses express being too tired to work.

#### 1.4.4.2 Specific shortage of nurses in the Eastern Cape

According to Dyantyi (2016:38), the former MEC for the Department of Health, the Eastern Cape had only 32.57% of the professional nurses needed to render adequate health services alongside other health care professionals. She further indicates that the professional nurses in the EC province have resigned from services in accelerating numbers fueled by the recently proposed and announced changes to the national pension fund which were consequently upheld after such resignations occurred. The professional nurses who resigned did so to secure their pension funds privately before the approval and implementation of the altered retirement funds policy. Their resignation led to a drastic drop in professional nurse coverage of 32.57% in 2016 in comparison to 57% in 2007. These professional nurses render services to a population of 6,562,053 in the Eastern Cape or 12.7% of the population of South Africa (Dyantyi 2015/16 Health Report).

## 1.5 COMMUNITY SERVICE: THE SOURCE OF THE RESEARCH PROBLEM

### 1.5.1 History

It is against the background of the problems in the sub-sections under shortage of health personnels in this chapter that the South African Department of Health came up with an intervention like the CS Policy (Department of Health1998) to improve health care delivery to the country's communities and ensure equitable distribution of healthcare and coverage for all communities in South Africa. Such would help alleviate and solve the health care delivery problems in South African communities, especially those residing in rural areas, experienced.

Community service is crucial for the South African government to ensure access to health care by all citizens and to curb the problem of a shortage of health care professionals to serve the country's communities equally (Mohamed 2005:1). The Community Service Policy introduced in 1998 mandates the health professionals to render one-year compulsory service to South African communities immediately after attaining their qualifications within their specific professional categories. The South

African Nursing Council under the direction of the Nursing Act (South Africa 2005:s 40 (1) and issued regulation (R765, 2007 Paragraph 58.1 (n) on 24 August 2007 which stipulates the regulations relating to nurses' community service.

The first group of health professionals to perform CS in 1999 was a cohort of doctors. Dentists followed suit in 2000 and pharmacists in 2001 (Reid, Peacocke & Kornick 2018:[Sa]). The other health professionals followed in 2003. These included the dieticians, physiotherapists, occupational and speech therapists, clinical psychologists, radiographers, and environmental health professionals with nurses joining in 2008.

The principal aims of CS in the health care area are to:

- ensure the improved provision of health care services to all the citizens of the Republic,
- cope with the problem of shortage and lack of health care professionals in delivering health care to all communities,
- ensure equitable distribution of health care professionals to the rural and urban underserviced area to meet the health care needs of these communities,
- attract professionals to work in rural areas, and
- slow down the exodus of South African health professionals to greener pastures

Secondary to these aims, the government envisioned a longer-term advantage, namely, the development of essential skills by newly qualified health professionals (Reid et al (2018:[Sa]) During the decade since the implementation of CS, researchers have conducted several studies in various parts of the country on different aspects relating to CS. The researcher, however in her recent search on studies conducted in the Eastern Cape on phenomenon could not find any evidence of a study conducted in the Eastern Cape about the experiences of the professional nurses doing CS. The only study found was on midwives conducted by Seekoe and du Plessis in 2013.This, therefore, served as a partial justification to conduct this study. The next section gives further details on this issue.

### 1.5.2 Reported reaction to community service in South Africa.

According to literature obtained before the introduction of community service for nurses in 2008, and early implementation of it for doctors, in 1998, the introduction of Community Service triggered mixed reactions from health allied stakeholders and other South African citizens. Some stakeholders responded to it with the positive attitude and some viewed it negatively. The affected health professionals, especially doctors, felt that this strategy was retarding their future career progression as it would lead to a delay of a year spent in community service. The individuals who commented did so at the time of commencement of the community service which occurred over two decades ago.

Reid (2004:2) claims that CS could encourage the newly qualified doctors to look for jobs in other countries, thus further worsening the shortage of health professionals. Reid (2004:2) furthermore warned that CS in the long term would not be an effective strategy of retaining nurses in SA as nurses would continue to leave the country in pursuit of better-paying jobs. Fouch of the Department of Nursing and Midwifery at the University of Cape Town equally warned that “there are more numbers of nurses that leave the country than numbers of potential graduating nurses” (Ndaki 2004:2).

Literature attests that the health care professionals in community service have expressed some challenges such as unclear policy guidelines in the first year of implementation of the policy and community service practitioners treated newly qualified nurses as a “nuisance”. Some found the environment in which they worked demoralising and resented their allocation to it. Newly allocated CS candidates also mentioned social and geographical isolation, lack of adequate accommodation and infrastructure as some of the challenges they had to deal with (Reid 2000:144,150).

Reid (2002:1) envisioned that this might worsen the tendency to look for employment abroad.

Nurses, who form the backbone of the nursing profession and patient care, also expressed frustrations and anger towards the introduction of community service. In fact, they informed Tshabalala- Msimang ( former Minister of Health) that the Bill that proposed the implementation of the strategy, ‘stinks’ and that they did not like it (Caelers 2005:1).

Caelers (2005:3) reports that a Medi-Clinic regional Manager stated that CS would impact negatively on the staff who trained in private institutions because they are permanent employees. CS for the whole year would imply a break in years' service. This would impact negatively on their pension plans and disrupt their medical scheme benefits. More seriously, CS would lead to a shortage of staff impacting negatively on the services of the MediClinic discouraging training by the private sector that invests a lot of money and then set to lose newly qualified persons through the implementation of CS. Gwagwa, from DENOSA, declared the organisation's support and understanding of the philosophy of CS, however, she complained about inadequate consultation prior to the implementation of the strategy (Caelers 2005:3). Current literature attest that although the health professionals had either negative or neutral attitude towards its implementation, they have currently tended to move significantly towards a positive attitude about it (Reid et al 2018:[Sa].

### 1.5.3 Personal observations and experience

Reports given at the "review workshops" conducted by the Eastern Cape Department of health officials who sought to know from newly qualified health professionals how they experienced doing CS in the province kindled the researcher's interest in this topic. The health professionals at such workshops articulated their enthusiasm to render services in the communities, but unfortunately, they indicated that CS marked constraints of staff shortage and unfavourable working conditions including lack of facilities and infrastructure to support their practice. The researcher, as an educator with a vital contribution to educating nurses, developed an interest in exploring the lived experiences of nurses in CS amidst these problems. It was envisaged that the findings emanating from the study might shed light regarding the successes or non-success of CS in meeting its intended objectives as stipulated by the Regulations Relating to the Performance of Community Service (R765 of 24 August 2007). On reading for the current study, Section 8 of the South African Nursing Council's Policy, "Instructions for Registration in the Category Community Service" further kindled her interest. This section alarmed her as it reads:

- *"8.1 Only designated public health establishment or complexes of public health establishments can be utilised to perform community service.*
- *8.2 A practitioner who does his/her service in an establishment **not** designated by the Minister of Health will **not** be registered, and the period of community service will **not** be recognised*."

The fact that pre-established sites might limit the CS candidates' choices left the researcher with the question as to how NQPNs would react. Some might want to find a position closer to home and family a priority. Others might prefer urban areas and yet other rural areas, none of which could be guaranteed. Furthermore, if the understaffing of experienced personnel ravished the predetermined sites, how would this impact on NQPNs' skill development, support, and continued learning?

The institution, at which the researcher worked for at the time identified the researcher (a lecturer) to attend the annual stakeholders' meetings for CS with officials from the National Department of Health. It was at this meeting where the researcher heard representative NQPNs sharing their experiences of being in CS. The researcher has also attended sessions where the newly qualified health professionals in the Eastern Cape Province gather, to give feedback to the government officials about CS. These feedbacks supported the researcher's initial concern and questions about NQPNs' experiences of CS. CS practitioners, especially nurses, lodged complaints such as lack of accommodation, inadequate supervision in some areas, and being left to their own devices, especially at rural clinics, to manage complicated maternity cases. They also voiced that they did not learn much as sometimes they were not rotated to various units of the institutions to gain vast experiences. Lack of infrastructure to support their nursing activities as well as the negative attitudes of some unit staff members towards them also tarnished their experience.

## 1.6 THE STATEMENT OF THE RESEARCH PROBLEM

Based on the background information on the research problem, especially preliminary experiences voiced by all categories of healthcare personnel, the

statement of the research problem follows in the ensuing section. The Nursing Act, 2005 (Act 33 of 2005) prescribes the compulsory community service (CS) for nurses. CS aims at contributing significantly, to the efforts that are meant to ensure equitable distribution of nurses to meet the needs of the community as well as further developing the NQPNs' skills. However, a move to introduce CS invited adverse reactions from some health professionals.

In the wake of these health care professionals, having expressed some negative experiences, the researcher developed an interest to gain in-depth information from the nurses regarding their lived experiences of CS. Hence a question arose in her mind as to: "What are the lived experiences of nurses in community service?" or: "How do nurses experience community service?". The researcher's interest was focused on the Eastern Cape, specifically. As indicated earlier, in subsection 1.5.1, the researcher could find no evidence of a study conducted on the experiences of the nurses doing CS in the Eastern Cape. Knowledge of these experiences is vital to assist nurses in CS to develop their skills and professional endurance to a professional level thereby contributing to the alleviation of the staff shortages thus attaining the objectives of the CS programme. In South Africa, studies about the nurses' experiences in doing Community Service have been conducted in various provinces like Limpopo, Gauteng, KwaZulu Natal, and Western Cape between years 2013-2015.

The researcher's interest was focused on the Eastern Cape, specifically as indicated earlier, the researcher could find no evidence of a study conducted on the experiences of the nurses doing CS in the Eastern Cape during the time of developing the present study.

## 1.7 THE RESEARCH QUESTION

How do newly qualified professional nurses in the Eastern Cape Province experience doing one year compulsory community service which is mandatory for all health care professionals?

## 1.8 THE AIM AND PURPOSE OF THE STUDY

The aim of this study is to establish whether the government's policy is effective regarding the selected categories of health care professions through investigating the lived experiences of the NQPNs during Community Service in order to develop guidelines to assist the NQPNs to adjust to the community service, to understand the structure and meaning of the immediately lived experiences and the professional socialisation potential of CS into the nursing profession as well as to suggest improvements to the implementation (execution) of CS programmes.

## 1.9 RESEARCH OBJECTIVES

The objectives of this study were to:

- explore and describe the experiences of the newly qualified professional nurses in compulsory community service
- Identify and describe the gaps of the community service in the Eastern Cape
- Assess the knowledge gained from the community service from the newly qualified professional
- Develop the guidelines to assist the NQPNS to adjust to the community service to understand the structure and meaning of the immediately lived experiences
- Suggest improvements to the implementation of the Community service programme

## 1.10 RESEARCH QUESTIONS

- What are the experiences of newly qualified professional nurses in compulsory community service?
- What are the gaps of the community service in the Eastern Cape?
- What is the knowledge gained from the community service from the newly qualified professional?

- What is the potential application of the developed construct (adaptation/adjustment) into nursing practice as experienced by NQPNs in doing CS?
- What measures can be used to assist the NQPNS to adjust to the community service to understand the structure and meaning of the immediately lived experiences?

## 1.11 SIGNIFICANCE OF THE STUDY

The researcher anticipated, at the beginning of the research, that the findings would be relevant to stakeholders associated with the different aspects of health care delivery, as indicated in the sub-sections to follow.

### 1.11.1 Significance to policymaker

Initially, the researcher envisioned that this study might indicate gaps in the fulfilment of the government's aim of the CS initiative regarding ensuring health care coverage of Eastern Cape communities. Also, the study might shed light on whether doing community service after training, indeed, does facilitate refinement competencies of the NQPNs; that is, their socialisation into the nursing profession.

The knowledge gained from exploring the lived experiences of the NQPNs in community service is crucial in determining whether the Government's policy is effective regarding the selected categories of health professionals. Where CS is effective, the allocation of the newly qualified health professionals to community service should enhance their continued skill and attitude development, thus ensuring their adequate further development of these competencies as professional nurses.

Furthermore, the results of a study such as this might indicate whether there is adequate coverage of the delivery of health services to all communities served. In instances where it is found to have constraints, it is envisaged to evoke Government to come up with measures to overcome such constraints. As community service was partially introduced to bridge the "student nurse-professional gap" by improving

NQPNs' competencies in health care delivery, such delivery is to some extent secured, especially in the rural and underserved areas.

### 1.11.2 Significance for consumers of health services (communities)

The findings emerging from the study might assist in improving equity by delivering better health care to marginalised groups. Such improvement of care would translate to decreased errors, minimal delays in health care delivery, intensified market share improvement in efficiency and decreased cost (Maphumulo & Bengu 2019:1).

Awareness of the need and opportunity to improve the policy governing CS practice could assist in formulating a carefully defined and more unambiguous policy; one that would invite inputs from all stakeholders concerned. The criticism levelled against the current policy is that the Government took a decision and it lacks consultative contributions from affected stakeholders.

The findings of the study have also led to formulation of the guidelines which might assist the newly qualified nurses to readily adjust to complex practice environment which has contextual challenges so as to be able to concentrate on refining their competencies and consequently be in a position to render effective nursing care to their patients. The formulated guidelines will contribute by providing a model for implementation of recommendations that strengthen the operationalisation of community service which might be an advantage than the one presently implemented. This would lead to more innovative ways of applying the community service policy that might benefit the newly qualified nurses, the consumers of services and the improved ways of coping with the challenges found in the clinical areas.

## 1.12 DEFINITIONS OF KEY CONCEPTS

Phenomenological analysis; Experiences; Newly qualified nurses; community service; Eastern Cape (alphabetically)

### 1.12.1 Community service

The Community Service Policy mandates the nursing profession to impose on newly qualified health professionals' compulsory service to the South African community for a year following immediately on the attainment of a professional qualification in nursing. For nurses, such a policy was published in the Government Gazette, under regulation R765 of August 2005. The nursing profession implements CS under the direction of the Nursing Act 2005 (Act no 33 of 2005 sections 40 (1) and 58 (1) n. (South Africa 2005**).** In the context of this study community service means a one year period during which the newly qualified nurses are allocated in the clinical areas in order to ensure further refinement of their competencies. It also means enhancing distribution of the newly qualified nurses to clinical facilities to enhance the access of the communities to the health care services available in the country. The definition highlights the importance of this policy as it improves NQPNs competences and assist provision of health care workers in the hard to reach areas.

### 1.12.2 Eastern Cape

The Eastern Cape, sited in the Southeastern South African coast, is one of nine (9) South African Provinces. It is a province known for its natural beauty, and constitutes of rugged clifts, rough seas and a green bush streach which is referred as the Wild Coast. It spreads out on an area which is equivalent to 168, 966 square meatres. According to the 2020 South African statistics, it is densely populated with 6,8 million people, who mostly speak Isixhosa. In the context of this study the Eastern Cape is the part of the continent where the participants in the study reside and were exposed to clinical areas to have direct experience of being in professional practice.

### 1.12.3 Experience

Colloquially, an "experience" is the actual observation of, or practical acquaintance with, facts or events which could be known or skills resulting from this (The Concise

Oxford Dictionary 2010:411). Phenomenologically, experience refers to “moment-to-moment awareness of life” (the researcher’s understanding), and it describes what people experience concerning a specific phenomenon (occurrence) as well as the meaning the experience holds for them (Brink et al 2012:122). According to Streubert and Carpenter (2011:74), lived experiences present occurrences in the life of an individual what is true or real to him/her and the meaning they attach to it. In the case of the current study “experience” also implies “opinion” as the researcher anticipated she might encounter opinions as the mode of expressing experiences in line with Streubert and Carpenter (2011:74). Schwandt (2007:102) circumscribes experience as processual, historical, anticipatory and open, and “there is knowing in experience” (Schwandt 2007:102).

### 1.12.4 Newly qualified professional nurses (NQPNs)

A NQPNS is a person who has been educated and trained under the South African Nursing Council Regulation R425 of 22nd February 1985 (as amended) which leads to registration as a nurse (general, psychiatric, community) and midwife. According to the Nursing Act, 2005 (Act No 33 of 2005), Section 30 (1) a professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who can assume responsibility and accountability for such practice. Section 31(1) of the same Act (2005) indicates that a professional nurse is a person registered as such under this Act with the South African Nursing Council.

A newly qualified professional nurse in the context of this study refers to a nurse who recently completed the final examination of her/his study. This professional nurse is either at the end of the year’s community service or has just (within two months) completed a year of community service.

### 1.12.5 Phenomenology

Polit and Beck (2017:471) state that the focus of phenomenology is on understanding people’s lived experiences. On the other hand, Streubert and Carpenter (2011:76) argue that the purpose of phenomenology is to describe a

phenomenon or appearance of things as lived experiences that are perceived by the study participants. Grove, Gray and Burns (2015:69) indicate that in phenomenological terms, people and environment are inseparable and perception and experience always relate to "something." In this regard, the researcher followed the North American tradition of phenomenology, as a variant of qualitative research, reflecting "a subjectivist, existentialist and non-critical emphasis" (Schwandt 2008:227). Phenomenology is thus both a philosophy and a research methodology. In this study, the researcher envisaged that following phenomenology as a design to obtain the essence of the experiences of the participants that might help in realising the kind of environment into which newly qualified nurses are exposed, and how such environment shapes them for their future practices in order to adjust in it and thus render effective and efficient patient care.

### 1.12.6 Phenomenological analysis

In the context of this research project, a phenomenological study refers to the investigation of the lived experiences of individuals and groups. More specifically, in the current study; NQPNs (people) in community service's (environment) constitution of experiences ("life"). Participants in the study expressed their experiences linguistically, allowing for content analysis to categorise concepts into categories and themes. This further allowed phenomenal descriptions of these experiences and presenting these descriptions as scientific knowledge in the form of the findings of this study. In this regard, Schwandt (2007:225) states that "phenomenology rejects the scientific realism and the accompanying view that the empirical sciences have a privileged position in identifying and explaining features of a mind-independent world."

## 1.13 DEFINING A THE THEORETICAL GROUNDING FOR DEVELOPING THE GUIDELINES IN THE STUDY

Literature search conducted from national and international journals revealed that there is a wide range of studies that have been conducted on the experiences of the newly qualified nurses who had their first experiences in the practice areas post-their registration**.** In South Africa, most of these studies examined the experiences of

the newly qualified nurses, who were exposed to clinical practice areas doing one year mandatory community service in various provinces of the country. What stood out in the findings of these studies was that, the nurses were sort of in a journey, transitioning from being novices to being fully fledged professional nurses. During their career trajectory, they developed through phases and went through processes of growth. They also experienced exposure to complex clinical practice environment with contextual challenges which had impact on them as they encountered ambiguous situations (du Plessis & Seekoe 2013:1). This made some of them to struggle to adapt and adjust to specialised units which called for specialised skills (Snell & Daniels 2014:[Sa]). It was on the basis of such findings that, the researcher deemed it necessary to develop guidelines on assisting the newly qualified nurses doing mandatory community service to enhance their adjustment to the clinical areas when they are allocated for performance of their post registration responsibilities in the clinical areas. This would make them focus on their responsibilities and thus refine their skills in a better pace and even be able to make the patients access proficient and effective nursing care. In conducting this study, the Duchscher's 2008 transition theory was found best fitting, because it describes the phases, processes of development of newly qualified graduates for a year after they qualified. The processes of development and challenges faced by the newly qualified nurses investigated by Duchscher (2008) occurred over the equal length of time as experienced by NQPNs doing CS which were investigated in this study.

### 1.13.1 RATIONALE FOR UTILISATION OF DUSCHER'S 2008 THEORY OF TRANSITION

The researcher chose Duchscher's (2008) Theory of Transition as the main framework within which to discuss the emergent constructs of the current study which is adjustment/ adaptation and to develop guidelines to assist the newly qualified nurses to adjust to the community service to understand the structure and meaning of the immediately lived experiences and the professional socialisation potential of CS into the nursing profession as well as to suggest improvements to the implementation (execution) of CS programmes.

The experiences of the NQPNs, who did CS and participated in the present study, have much in common with Duchscher's (2008) theory. Hence the researcher chose

to use the latter as a framework for discussing the constructs that emerged during the current study and thus, also.

Duchscher's (2008) study presents a theory emanating from a study conducted on experiences of NQPNs, from the commencement of their placement in the clinical areas up to 12 months in the clinical field. Duchscher (2008:444) refers to the initial 12 months of transition from being a student to being a professional nurse in the clinical area as "a process of becoming." She terms the process of transition of these NQPNs as the process of becoming, which is accomplished through three stages, namely; the stages of Doing**,** Being and Knowing. Furthermore, the same author indicates that the entire journey of transition entails going through a process of anticipation, learning, performance, concealment, adjustment, questioning, revelation, separation, rediscovery, exploration and engagement.

During these first 12 months, the participants in her study had not written their "full registered nurse" examinations qualifying them as professionals. They worked under the title of "probationary nurses." In the case of the participants of the current study, although they were working under the title of a CS practitioner, they had already passed their qualifying examinations allowing them to be registered as professional nurses with the SANC once they had completed their community service. However, some participants in the current study shared that, having the title of a "CS Practitioner" created some challenges for them. Some senior professional nurses did not completely understand their position. Their position was even worse concerning the sub-categories of nurses who merely regarded them as their equals or as having a status inferior to theirs; regarding NQPNs as "children" or still as "student nurses." Hence, they were, at times, not allocated responsibilities appropriately. In some units, they would be used as messengers to be sent from ward to ward, or the pharmacy or X-ray departments to collect items appointed porters can do as well. Such practices could lead to the improper development of knowledge and skills of the CS nurses impeding their personal and professional development, leaving their confidence impaired. This would in turn culminate in failure to adjust to performing their professional responsibilities.

Duchscher (2008:442) reports that the journey of the transition of newly graduated nurses to professional nurse practitioners is not linear, but evolutionary and transformative; constituting successes and challenges. Nonetheless, such a journey of transition is instrumental in adjusting to changing personal and professional roles.

Additionally, it is a process during which the NQPNS goes through the processes of emotional and intellectual development. As their experiential and knowledge levels escalate, it broadens their professional skills and relationships which contribute further to their personal and professional growth.

Duchscher (2008:444), and Duchscher (2009:1104) share that the participants in her study entered into the practice field with some excitement about meeting certain set expectations and responsibilities and moving forward with their personal and professional development. However, challenges in the clinical field soon led to the realisation that things were not as they had anticipated. Such challenges included aspects of their personal and professional lives. As they commenced their clinical practice, they had to deal with professional role responsibilities and workload, which they were not prepared to tackle (Duchscher 2009:1105).

In line with the current study's findings, comparing the implicitly and explicitly identified characteristics of the experience of navigating their transition from being NQPNs to becoming successful professional nurses, participants did not perceive or experience their contexts in the same manner. In line with the expectations, set by phenomenology as philosophy, each newly graduated nurse presented a unique experience. There were similar experiences and varying ways of experiencing CS. Some participants were allocated to the same facility and exposed to the same context, but still, shared different opinions about their exposures. For example, some participants voiced having a problem of working without being allocated a supervisor to work with them, and this frustrated them as they felt they were not ready to function independently. For other participants working alone, without an allocated supervisor, was a golden opportunity to develop a sense of independence, self-confidence, growth, and responsibility, because it gave them a chance to take independent decisions. Participants, who regarded working alone as being positive, posited that it reinforced their development. This started when, as students, their superiors would delegate tasks to them either in the classroom or in the clinical field.

Duchscher (2008:443) emphasises that much as the NQPNs might have had remarkable successes in the clinical areas, they still encountered some challenges, especially during the first 12 months of their clinical practice. Examples of these challenges include, "a lack of clinical knowledge and confidence in skills performance, relationships with colleagues, workload demands, organisation and

prioritising relating to decision making and direct care decisions and communication with physicians" (Duchscher 2008:443).

These examples of challenges, cited by Duchscher (2008), are similar to the challenges mentioned by participants in the current study. Participants pointed out that they experienced a lack of clinical knowledge. These related to limited time during their exposure to some clinical areas while they were students**.** In other instances, they were not even allocated to certain areas, for example, operating theatres and intensive care units, which contributed to wavering confidence in performing skills, thus leaving a gap in their professional armour. Workload demands also posed a challenge. Interpersonal relationships with peers posed some problems, and senior professional nurses, at times, were not good. In some instances, some CS nurses encountered language barriers as a challenge, especially in cases where colleagues chose to use their traditional language when dealing with patient care matters in the presence of foreign colleagues. Some of the participants expressed that they were not supported most of the time due to a shortage of senior staff members. Also, they felt not acquainted and comfortable to directly communicate with physicians or making judgements and decisions about patients' conditions. It is under such premises that a thought of developing guidelines emanating from the experiences of NQPNs arose from the researcher mind and thus decided to develop guidelines that would potentially be helpful in making the NQPNs doing CS adjust with ease when on mandatory community service. In the current study the details of the framework are discussed in chapter 4.

## 1.14 REASERCH PROCESS FOLLOWED IN CONDUCTING THE STUDY

The following diagram shows the research process followed in conducting the study

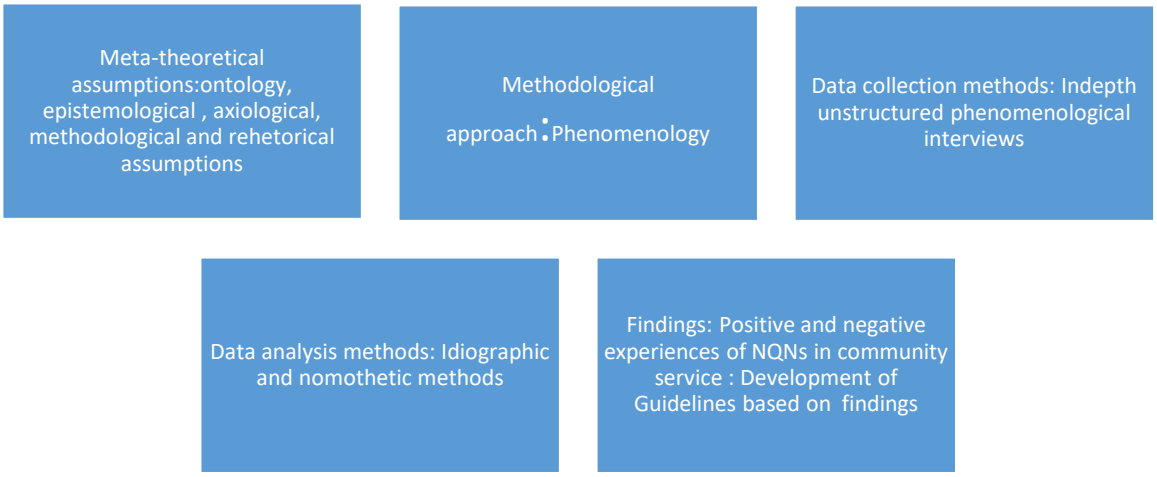



**Figure: 1.2 Research process**

### 1.14.1 PHASES OF DEVELOPING THE STUDY

This study was developed in 3 phases

**Phase 1:** An extensive phenomenological study was conducted**.** The experiences of the newly qualified professional nurses doing mandatory one year community service were explored. The sample was purposive. Data saturated after six participants were interviewed using unstructured in-depth phenomenological interviews which produced rich- data on the experiences of the NQPNs. Data analysis in the study was done using principles suggested by Grbich (2013:96-97) and Wertz et al 2011:134-156) wherein data is analysed at Idiographic (single case) and nomothetic( multiple case) levels. Five of the participants were interviewed twice and the second interview was meant to verify the authenticity of the information obtained from them during the first interview. Emanating from the findings of study, the concept of adjustment/ adaptation in the practice environment was outstandingly, perceived by the researcher and cited by all participants as a main concern during implementation of CS, hence the development of guidelines in this study which will assist the NQPNs to adjust to the community service, to understand the structure and meaning of the immediately lived experiences. Objectives 1, 2, and 3 of this study are addressed in this phase.

**Phase 2** Literature search of articles on adjustment of newly qualified nurses into their new roles in the clinical practice environment was conducted. There seems to be scanty literature on this area, hence, the researcher looked at literature that talks so closely to the first experiences of the newly qualified nurses being in transition and in the clinical environment and expected to take up the roles of the fully fledged professional nurse.

**Phase 3:** In this phase the researcher took into consideration the findings of this study, information from literature and views of operational managers from the sites where newly qualified nurses were allocated as well as from nurse educators and used that as the basis for developing the guidelines on assisting the newly qualified nurses in CS to adjust to the practice environment.

## 1.15 RESEARCH DESIGN AND METHODS

The subsections to follow substantiate the research design and methods deemed appropriate for the current study.

### 1.15.1 RESEARCH PARADIGM (QUALITATIVE RESEARCH)

This study employed a qualitative approach using a phenomenological design to explore the lived experiences of the NQPNs in community service in the Eastern Cape Province. The phenomenological design used in this study falls within the qualitative, descriptive, and contextual paradigm and encompasses both descriptive and interpretative phenomenological designs.

According to Holloway and Wheeler (2010:339), the term paradigm refers to a theoretical perspective or approach to “reality” that a community of scholars holds which posits a set of beliefs that guide research. Grove, Burns and Gray (2013:37) merely refer to a paradigm as a “[p]articular way of viewing a phenomenon in the world.” Polit and Beck (2012:Loc 24363) define a paradigm as a way of looking at natural phenomena - a worldview - that encompasses a set of philosophical assumptions that guide the researcher’s approach to research enquiry. In this regard, Andrews and Boyle (2012:Loc1842) state that a paradigm is like any other perspective, “a way of viewing the world and the phenomena in it. It includes the

assumptions, premises, and linkages that hold together a prevailing interpretation of reality".

Phenomenology is both a research method and philosophy, and its purpose is to examine, capture, and describe the lived experiences of the participants exposed to a specific phenomenon or situation. Polit and Beck (2012:494) assert that the experiential view of phenomenologist helps in understanding people and human life so that it can become effective working with them. The study of human life, according to Neubauer Witkop & Varpio 2019:[Sa].necessitates a philosophical context that generates specific assumptions about human nature and human living. This explains that it makes the researcher to "reflect on the philosophy they embrace". The chosen paradigm and design pertinently relate to the researcher's interest in discovering, understanding, and describing the lived experiences of newly qualified professional nurses' doing community service.

### 1.15.2 Population

The study's population comprised of newly qualified professional nurses who were involved in doing CS during the period from January 2010 to December 2015. The researcher obtained the target population from the graduates who were produced at an average rate of 295 - 300 to 800 each year. These were from both the local nursing college and the university. The actual time for conducting data collection from this population depended on the approval of the proposal and the progress of the study. So the study progress was delayed between 2016 – 2018 by the researcher's work related responsibilities and personal problems until 2019 when there was a suggestion that there be a need to push up the study to PhD level by developing the guidelines in 2020-2021 as guided by the findings of the study. The target population involved such newly qualified persons in the Eastern Cape Province targeted down to the Amathole District of the Eastern Cape Province according to the national system of districts and municipalities.

The ECP is vast and mostly rural, thus not attractive to the health care professionals, including nurses. It has a shortage of nurses as 57% of nursing jobs remain unfilled

according to the Daily Dispatch (2012), and, there is a growing gross shortage of nurses in the ECP. According to Kupelo (Spoke-person for Department of Health (2017), the indicated shortage is related to the financial constraints of the health department of the ECP. Manana (2016:30) too, confirmed that the professional nurses continued leaving the services in the ECP Province.

### 1.15.3 Sampling process

Sampling is the process or procedure of "selecting any units of observations" (Babbie 2013:124). The selected units of observations according to Grove, Burns and Gray (2013:37) can be subjects, events, behaviours or elements about the research topic. Polit and Beck (2017:250) indicate that the sampling process selects cases or elements to represent the entire population during the process of investigation. However, it might be more accurate in qualitative research to select these to understand and describe the phenomenon under investigation completely. The process of selecting these nurses involved obtaining their allocation list from Bisho (province's Capital Town) in the Eastern Cape Department of Health whose offices which are nearer where the researcher resides. The names of the nurses were randomly selected from the allocation list. The researcher ensured that these were allocated either in rural, urban or semi- urban hospitals and clinics.

#### 1.15.3.1 Sampling approaches/methods

Using a phenomenological design requires a nonprobability approach to selecting a sample. In a study that sought to explore the lived experiences of newly qualified professional nurses doing CS, purposeful sampling was deemed appropriate. The researcher specifically chose individuals who would provide her with the necessary understanding and insight into the daily experiences of NQPNs in CS in a manner that is most fitting to attain the research objectives (DePoy & Gitlin 2016:1).

#### 1.15.3.2 The sample

The sample in this study derived from the NQPNs who were still in or had completed their tenure of doing CS during or within two months before the time of collecting data. These nurses were from the Basic Nursing Degree and the Diploma obtained through SANC Regulation R425 of 1985 as amended (SANC 2005).

#### 1.15.3.3 Site sampling

The study was conducted in the Eastern Cape Province (the third biggest province in South Africa), in a natural setting without any manipulation or change as advised by Brink et al (2012:59). The sites where the participants worked often served as research sites. In other instances, data collection happened in the researcher's office on invitation. The office afforded fewer interruptions of interviews than the clinical area.

#### 1.15.3.4 The sample size

Only six participants took part in this study. The researcher did not predetermine the sample size but depended on data saturation to determine the size; an acceptable method of determining the sample size in qualitative research (Grove, Gray & Burns 2013:274, Creswell 2014:189; Streubert & Carpenter 2011:91). Nonetheless, the small sample provided rich, in-depth information (about the lived experiences of the NQPNs) as LoBiondo-Wood and Haber (2014:244) corroborate.

### 1.16 INCLUSION AND EXCLUSION CRITERIA

#### 1.16.1 Inclusion criteria

The criteria considered for inclusion in the study were NQPNs who had finished their CS no longer than two-months before data collection or who were still in the process of doing CS and were in the last trimester of service according to SANC Act 2005 (Act No 33 of 2005).

### 1.16.2 Exclusion criteria

All the participants who may have performed similar service elsewhere and have applied and provided proof of such service to the Minister, for exemption.

All professional nurses who have completed their period of CS or those nurses who do not fall under the mandate of the regulations on community service, for instance, the senior nurses in the health care centres.

## 1.17 DATA COLLECTION

The researcher has served as an instrument to conduct in-depth phenomenological interviews through use of a single unstructured, open-ended question (grand tour question) (Streubert & Carpenter 2011:34; Grove, Gray & Burns 2015:83). During such interviews, probing questions emanating from the nature of the information supplied by the participants were also asked. Meticulous data recording was done, and verbatim transcription of data was adhered to, thus ensuring collecting accurate data and adequate management of such data (Tracy 2013:160). The researcher tested the tape recorder for proper recording and functioning before starting the interview. She adhered to the principles of the selected strategy and procedures for qualitative data collection, as discussed in detail in Chapter 3 of this thesis. This included an interview protocol (Creswell 2014:194) containing the details of the logistics relating to the researcher's preparation to conduct the interviews (See Annexure D, G & H).

## 1.18 DATA ANALYSIS

In analysing the data in this study, the researcher followed the phenomenological principles of data analysis at the idiographic (individual) and nomothetic (general) levels of research (DePoy & Gilton 2016:3; Langridge & Hagger-Johnson 2013:446).

Since the study is qualitative, data analysis is intiated during data collection with data collection (Strebert & Capenter 2011:46). Holloway and Wheeler (2010:281) argree that data analysis in qualitative study occur sumultaneeously with data collection.

Silverman 2010; 221) in support of this, indicate that researchers should not just commence data analysis only after all data have been gathered. When the researcher began analysing data, she took into consideration what the question and the problem of the study were Grbich (2013:16).

Data was analysed manually using Ms Word, breaking it into segments. The researcher concentrated on analysing a single case at a time and this was done soon after data was collected. In fact, the researcher immersed herself in data whilst avoiding contaminating data by applying principles of bracketing. The data were read and re-read so as to gain the essence of what it meant. Furthermore, data were fragmented into smaller “meaning units” that are easy to manage. From these segments or data units, data categories, sub-themes, and themes emerged. Streubert and Carpenter (2011:44) assert that researchers often cluster similar ideas into themes which give structure to the data. Such themes provide a clearer understanding of the phenomenon to the intended audience. Chapter 3 of the thesis gives a detailed explanation of this data analysis process.

## 1.19 ETHICAL CONSIDERATIONS

The researcher applied the fundamental ethical principles of consideration for autonomy, equity, beneficence end non-maleficence to the institutions, participants, and the researcher herself as the primary instrument in the study. The latter reflects part of the researcher’s scientific integrity.

Polit and Beck (2017:150) refer to ethics in research “as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants.” Privitera 2017:67) indicates that research ethics implies the responsible and moral actions the researchers should engage in when conducting research. During the current study, the researcher considered the applicable ethics regarding to the following:

### 1.19.1The institution

Van der Wal (2018:379) declares it imperative that the researcher treats institutions as persons. Thus, permission to conduct the research at various institutions where newly qualified professional nurses were doing CS was sought from the respective managers of those institutions. Permission to access these institutions was obtained from the Eastern Cape Department of Health and the Directorate of Research, Epidemiology, and Surveillance. Pseudonyms were given to institutions used for data collection to ensure their anonymity. (See Annexure B & C) in this regard.

### 1.19.2 The scientific integrity of the researcher

The competence of the researcher to conduct the study was affirmed by UNISA's Department of Health Studies' ethics committee through approval of the proposal submitted to them before the researcher commenced with data collection. This Committee provided the researcher with the ethical clearance certificate that allowed the researcher to begin collecting data. (See Annexure A). Further to the researcher's scientific integrity, Annexure F and F1 contain an official similarity report (Turn-it-in).

### 1.19.3 The participants

The following sub-sections discuss the ethics concerning the participant

#### 1.19.3.1 Informed consent

NQPNs gave informed consent to their participation in the research on receiving adequate information about the research. Such information included the purpose of the study, its significance, benefits and risks, their role and data collection strategies as well as the time of commitment at each point of contact (Polit & Beck 2017:143). The researcher explained what was expected from the participants and what they could expect in return and handed each a written consent form to sign before the commencement of data collection (Streubert & Carpenter 2011:61; Maree 2016:44). (See Annexure E).

### 1.19.3.2 Protection from harm

Participants were being

duly respected, their dignity and rights upheld throughout the process of engaging with them during data collection by not asking inquisitive questions, keeping to the research topic, looking out for psychological distress, maintaining confidence and the like (Silverman 2010:156). This protected participants from any potential harm during data collection (Polit & Beck 2017:139).

### 1.19.3 3 Confidentiality of information

The provision of privacy, keeping in confidence and safeguarding access to information (tape recordings, transcripts, and the like) go hand in hand with the researcher's anonymity pledge. Pseudonyms replaced the details concerning participants and institutions from which the researcher obtained data. The researcher kept all data, in whatever phase of analysis, secured (under password protection and lock and key) to ensure confidentiality and anonymity. (Munhall 2012:306; Taylor & Francis 2013:210). However, Langridge and Hagger-Johnson (2013:502) argue that sufficient anonymity in qualitative research is not possible, because of face to face interviews during data collection and the sharing of life stories.

### 1.19.3.4 Maintenance of right to anonymity

The researcher ensured that each participant consented to participate in the study assuring them that the information they volunteer would not be shared without their knowledge or against their will (Grove, Gray & Burns 2015:105) in adherence to the ethical principle of the right to privacy. The researcher clarified the use of information for academic purposes with the participants.

## MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is the measure that qualitative researchers apply in the place of validity and reliability in quantitative research. Various strategies enhance the trustworthiness of research, as outlined by de Vos, Strydom, Fourche and Delport

(2011:419-421): Streubert and Carpenter (2011:48-49) and Schwandt (2007:299). These criteria include credibility, dependability, confirmability, and transferability. Table 1.3 exhibits these criteria and their accompanying strategies as these were applied during the current research. These criteria and enhancing strategies are discussed in more detail in Chapter 3; the research methodology.

**TABLE 1.3 Trustworthiness criteria and their enhancing strategies**

| CRITERIA: | Enhancing strategies |
|---|---|
| **CREDIBILITY** | • In-depth explanation of the study conducted<br>• References were appropriately cited<br>• Analytic methods employed were articulated<br>• The results of the study were corroborated by the participants<br>• Colleagues with experience in qualitative phenomenological research were consulted to obtain comments regarding conducting a study using this design |
| **DEPENDABILITY** | • The audit process ensured clearly explained and documented details regarding the following<br>• Methodology selected,<br>• Data collection and analytic methods<br>• The findings |
| **CONFIRMABILITY** | • Use of a digital audio tape recorder allowed the researcher to linger with the data<br>• Transcribing the information provided by the participants verbatim<br>• Participants were requested to confirm that the information on the findings resembled what they provided<br>• Exclusion of biases and or perspectives of the researcher<br>• Ensuring that field notes were taken during data collection<br>• Ensuring that notes taken were comprehensively written |
| **TRANSFERABILITY** | • Unstructured interviews were conducted to obtain in-depth and rich information<br>• No manipulation was applied, and interviews were conducted, where possible, in the natural setting<br>• A detailed description of the research setting and the context of research were provided to enhance transferability<br>• No preconceived formal theory skewed the data collection or analysis of the data |

## 1.20 LIMITATIONS OF THE STUDY

This section summarises the research limitations the researcher anticipated at the onset of the research, which could have proven to be challenging during the research. These challenges, however, did not threaten the validity of the research.

### 1.20.1 The researcher as the main instrument

As the researcher is the primary research instrument during data collection and analysis in qualitative research, findings intercede through this human instrument., The researcher's preconceived beliefs, ideas, knowledge, interests, perceptions, and values about the phenomenon under study might interact with the participants' perceptions thus contaminating the data collected from the participants. During data collection, reflective records of these aspects were therefore kept, as explained in the methodology chapter (Chapter 3) of this thesis.

Finlay (2009:10) argues that the researcher, as an instrument of data collection and analysis, "allows reading in between lines" to interpret data to access implicit dimensions and intuitions. This raises some questions regarding the degree to which the researcher might colour the central meaning offered by the participants on the phenomenon under study. This was of particular concern during the current research as the researcher had previously been a lecturer to some of the participants. These participants regarded the researcher as an authority figure leaving some participants hesitant to share information with her. The research endeavoured to established and maintain rapport to curb this issue by using an icebreaker conversation opener and referring to the former relationship between the participants as belonging to the past. The researcher assured the participants that she distanced herself from that as she was more interested in the participants' current experiences and future welfare.

### 1.20.2 The volume of data

The data collected was voluminous and time-consuming to analyse. During transcription and analysis, the researcher became daunted and exhausted to work

through such a volume of data. The researcher feared losing concentration, thus negatively affecting the value of the findings of the study. However, she persisted systematically in breaking up the amount of work to reasonable amounts (units). Attending to these smaller units helped her to regain self-trust, direction, and perseverance.

### 1.20.3 Use of a tape recorder

Qualitative research uses the researcher as an instrument, and thus, the participant's information is captured using a tape recorder. Some participants do not feel comfortable with their conversation being taped. They develop a degree of nervousness, and this affects the value and depth of information shared. The rapport established during the current research assisted in overcoming this issue.

### 1.20.4 Limitations associated with the research setting

The researcher conducted the research in one province only, and thus, the study findings cannot be generalised to the entire country.

## 1.21 CONCLUSION

This chapter serves both as an introduction to, and overview of the study aiming at allowing the reader a better understanding when reading the whole thesis. It summarises the background to the research problem, problem statement, aim, purpose, objectives, and questions of the study. Further, the chapter explicates the research paradigm supporting the research design and methods. It also highlights that the study will formulate some guidelines based on the findings of the study. The guidelines are on adjustment of newly qualified professional nurses in the clinical areas during their placement for doing compulsory one year community service. The chapter also alludes to the ethical considerations of the study, including maintaining the trustworthiness of the study. The chapter further touches on the initially envisioned significance of the study.

## 1.22 OUTLINE OF THE STUDY

**CHAPTER 1** constitutes the background and overview to the study which includes the problem statement, the aim of the study, purpose, objectives, questions, the definition of concepts, assumptions, indication of theory chosen to guide the development of the study and the rationale thereof, ethical considerations, and scope and limitations.

**CHAPTER 2** contains a preliminary literature review on the community service policy of the government, documents on the legal foundation of the phenomenon under study, experiences of other health care professionals in community service as well as studies on nurses, which relate to issues associated with community service.

**CHAPTER 3** explicates the research methodology, design, and data collection methods and techniques and the theory of data analysis as well as the ethical considerations relating to the current research

**CHAPTER 4** The theoretical framework based on Duchscher's 2008 Theory of transition has been discussed in this chapter.

**CHAPTER 5** reflects on data presentation, categories, themes, and supporting literature.

**CHAPTER 6** Development of guidelines to assist the newly qualified nurses to adjust to community service, to understand the structure and meaning of their immediate environment

**CHAPTER 7** This chapter constitutes the conclusions, limitations and recommendations of the study.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 INTRODUCTION

The literature review is an assessment of the existing empirical and theoretical knowledge available on the research topic (Becker & Bryman 2009:69). It constitutes mostly material from textbooks, journals, theses, research reports, and pamphlets from conference proceedings (Parahoo 2014:115). Grove et al (2013:40) indicate that an organised literature review purports available information on the research topic. It puts the research project into context, showing how it fits into a particular field.

The researcher reviewed the literature extensively to gain an understanding of the material that is available on different aspects relating to NQPNs doing CS. The literature review also informed her about concepts relating to the research topic and study as well as the parameters of the study. Furthermore, the researcher read books and articles on phenomenology to get a grip on how to apply it in conducting research on the lived experiences of the newly qualified professional nurses doing CS. She found it equally enlightening to observe the designs and approaches that had been rummage-sale (without acknowledgement and references) in previous studies.

Streubert and Carpenter (2011:25) indicate that when conducting phenomenological studies, researchers can either do no literature review or only a very scanty one before conducting the study. This emanates from phenomenologists' belief that doing a literature review before conducting a study, might lead the researcher to become biased by the ideas obtained from the literature, which might influence the findings of the study. Contrary to such a belief, the researcher went ahead to embark on an extensive literature review as she felt it would assist in gaining optimal insight into the phenomenon under study. This, in turn, would add to the authenticity of the findings of the study.

The literature review also sensitised the researcher to theoretical concepts as well as how these are related to the present study (Silverman 2011:319). It also assisted her to improve her vocabulary on qualitative research in general and phenomenology specifically and to demonstrate command of the subject area and the research problem (Hart 1998:13 cited in Silverman 2011:321). The researcher's understanding of phenomenology as the design of choice for the study expanded through reading associated literature from fields other than nursing (Polit & Beck 2017:87). The researcher also embarked on reading literature to understand the underpinning philosophical issues in phenomenology as discussed in Langridge and Hagger- Johnson (2013) and Wertz et al (2011). This helped her to gain a broader understanding of the concepts related to the current study.

To search for literature to guide the present study, the researcher conducted a literature search using Google Scholar, EBSCOhost, Medline, African Healthline, Africa Wide Information, CINAHL, Science Direct Academic Search Premier, Nexus Database of Current and Completed Research in South Africa and Health Source Consumer information to obtain articles and chapters of books from the internet. The researcher also used the Firefox online search engine to locate sources online as well as sources from the libraries at UNISA and the University of Fort Hare. Most articles online were also obtained via the UNISA library using the UNISA electronic resources. She also accessed the articles online using a Google Scholar search.

The literature that mainly assisted the researcher in gaining a broader insight into the phenomenon under study was from articles reporting on previously conducted studies on CS. These were primarily on experiences of health care professionals other than nurses. News, comments from specific stakeholders about CS service, laws, and guidelines about how health care professionals should implement CS constituted vital sources for the literature review.

The researcher also obtained several studies that have been conducted on experiences of professional nurses doing CS in various provinces of South Africa, including Gauteng, Western Cape, Limpopo, and Kwa-Zulu Natal. However, she could not find any reports on studies on the experiences of NQPNs doing CS in the ECP. The only study remotely akin to the current research topic focused on the

challenges the NQPNs experienced in practising midwifery during their CS. This reassured the researcher about the need to conduct, and the significance of conducting the present study.

Table 2.1 exhibits a framework for assessing the literature which the researcher constructed once she had become acquainted with the field of research and search topic.

**TABLE 2.1: A guiding framework for the presentation of the reviewed literature**

| **Introduction of the concept of CS in South Africa** | **Reaction, opinions, and views on CS by healthcare-related stakeholders** | **Evidenced-based information on CS: Positive factors** | **Evidence-based information on CS: Negative factors** |
|---|---|---|---|
| What is CS?<br><br>Why was it introduced?<br><br>When did it commence for health care professionals and when for nurses?<br><br>Guidelines regarding the implementation of CS<br><br>Legal foundation of CS pertinent to nurses<br><br>Source: SANC: Nursing Act, 2005 (Act No 33 of 2005) R765 & circular 1/2009<br><br>Prescribed requirements:<br>Any person intending to register for the first time must do CS<br><br>Facilities for CS placement will be indicated<br>Date to commence to be stated<br>Persons undertaking CS to be registered in such a category<br>CS practitioners confined to practice in | Inadequate consultation - a unilateral government decision<br>Viewed as coercive<br><br>Delay in pursuing further studies<br><br>Restrictive; No opportunity for pursuing other sources of income<br>Lack of initiative to support the young and inexperienced in CS<br><br>Would make the nurses look for lucrative jobs somewhere else.<br>Lessons learned regarding CS such as:<br><br>(a) importance of communication<br>(b) constant positive feedback about how the CS professionals fare in their areas of allocation<br>(c) importance of adequate and appropriate orientation of those commencing CS<br>(d) treating CS health | Not as negative as was initially portrayed<br><br>The main aim of CS is ensuring better health services for all South Africans was probably met<br><br>Partially meeting the object of developing health professional skills<br><br>Is motivational<br><br>The presence of CS doctors makes a difference (community members)<br><br>Felt that the communities valued them | Lacking technical and "soft skills" for instance; attitudes, teamwork, clinical decision making, confidence and communication<br>Lack of supervision and support by seniors<br>Conditions of service: social and geographical isolation<br><br>Lack of responsiveness of certain Provincial Departments<br><br>Inadequate resources<br>Lack of rotation within the institution where practitioners are allocated<br><br>Lack of appropriate CS allocations<br><br>Lack of community awareness and thus underutilisation of CS practitioners<br><br>Detrimental effects on private practice nurses |

| | | | |
|---|---|---|---|
| a designated facility Observed Characteristics of CS Models for compulsory CS programmes | professionals as individuals and be sensitive to their individual needs | | |

## 2.2 THE CONCEPT OF COMMUNITY SERVICE FOR NURSES

In the wake of the shortage of health care professionals and inadequate access of health care services by community members**,** the South African Government came up with the policy of CS for health professionals which compelled newly qualified doctors to do one-year CS since 1998. This started with the cohort of 26 doctors, followed by dentists in 2000, and pharmacists in 2001. Seven other groups, including clinical psychologists, dietitians, environmental health officials, occupational health officials, physiotherapists, radiologists, and speech, language and hearing therapists followed in 2003. According to Mahlathi (2006:1), there were about 3380 health professionals allocated to CS in 2006. According to Ndaki (2004:1), CS for nurses specifically, in South Africa was proposed in 2005, but it was only implemented in 2008, after the NDoH and the relevant stakeholders such as the SANC had addressed specific logistical issues.

The Government Gazette published the CS Policy for nurses as Regulation 765 of 2007, Paragraph 40 (3) and 58 (1) (n) (South Africa 2000). Commencement of a nurse's CS depends on providing proof of recognition of an appropriate qualification by the SANC as stipulated under sub-section (South Africa 2005:s31). Furthermore, nurses doing CS must inform the SANC on the exact date of commencement and of completion of their CS.

### 2.2.1 Definition of CS

The Community Service Policy mandates newly qualified health professionals to render compulsory services to the South African community for a year immediately after qualification in their specific categories (Regulation R765 of 2007, Paragraph 2.1 (a); South Africa 2005 s 40 (1).). It mandates any person who is a South African

citizen, intending to register for the first time as a professional nurse, in terms of the Act, meeting the registration requirements, to perform an obligatory remunerated one-year CS as stipulated by Regulation R765.year

### 2.2.2 Principal aims of introducing compulsory CS

The principal aims of the South African Government with the introduction of CS were to ensure:

- improved provision of health care services to all the citizens of the Republic of South Africa (Mahlathi 2006:1) thus addressing the problem of the shortage and lack of health care professionals in delivering health care to all communities,
- equitable distribution of health care professionals to the rural and urban underserviced area to meet the health care needs of these communities (Mohamed 2005:3),
- improved provision of health services to rural and underserved areas of the country as well as to further improve the competencies of newly qualified health professionals (Mahlathi 2006:1), and
- attracting professionals to work in rural areas and thus improve the health status of the rural population though it is still a challenge (Rose & van Rensburg - Bonthuyzen 2015:1)

According to Reid et al (2015:741), in the longer term, implementing the CS policy could hold added advantages for health care professionals, such as the development of essential skills, acquisition of contextualised and practical knowledge, improved professional behaviour patterns and critical thinking abilities which could assist their professional development. However, in a longitudinal study published in 2015 by these authors indicated that there is not much that has been achieved in the competencies of the doctors. The area where there is much improvement achieved is the redistribution of the doctors to needy communities. This means that CS would not only serve the purpose of the government and answer the needs of the communities, it would also assist in developing the knowledge, the competences and “fine skills” of health care professionals.

It is over a two decades since introducing the nursing profession to CS. However, according to the recent review of literature on studies conducted in the EC on the phenomenon of interest in this study, no study has emerged on the experience of newly qualified professional nurses' doing CS in the ECP; hence, conducting the current research was essential to provide the relevant knowledge.

### 2.2.3 The legal foundation of CS service for nurses

The South Africa Health Act 2003 (South Africa's 2003: 48 (1) mandates the National Health Council to "develop policy and guidelines for monitoring the provision, distribution, development, management, support and utilisation of human resources, as well as ensuring effective and efficient health care delivery within the national health system". It provides guidelines for addressing the inequitable distribution of human resources, the enhancement of appropriately trained staff, and increased the accessibility of health care services to needy communities as per sections 48 (2a) 48 (2b), (49) and 51(a)(f) respectively. These satisfied the claims (Reid & Conco 1999:237) about the "lack of clear guidelines" to facilitate the implementation of CS before allocating the first cohorts of health care professionals to CS in 1998.

### 2.2.4 Guidelines for CS for nurses

Literature provides evidence of many complaints by health care professionals, other than nurses, regarding the lack of guidelines for the implementation of CS. Reid and Conco (1999:237) reported that CS had unclear instructions leaving doctors unsure of their job descriptions. Pharmacists expressed unhappiness about the process of CS as it posed role ambiguity to them (Reid 2000:144). The process lacked transparency and clear guiding criteria for the allocation of candidates to CS sites (Reid 2000:148). Dentists considered the process to be poorly organised with inadequate information, lacking proper orientation, and clear job descriptions (Reid 2000:152).

It is therefore, laudable that clear guidelines, based on lessons learned from the experiences of other health care professionals, assisted nurses to implement the

policy in the orderly way in which the SANC executed its responsibilities in this regard. These guidelines stem from legislation (Chapter 2, South Africa 2005 s 40). It mandates any person who is a South African citizen, intending to register for the first time as a professional nurse, in terms of the Act, meeting the registration requirements, to perform an obligatory remunerated one-year CS as stipulated by Regulation R765 of 2007.

The guidelines for CS, particularly in the ECP, according to Links (2008:4) have an underpinning mission and core values that are meant to ensure equitable distribution of health care services that respond to the health care needs of the ECP's communities.

The mission statement reads thus "providing and ensuring accessible, comprehensive, integrated services in the Eastern Cape Province, emphasising the Primary Health Care approach, utilising and developing all resources to enable its present and future generations to enjoy health and quality services." On the other hand, the values on which the guidelines for CS are entrenched in the mission statement are "equity of both distribution and quality of services and service excellence for customer satisfaction" (Links 2008:5).

The researcher envisions the indicated mission and values as an attempt to meet the objectives of community service of ensuring coverage of all the communities with health care resources (human and physical) for the equitable and quality health care systems for the benefit of those residing in the communities of the ECP.

### 2.2.5 Actual implementation of community service in the Eastern Cape

The ECP policy directs the commencement of CS. Prospective CS practitioners receive information concerning their role during their CS placements to ensure clarity about the expectations relating to CS on the part of both nurses and the government. Officials from the ECP's Department of Health visit the nursing colleges' campuses and the university departments of nursing during convenient months in the second semester of the fourth year of students' training to orientate them about CS. These

officials explain to the students the mission, vision, core values, purpose, and expectations of CS.

#### 2.2.5.1 Critical information shared with the students regarding CS

Officials from the ECP's Department of Health share the following crucial information with prospective CS practitioners.

- The need to register as CS Nurse Practitioners (CSNP) for one year with the SANC in accordance with the Nursing Act, 2005 (South Africa's 2005: 40 (1).
- The opportunity to suggest a personal choice of five institutions where students would like to do their CS provided that where it is not possible to honour their choice, the team responsible for allocating prospective CPNSs, decides on their placements. Such a decision rests on the requirements of providing the acquisition of the essential professional experiences and the equitable distribution of nursing care (Links 2008:27).
- The stipulation that only accredited/approved CS clinical centres in the province can provide the necessary experience and that candidates must choose among these sites (Links 2008:28).
- The stipulation that the period of the one-year CS should be continuous. If any interruptions do occur, the practitioners concerned must complete their CS commitment within two years from the date of receiving their qualifications.
- During the CS period, the conditions of service for public service apply, and the CS practitioner must abide by those conditions (Links 2008:28).

#### 2.2.5.2 Conditions of service of CSNPs

According to the South African Nursing Act, 2005 (South Africa: 2005) and Scope of Practice regulation by the SANC R2598 of 30 November 1984 as amended by R1469 of 10 July 1987, R2676 of 16 November 1990 and R260 of February 1991 (Links 2008:36), the following conditions of service apply for the NQPNs who are doing CS.

- A predetermined salary scale with variable notches for each year.

- The CSNP must practice within the scope of practice of the professional nurse as determined by the SANC's Regulation R2598, as amended.
- Registration as CSNP with the SANC entails a fee of R340.00 on commencement of CS, and R340.00 on completion of CS - all in all, a registration fee of R680.00 (R340 due as a registered professional nurse and R340 as a registered midwife (SANC Circular 6/2010).
- During the period of placement in the clinical centres, CS practitioners can expect constant supervision, guidance, support, mentoring, and nurturing from experienced professional nurses to enhance the further development of their clinical skills. These supervisors have to compile quarterly reports on their performance and progress as well as a final report on completion of the CS period. The relevant health authorities issue similar reports as evidence that a person has satisfactorily completed his/her CS exposure (Links 2008:35).

#### 2.2.5.3 Reactions to the introduction of CS

The announcement of the commencement of CS stirred a range of views, opinions, and reactions from various stakeholders, such as politicians, professional organisations, organised labour authorities from both the private and public sectors as well as from health professionals. Although the issue of CS evoked mixed reactions from various sections of the South African population, some stakeholders responded to the CS policy implementation positively while others rejected the motion. The reaction came from both those who were directly (health professionals) and indirectly (the politicians and unionists) involved in health care delivery. These reactions are as indicated in the previous chapter, under subsection 1.5.2.

In spite of the reactions that were there, nevertheless, CS was commenced and is still in progress up to date time of developing the study). The health professionals who had been involved in doing community service since its inception, have portrayed various views about its benefits and their concerns about its implementation. The landscape for their views show a swift from being negative and neutral about it towards being positive. The views indicated are depicted in a number

of studied conducted from the studies which were conducted after a year of CS (2019).

The following discussion therefore consists of the positive and negative attributes of community services being experienced by doctors and doctors in particular. Such studies have been conducted in various provinces of this country (South Africa).

## 2.3 MODELS OF CS PROGRAMMES

The literature suggests that compulsory CS programmes for health care workers to serve underserved remote areas are not unique to South Africa. The practice of allocating graduates to serve in the community dates to the early 20th century (Frehywot, Mullan, Payne & Ross 2010:3). According to these authors, African and European countries have since the inception of the programmes in their respective countries, practised a range of models of compulsory CS programmes, referred to by many as “mandatory/compulsory, obligatory or coercive.” In South Africa, the model of CS is “obligatory,” a “requisite” in Turkey, Mongolia, Viet Nam, New Zealand, Lesotho, and Japan and “compulsory” in Ecuador and Puerto Rico. Some of these models require the implementation of CS while the concerned health professionals are still students, as is the case in New Zealand. The length of such programmes ranges from one to ten years of service. In Australia, for instance, the doctors are required to spend up to ten years working in the district where such a programme is implemented (Frehywot et al 2010:4).

These CS programmes mandate the professionals of any country, to focus on working for the government and meeting the specific health needs of communities. The target communities are mostly those who are in the rural and underserved urban areas. These programmes demand varied service conditions, challenge management, and confront management with new experiences, varying in uniqueness in different countries.

According to the South African Nursing Act (Act 33 of 2005) Section 40 (1) (SANC 2005), NQPNs are registered as nurse professionals designated CS Nurse Practitioners (CSNP) and are required to perform their responsibilities in compulsory

CS, within the scope of practice of a registered professional nurse, as determined by the SANC. Allocated NQPNs are given full responsibility to work as members of the multi-disciplinary team under the supervision of the senior registered nurses. They carry out their responsibility for critically analysing situations, problem-solving, and decision making independently. They consult senior nurses as would any person who does not have vast experience when there is a need to do so.

Figure 2.1 illustrates the different frameworks/models adopted by various countries in implementing CS programmes, including South Africa. According to Frehywot et al (2010:3), the literature review and interviews they conducted, showed three classification systems for compulsory CS programmes. These systems (models) are (1) conditions of service/state employment programmes, (2) mandatory services with incentives, and (3) compulsory services without incentives.

### 2.3.1 Compulsory CS with incentives

According to Frehywot et al (2010:6), CS, which provides incentives is divided into three sub-classes, as indicated below.

#### 2.3.1.1 Education-incentive linked CS service

The category links up with both basic and post-basic students. The implementation of the programme follows three schemes, namely:

- implementation while prospective health professionals are still students in training,
- serving as a prerequisite for entry into postgraduate/specialisation programmes, and
- allocating of professionals to the CS programme after graduation, for a period equivalent to the number of years for which the newly qualified professionals received financial support for their studies. Australia mostly uses this model. In cases where students fail to complete CS, educational institutions do not confer students' diplomas or degrees. This is typical practice for pharmacy students in New Zealand (Frehywot et al 2010:6).

#### 2.3.1.2 Employment-linked incentive model

This category of compulsory CS programmes bears two sub-classes, namely:

- where the graduates are expected to do compulsory CS to ensure obtaining a licence to practice in private or public service; and
- serving as a prerequisite for career advancement.

South Africa, with its compulsory CS and Ecuador, serve as the examples of such practice (Frehywot et al 2010:6)

#### 2.3.1.3 Living provision-linked incentives

The living provision-linked incentives link up with material benefits and personal development amongst families. These include car loans at low-interest rates, scholarships for children, and housing subsidies. Such a practice is common in Kenya and Mozambique. The purpose of these programmes is to influence graduates to stay in rural areas after the completion of their compulsory CS (Frehywot et al 2010:6).

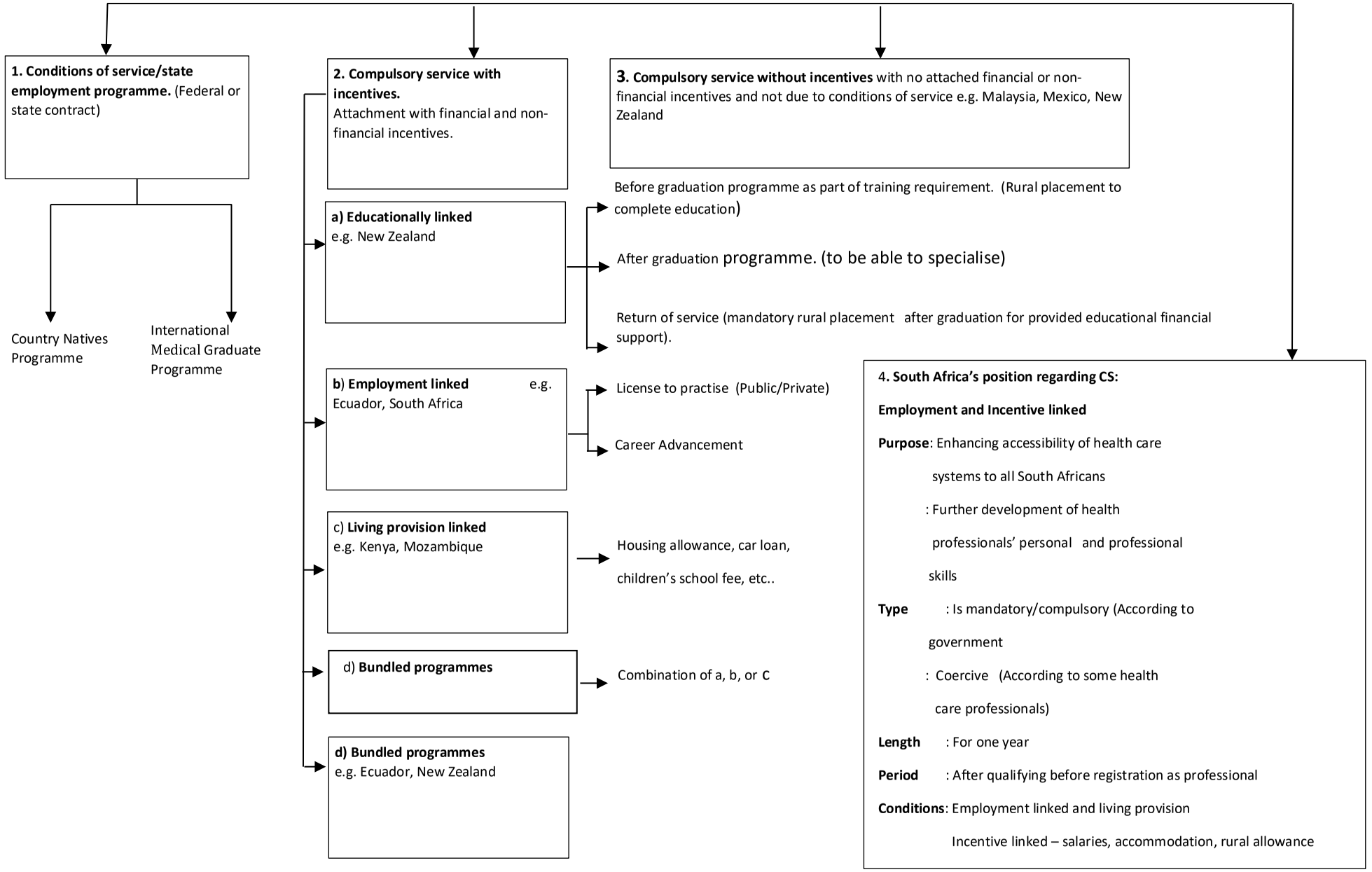



**Fig. 2.1 A modified model of community service programmes adopted from Frehywort et al (2010:4)**

### 2.3.2 Bundled model

According to Frehywot et al (2010:6), these programmes entail incentives linked to education, employment, and living provisions. The incentives vary according to certain conditions, for instance, for more rural areas the newly qualified health care practitioners are given higher living salaries and may even be allowed to complement their salaries by concurrently practising in private sectors, as well as being afforded better opportunities to access postgraduate education. Thailand and Ecuador use this model.

### 2.3.3 Compulsory CS without incentives

In this model/programme for compulsory CS, there are no attached incentives, and CS is done for one year. This means that, what is of benefit to the practitioners, is only the development of skills, rather than any material benefits, which are enjoyed by the other two programmes, where there are related incentives. It means that the primary rights to consider in this programme are those of the consumers of services and those of the government that sponsored professionals' education. Malaysia, Mexico, and New Zealand apply this model (Frehywot et al 2010:6)

### 2.3.4 South Africa's Model of CS

As indicated, South Africa introduced CS is an incentives-linked model to assist practitioners in refining their competencies as well as to ensure adequate coverage of the communities with health care practitioners, especially in the rural areas which are underdeveloped and underserviced by health care delivery systems**.**

The South African model of CS stretches over a year. It is compulsory for all health care professionals. The CS practitioners receive a monetary incentive in the form of a stipend. The CS practitioners are given a choice to identify areas to which they would like to be allocated. However, institutional needs enjoy priority over personal preferences of allocation. Practitioners assigned in the rural areas receive an

additional rural allowance (Nursing Act, 2005 (South Africa 2005: s 40 (1); Links 2008:28).

## 2.4 CHARACTERISTICS OF THE COMPULSORY CS PROGRAMMES

CS programmes reveal specific characteristics depending on their countries of origin and the purposes of their implementation.
These include:

- clarity regarding the initiation of implementation,
- differences in the purposes of their implementation,
- differences in the statutory bodies that initiated them,
- differences in pre-requisites for implementation,
- conditions under which the programmes are implemented, and
- cost of implementation as influenced by the status of each country, the size of areas that need services, the economy of the country, and the population density of the various countries.

## 2.5 EXPERIENCES OF PROFESSIONALS DOING CS

Studies on CS conducted in South Africa cover all nine provinces, especially in rural and underserved communities in these provinces, as well as in the South African Military Health Services. These initial studies targeted health professionals other than nurses as nurses commenced later with CS. These studies involved mostly focus groups discussions. The results reported concentrated mainly on the personal experiences of these newly qualified health professionals. The results reflect both positive and negative experiences of the health professionals.

### 2.5.1 Positive attributes of doing CS by doctors

All studies conducted show that there are essential benefits for health care professionals and more importantly, for the underserviced communities, as discussed in the following sub-sections.

Although the attitudes were negative when they commenced doing community service, later on the doctors developed positive attributes towards CS. Some newly qualified professionals felt that it enhanced their professional development as evidenced by their ability to function independently and handle most medical problems with confidence (Reid, Peacocke, Kornick & Wolvaardt (2018:746). They further reported that they were able to acquire "soft skills," which included professional attitudes, teamwork, independent decision-making, self-confidence, and communication skills (Hatcher, Ona, Kornick, Peacocke & Reid 2014:[Sa]) as they cited that their presence in the clinical areas benefited the needy communities as well, as they were able to render services in such communities.

According to Reid et als' (2018:746) study, the doctors, also reported that they formed excellent working relationships with the hospital managers in their allocated clinical areas. Hatcher et al 2013:[Sa]) viewed support by clinical managers as contributory to work satisfaction, and professional development. CS leads to decreased work pressure, especially for senior doctors and nurses as the facilities were now covered most of the time with doctors (In the same study, the hospital managers equally voiced that the CS doctors contributed towards improving the services of the rural underserviced communities as their presence encouraged more patients to come to the hospitals for services. The hospital managers also treasured the presence of CS doctors claiming a boost to the image of their hospitals and improved services in the clinical areas and decreased numbers of vacant posts. The doctors also were satisfied with manner the site managers tackled their concerns about issues (Hatcher, et al 2013:[Sa]).

The serviced communities also appreciated the presence of CS doctors and the services they rendered at the health care centres because community members no longer needed to wait for long periods at hospitals before they received services. The community members indicated that they valued the services of compulsory CS doctors as they made "the difference" Mohamed 2006 in Frehywot 2010:7

### 2.5.2 Clinical area rotation

Clinical rotation is period in which health professionals, while they are still students and post-registration, are allocated to various "working service areas" (Home blogs

(n.d); American University Blog 2013:[Sa] so that they can gain knowledge and broaden their experience. In the context of this study the rotation of newly qualified health professionals, to various departments in the health care centres, during their CS period, particularly for the nurses, would help them acquire an array of the much-desired competencies to respond to the needs of their community members after CS

### 2.5.3 Clinical supervision, mentoring, and support

Clinical supervision is a formal and disciplined working cooperation which exists or created between a more experienced and a less experienced worker (On line definitions: Resources and publications 2013:[Sa]). In such association , supervisee's clinical work is reviewed and reflected upon to work of those supervised and the consumers of services of benefit from the services rendered. Furthermore, the professional development of those supervised is enhanced and *the* welfare of the clients is improved. Considering what has been purported by this definition, newly qualified health care officials must be supported by others in the clinical field with the required qualifications, experience, and proficiency in that field of health care. This practice usually assists the newly qualified person to refine the competencies which they acquired during training.

Studies reviewed from available literature, which were conducted on Community service revealed the following regarding positive attributes associated with clinical supervision of the newly qualified health professionals.

In the study conducted by (Manthorpe, Moriarty, Hussein, Stevens & Shorpe 2015:[Sa] indicated that the newly qualified appreciated supervision as this made them to engage more and comfortable with the work they performed. Zymaan and Daniels 2016:27) concur support the previous authors regarding supervision being beneficial for supporting professional development. They further indicate that is strengthens interpersonal relationships between the experienced professional and the novice ones. Since newly qualified CS professionals, reported receiving excellent positive support from committed seniors, some even indicated that such support might motivate them to stay on for a further year once the CS period has expired.

According to the Concise Oxford English Dictionary (2010:733), a “mentor is an experienced and trusted advisor.” Faure (2013:1) refers to mentoring as a supportive learning relationship between a caring individual who shares knowledge; experience and wisdom with another individual who is ready and willing to benefit from this process thus enhancing his/her professional “journey.”

Doctors who were in community service also gave confirmed that they were mentored by senior doctors especially in rural clinical areas. Such senior doctors volunteer to take such responsibility. This favourable view about their CS experiences might have been incited by the concerned senior doctors, from mostly the KwaZulu Natal Province who acted proactively and came up with the process of developing mentors to supervise and mentor the CS doctors (Couper 2004:34)

## 2.6 NEGATIVE EXPERIENCES OF DOCTORS DOING COMMUNITY SERVICE

### Conditions of service for doctors

According to Frehywot et al 2010:7, added to these, were inadequate equipment as well as a lack of medications, challenges encountered in performing specific skills that were learned at the medical schools, making it impossible to ensure the rendering of adequate care. These authors, further highlight cost-utility and sustainability as problems. Inadequate provision of clean water and poor electricity provision were also encountered. Such conditions were unacceptable to health care professionals. They regarded CS as being a non-enjoyable and coercive practice imposed by the government. Heavy workloads, under-staffing, poor hospital management, lack of essential equipment, poor interpersonal relationships, lack of recreational facilities and good schooling for children were also highlighted as other factors that influenced the CS health professionals’ intentions to leave the rural health care areas.

Earlier on when the programme was started in 1998, doctors experienced a wide range of problems in the clinical areas. However, when a review study was conducted by Reid et al (2018), it seemed as though things had drastically changed to being progressively positive.

## 2.7 EXPERIENCES OF THE NEWLY QUALIFIED PROFESSIONAL NURSES (NQPNs) DOING CS

Up to this point, the researcher discussed the experiences of health care professionals, other than nurses. The forthcoming paragraphs focus on the experiences of NQPNs' transition from student life to professional nurses during their CS year.

Figure 2.2 depicts a diagrammatic presentation of the experiences of NQPNs, followed by a discussion of these experiences. When comparing NQPNs' experiences with those of the other newly qualified health professionals, similarly, the negative experiences out-number the positive ones, as depicted in figure 2.2. However, this does not indicate that all-in-all CS is an unpleasant experience for most NQPNs.

Qualifying to be professional is a pleasant experience enjoyed by all who go through such an experience. Burton and Ormrod (2011:1) refer to it as a rewarding achievement which does not come without challenges. This achievement comes with expectations, sets of roles, responsibilities, and accountability. According to Wong, Che, Cheng and Chueng (2018:1) newly qualified, nurses get to the practice field/ environment without being fully aware of the vicissitudes and challenges they might encounter there. These changes and challenges become apparent only after students get to the practice field, where these seem to overwhelm some newly qualified practitioners

### 2.7.1 Positive experiences of NQPNs

Literature reveals that NQPNs had positive experiences of becoming qualified nurses. Friendly staff members who were willing to share their knowledge with them, and supported their professional development, welcomed them when they got to their clinical areas (Beyers & Jooste 2013:52). Some of these nurses attest receiving valuable support as they were well orientated, guided and provided opportunities to consult their peers, senior professional nurses, unit managers and doctors during their CS (Andren & Hammami 2011:12; Beyers & Jooste 2013:41). In some instances, the positive experiences were due to programmes that were designed and

implemented to assist in mentoring, guiding, and supporting the NQPNs over a specific period.

A study conducted by Bisholt (2011:1) in Sweden reports about the exposure of NQPNs to a one-year programme to socialise them into the profession. During the exposure to the programme, these nurses worked alongside senior qualified nurses introducing them to the norms, principles, and rules of the profession. At the end of the set period, they were interviewed to explore their experiences in what Bisholt (2011:3) refers to as “being formed into a profession.”

The findings of the interviews Bisholt (2011:3) had conducted reveal that the NQPNs perceived themselves as nurses in environments where the senior staff members displayed confidence in their occupational skills. It further indicates that at the time, newly qualified staff felt that they had gained recognition, a sense of being trusted as well as receiving acknowledgement stemming from the positive feedback they had received from other staff members (Roziers, Kyriacos and Ramugondo 2014:91). These nurses felt accepted, been allowed to participate in professional activities.

They even articulated that they were made to feel significant, and thus had a sense of being an integral part of the team. Even senior nurses applauded their outstanding achievements in internalising the organisational culture. They further showed a high degree of adaptation into the expected roles and professional requirements (Bisholt 2011:3) and indicated that they were satisfied with their placements. The placements were congruent with their choice. These practitioners expressed that, during their exposure to working independently, they felt sufficiently prepared for the role of a professional nurse as they were enabled to render care with confidence and pride. They received mentoring, guidance, encouragement, and feedback regarding their performance.

Similarly, in a study conducted by Andren and Hammami (2011:11) the participants affirmed that being in transition to becoming professional nurses was an excellent experience that provided them with an opportunity to learn and gain knowledge and skills they never encountered during their training years. They found it comfortable and pleasurable to seek assistance from the unit managers. Roziers, Kyriacos, and

Ramugondo (2014:91) indicate that the NQPNs experienced a sense of joy, excitement, achievement, and happiness in realising that they were developing professionally and seemed to attain maturity in their role of being professional nurses. It was a joy to earn a salary. A study conducted by Govender, Brysiewicz and Bhengu (2015:5) in the KwaZulu-Natal Province of South Africa, reports that CS is a good policy and CS practitioners appreciate its objectives

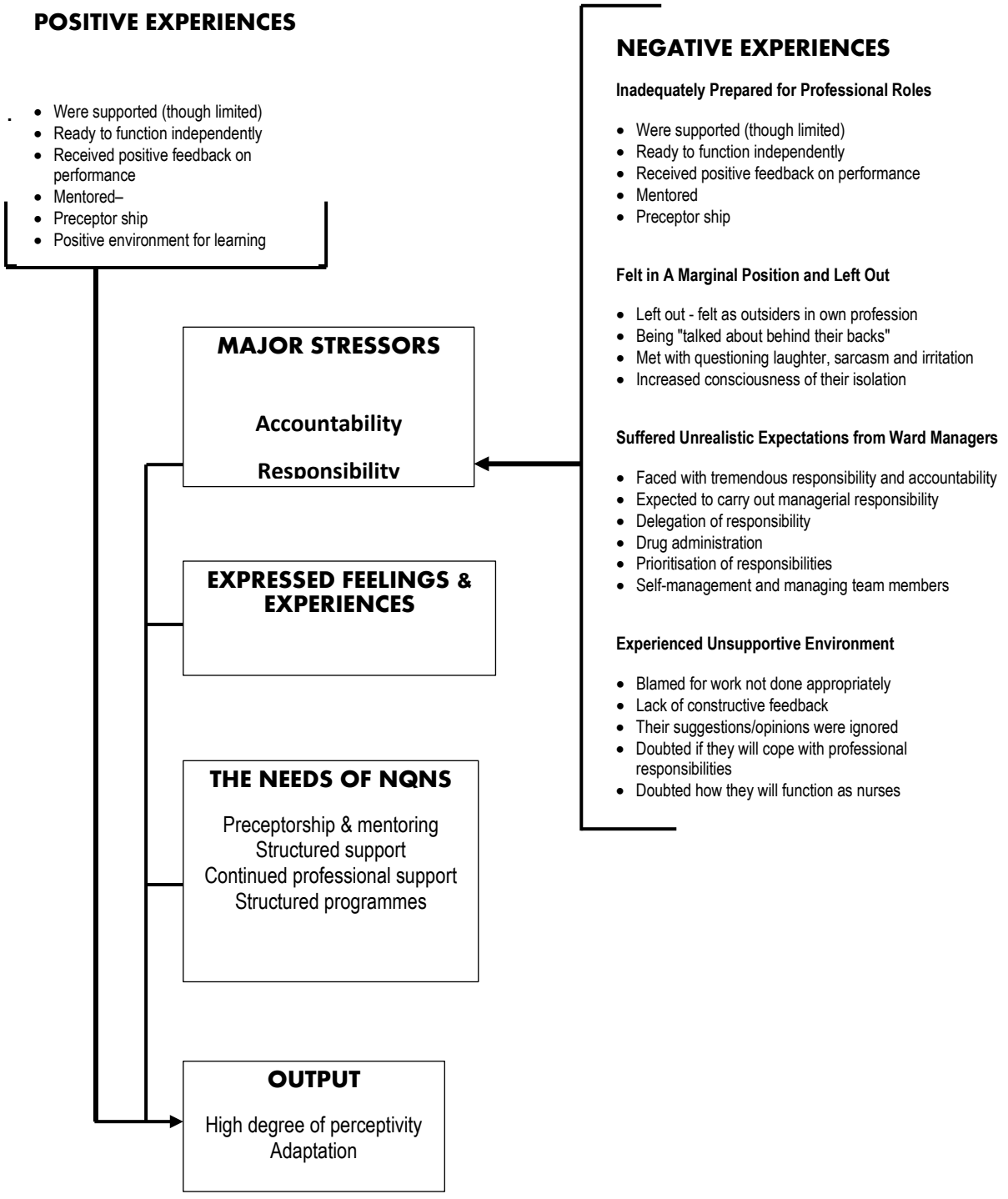



**Fig 2.2: Diagrammatic presentation of the experience of NQNs**

**(Adapted from the work of Bosholt (2011); Baillie(1999) in Whitehead & Holmes 2011;Gerrish 2000; Hickie, Lyttle & Harris (2007) Mooney (2007); Moore (2006); O'Shea & Kelly (2007); Ross & Chifford (2002); Whitehead & Holmes (2011)).**

### 2.7.2 NEGATIVE EXPERIENCES OF THE NEWLY QUALIFIED COMMUNITY SERVICE NURSES

It also evolved from numerous studies for instance conducted by Mthembu and Zakwe 2012:13; Beyers and Jooste 2013:32; Zaayman and Daniels 2016:61; Ndaba and Nkosi; Governder et al 2017and Gadieja et al 2014:50), that while the NQPNs received credit from the staff in various situations and enjoyed being qualified nurses, when the they commenced their responsibilities during the first year after registration, they encounter stressful and challenging situations. They experienced the transition process stressful, describing it as “anxiety-provoking.” Bisholt (2011:1) highlights that many recently qualified nurses express the transition from education to professional life as being difficult, strenuous, and even shocking. The difficult encountered is associated with inability to adequately integrate theory to practice (Abiodum, Daniels, Plummer & Chipps 2019:[Sa]). (Ndaba and Nkosi (2013:51), refers to it as “fraught time,” because the newly qualified practitioners might often experience severe anxiety such as inadequate knowledge and skills as well as a lack of formal support systems during their post-registration period (Beyers & Jooste 2013:44). The negative experiences also emanate from the responsibilities encountered during the transition from a student nurse to a professional nurse. The negative experiences expressed about the clinical practices of the NQPNs are associated mostly with responsibility and accountability expected from them by senior professionals in the clinical practice environment Roziers et al 2014:94; Whitehead & Holmes 2011:3). They felt quite overwhelmed by patient care responsibilities (Govender et al 2015:8). Malhaba, Pinaar and Sehularo (2019:[Sa]) confirms that there were cases of noticeable incompetency among some of the NQPNs in carrying out their professional duties. The NQPNs found having to account for their responsibilities incredibly stressful, and they often expressed feeling apprehensive about the consequences of erroring during the performance of their responsibilities (Frogeli, Rudman, Ljotsson & Gustavsson 2018:5,7). Even having to delegate work to other members of staff made them feel anxious, fearing that those to whom they entrusted work might perceive them as either abandoning their (NQPNs’) responsibility or as being “bossy” towards them. They felt pressurised to do the routine work, had trouble in clinical decision making, which they associated with a lack of confidence to act even though they knew the fundamental theory of

how to apply it. How they performed their duties and roles reflected their frustrations.

Exposure to the negative attitudes of the other professional groups magnified the situation. They endured frivolous questioning by other staff members, criticising them for being incompetent and taking too long to learn. There were even moments where the NQPNs felt alienated as they were disregarded and not involved in the performance of some professional duties. At times they were regarded as being incompetent by senior health professionals. The experienced professional groups undermined the knowledge levels and competencies of the NQPNs and doubted their adequate ability to function as professional nurses (Bisholt 2011:3). Much as this was the case, some NQPNs also affirmed that they felt inadequately prepared, to the extent that they expressed having had limited opportunities to develop management skills (Duchscher 2008:444).

According to Govender et al (2015:7), senior professional nurses do not regard them (NQPNs) as being professional nurses, except when short-staffed. Most negative views and opinions about the competencies and the capabilities of these NQPNs came from doctors who doubted the quality of their education and skills acquisition.

Information obtained from literature attests that some of the NQPNs failed to endure the hardships they experienced. Some of them even went to the extent of quitting their jobs after emotional breakdowns due to excessive job demands expected from them (Bisholt 2011:4).

#### 2.7.2.1 Realisation of ill-preparedness for newly qualified professional roles

The literature also revealed that although nurses complete their training, that does not necessarily mean that they adequately acquire all the required knowledge and skills to enable them to perform as independent professional nurses. Despite adequate coverage of theoretical principles, practical skills may be deficient, as their development takes time, calling for support, guidance, and preceptorship that lacked during their training (Khonou 2019:[Sa]). Such a deficit can at a later stage lead to shortfalls in NQPNs' management of their professional roles. Hence, Burton and

Ormrod (2011:4) assert that although NQPNs are given authority to practice and maintain standards of proficiency, supplementary and continuing professional development is essential to ascertain that they socialise well into the clinical area.
Whitehead and Holmes (2011:3), in their exploratory study on NQPNs, discovered that the work performance of those nurses evidenced a noticeable gap between theory and practice. This was evident from the haphazard way in which some nurses performed their work. Their work would be fragmented and thus this made them bad and not respected by the experienced nurses. (Bejerknes & Bjork 2012:[Sa]). They even struggled to carry out some responsibility meant for the essential management of groups of patients. These primary responsibilities include for instance; leading in care management and care delivery situations, maintenance of standards of care, working in teams, teaching others, making ethical and legal decisions and being accountable (Burton & Ormrod 2011:1). They seemed indecisive about prioritising their activities regarding patient care. They expressed the gaps they were experiencing from what they perceived as being inadequate preparation (Konou 2019:[Sa]). Such feelings of inadequate preparation induced tension and heightened anxiety amongst the NQPNs (Whitehead 2001 in Whitehead and Holmes 2011:3). The difficulties which the nurses experienced made them realise their unmet needs, which they incurred as student nurses (Mooney 2007:5).

#### 2.7.2.2 Perceptions of NQPNs about other qualified nurses

The NQPNs perceived the other qualified nurses in the clinical areas as having unrealistic expectations towards them. According to Khonou (2019:[Sa]), NQPNs expressed that the ward managers had unreasonable expectations about the extent of the competencies of the NQPNs as ward managers expected NQPNs to know everything. In many instances, they had to work without the necessary orientation, guidance, support, and mentorship. These NQPNs faced tremendous responsibility and accountability, for example, they had to do management, delegation, drug administration and prioritising of responsibilities (Whitehead & Holmes 2011:3) while at the same time they needed to quickly adapt and familiarise themselves with the pressures of the ward environment.

Furthermore, they had to manage themselves and manage their teams, yet they were accustomed to working under direct and close supervision during their days of being student nurses. They expressed their frustrations through such utterances as “feeling thrown into the deep end and made to cope on their own” rather than enjoying an opportunity of being guided and supported (Whitehead & Holmes 2011:1; Bisholt 2011:4). This means that their survival merely depended on how strong their characters were rather than on appropriate mentoring and support.

#### 2.7.2.3 Integration into the hierarchical structure of the organisation

The hierarchical structure and their scope of practice in the clinical setting dictate what novice nurses are expected to do or not to do. The NQPNs found themselves placed at the bottom of such a structure compared to other categories of staff in the wards (Bisholt 2011:3). In such a position, most of the time, their decisions and suggestions about performing specific responsibilities were ignored. In some instances, they were ridiculed when they asked for assistance. These nurses lamented the way colleagues treated them, how they laughed at them, exposed them to sarcasm and irritation, and queried them while they did their work (Bisholt 2011:3). Such behaviour from the senior staff members caused the NQPNs not to feel part of the group of professionals. They “felt marginalised and left out.” Lack of clarity about the extent to which they needed to carry out their responsibilities was also one of their primary concerns (Hickie et al 2007:5). The perceived “position” of others complicated this due to the hierarchical position the newly qualified staff held.

#### 2.7.2.4 Experience of an unsupportive work environment

The consulted studies disclose that NQPNs experienced a lack of support (Hickie, Lyttle & Harris 2007:3; Higgins, Spencer & Kane 2010). The nurses also found it difficult to organise and sort out and their attention to patients. The level of support for the new graduates was also lacking, and at times the senior nurses would not spontaneously volunteer their support to support them. They would wait for the newly qualified to request such support. This made them feel at times intimidated to do so (Khonou 2019: Sa].

They blamed it on the shortage of staff, rather than on an unwillingness of senior staff (Mooney 2007; Whitehead 2001 in Whitehead & Holmes 2011:3). In some instances, some of the wards would be subjected to, too much pressure due to a busy practice environment and would not have adequate opportunities to pay attention to NQPNs' needs. The NQPNs felt that their learning needs during the transition to experienced nurses were not a priority to the senior professional nurses. This is the reason why after qualifying they found themselves in stressful experiences of failure to cope with some of their professional roles (Ross & Clifford 2002; Whitehead & Holmes 2011:2).

It is crucial that when the NQPNs start working in the clinical environment, they should be accompanied through such a transition smoothly and comfortably. If community service is planned and implemented meticulously, it can serve the purpose of a smooth "transition" of students into the world of fully practising professional nurses. However, the literature shows gaps in the support, coaching, and placement of these professionals as sometimes they are denied the opportunity of being exposed to the full spectrum of available clinical areas, where they could gather maximum experience within their fields of practice. Making a successful transition from a student nurse to a professional nurse is a very complicated process for the NQPN (Hickie et al 2007:1). It is in this regard that Gerrish (2000:14) claims that supporting programmes of preceptorship post-registration would render this to be a less stressful experience. The findings of the study conducted by Mooney (2007:1) support this as it reports positive outcomes of the support programmes as NQPNs indicated it was a pleasurable experience as they learned much in an atmosphere conducive to learning.

Lack of the necessary support might have caused the newly qualified CS health professionals to practice with some anxiety and lack of confidence. It also defeats one objective of the CS policy, namely, to ensure refining the skills of these newly qualified professionals. It also denies CS practitioners the opportunity to fulfil their duties adequately. Lack of support thus renders the effectiveness of the CS policy doubtful.

Furthermore, contrary to the bleak picture of lack of support and supervision, some newly qualified CS professionals, reported receiving excellent positive support from committed seniors. Some even indicated that such support might motivate them to stay on for a further year once the CS period has expired.

#### 2.7.2.5 Unrealistic expectation

In a study conducted by Khonou (2019:[Sa]) the participants reported that the majority of managers and professional nurses showed a rather unfair treatment and had unrealistic expectations from these .This was associated with the expectations that the newly qualified nurses should be competent in all the skills they performed and thus were expected to have a high level of responsibility and shoulder accountability of everything in the ward situation.

According to Brown and Crookes (2015:2) nurses' competence levels directly affected their ability to provide particular care for their patients. This study findings indicated that the majority of participants felt that they were incompetent in basic nursing procedures, which made it difficult for them to render quality care for the patients. Similarly, Shezi (2014:60) claim that, it was not all CSNs who indicated that they were fully competent and independent to practice autonomously during their community service. This implied to newly qualified nurses that they developed during CS

#### 2.7.2.6 Staff shortage, human and material resources

A study conducted by Thopola, Kgole and Mamogobo (2013:[Sa]) showing that participants perceived shortage of human and material resources as their greatest challenge during community service, which had a negative impact on the provision of quality nursing care. This was perceived as a challenge, as it was difficult for CSNs to know exactly what is expected of them in undertaking their daily duties as one participant mentioned. It was for the participants a concern that there was shortage of material resources, because these are viewed as critical in supporting development of competencies and leading to effective patient care.

#### 2.7.2.7 Rotation to different areas in clinical sites

In a study conducted by Matlhaba, Pienaar and Sehularo (2019:[Sa]) the participants expressed dissatisfaction for not being exposed to different clinical units. They felt that they should have been allocated to a broader range of units to allow them to gain reasonable experiences and thus develop comprehensive competencies. Furthermore, they considered it logical and essential to be rotated during clinical allocation as that provides opportunities to experience working in different wards or disciplines. The study too, conducted by Aggar, Gordon, Thomas, Wadsworth & Bloomfield (2018:[Sa] also reported that graduates viewed it as crucial to be allocated in different units for clinical exposure as very especially during the 12-month transition period this contributes towards enhancing their competency development.

## 2.8 OUTCOMES OF THE IMPLEMENTED COMPULSORY CS PROGRAMMES

The CS programmes appear to have been reasonably successfully implemented. The benefits attained by both the providers and consumers of health care services mark this success.

### 2.8.1 Success stories of implementation of CS

Although the attitudes of many newly qualified health professionals towards CS were negative, the experience of CS, for some, turned out not to be bad as they anticipated. (Reid et al 2020:[Sa].. It was reported that some young professionals considered it quite beneficial being in CS. Some even referred to it as having made them grow tremendously within their profession. (Hatcher et al [2014:[Sa]) Such growth has even made them be better persons; personally, and professionally. Surprisingly, such positive acclaims came mostly from those professionals who did CS in rural areas. These newly qualified professionals have even commented that their counterparts in sophisticated tertiary hospitals had missed out on the excellent experience of working independently and making tough decisions and growing in the rural, under-resourced and underserved, institutions (Mohammed 2005:1).

Research reports also reveal that CS programmes had some substantial benefits for communities. It is, therefore, essential to recognise that compulsory CS programmes influence policy issues. These programmes are regarded as being instrumental for social justice to ensure equal distribution and provision of health care to all communities inclusive of those in isolated geographical areas which are not well served and not so attractive to the market forces and health workers' preferences (Frehywot et al 2010:8). The countries that enforce CS, sponsor the education of the health care professionals and these, in turn, should realise the need for "payback" time to reinforce the sustainability of CS programmes.

## 2.9 CONCLUSION

The researcher embarked upon a literature review to alert her to issues relating to the implementation of CS for health care professionals.

The following aspects emerged from the available literature:

- legal underpinning relating to the introduction and implementation of CS for newly qualified professional nurses,
- guidelines for the implementation of CS,
- different models of implementation of compulsory CS for health professionals globally,
- the South African model of implementation of CS for health professionals,
- benefits of CS enjoyed by both the health practitioners and health care consumers,
- weaknesses of the implementation of CS pronounced by health care professionals other than nurses, and
- positive and negative experiences of the NQPNs in the practice environment who were not necessarily in a compulsory CS programme

The following chapter presents the research design, data collection techniques, and methods to ensure the ethical scientific comportment and trustworthiness of the study and the researcher.

# CHAPTER 3

# RESEARCH DESIGN

## 3.1 INTRODUCTION

This chapter constitutes a discussion of the research design: the philosophical/ theoretical underpinnings (phenomenology) of the research, the research methods (sampling, data gathering and data analysis) and the ethical considerations applied during the study, to uncover the experiences of the newly qualified nurses (NQPNs) doing CS in the ECP. An attempt has been made to uncover new insights and understanding of the phenomenon under investigation.

The researcher grounded conducting this study on theoretical assumptions and Duchscher's (2008) theory in order to strengthen it. This made the researcher too, to be acquainted with existing knowledge about the phenomenon and thus engaged in selecting appropriate methods used. Furthermore, this facilitated that she attains wider understanding of the study, and its variables and concepts were made clearer as advised by Gabriel 2008:[Sa];Richard ;2013:[Sa]).

The chapter also gives an introduction of the theoretical framework adopted to guide the development of the guidelines regarding assisting the newly qualified nurses to adjust in the practice environment to enable them to fully execute their professional roles in order to render effective patient care. The thought about the development of guidelines arose, because from the findings of the study, all participants interviewd emphasised the significance of adjusting soon or fully before they could be in a position to succeed in carrying out their professional role. A few of the participants found adjusting easy., whille the others struggled with attaining it.This was based on situations they experienced. The few that reported being orientated and supervised constantly, in a healthy working enviroment and with adquate equipment adjusted well. Some of them expressed having to use a lot of defence mechanisms to adjust because of untoward experiences that were faced with as according to this study,

hence a felt need to develop the guidelines in a study that was set out to explore the experiences of the newly qualified nurses doing mandatory community service.

- **Introduction to Duchscher's (2008) theory**

Duchscher's (2008) study presents a theory emerging from a study she conducted on experiences of NQPNs, from the beginning of their allotment in the clinical areas up to 12 months in the clinical field. Duchscher (2008:444) refers to the initial 12 months of transition from being a student to being a professional nurse in the clinical area as "a process of becoming." She maintains that the process of transition of these NQPNs as the process of becoming, which is accomplished through three stages, namely; the stages of Doing**,** Being and Knowing. Furthermore, the same author indicates that the entire journey of transition entails going through a series of processes like; anticipation, learning, performance, concealment, adjustment, questioning, revelation, separation, rediscovery, exploration and engagement. The process of adjustment thus, became a key concept on which the research concentrated, hence decided to develop the guidelines on it .The rationale for that she is of the opinion that if the newly qualified nurses adjust well in the clinical areas they will be in a position to carry out their professional roles efficiently and effectively. The details of such a theory are explicitly given in chapter 4.

## 3.2 RESEARCH PARADIGM

Grove et al (2015:36), LoBiondo-Wood and Haber (2014:577) define the research design as a means, rules or blueprint of how a researcher intends to conduct the research and thus attains control over research. The research design guides the researcher in planning and implementing the study project in a manner that is most likely to achieve the intended goals. Furthermore, it assists the researcher to have focus and clarity about the protocols to be followed when conducting any particular study (Miles et al 2020:13). Parahoo (2014:164) corroborates this by indicating that the research design directs a researcher regarding the research approach to be adopted in a study, methods of data collection and analysis, time for conducting the study as well as places and sources of data collection. Harding (2013:15) assert that, whenever qualitative designs are selected, the researchers often have a choice of

research methodologies. The same authors further expound that whenever such a choice of methodologies is made, they are often put into perspectives that suit the disciplines in which they are used.

In the case of quantitative studies, the primary purpose of the research design is to control as much as is practically possible the influence of extraneous variables of human life (threats to internal and external study validity), which could lead to false results (Chiang, Jhangiani & Price 2015:[Sa]. However, in qualitative studies, the research design attempts to leave the research setting and variables as uncontrolled and natural as possible, thus contributing to the trustworthiness of the study and its *naturalisticness (*Salkind 2010:1).

A qualitative approach entails a systematic inquiry, oriented towards a wide range of research designs and methods used to explore phenomena of social action about which limited knowledge exists (Brink et al 2012:120). Furthermore, the researchers seek to uncover the meaning or to describe how they understand human experiences of individuals as they interact with their immediate world in which they live (Holloway & Wheeler 2010:4).

Qualitative research offers the opportunity to focus on finding answers to questions about social experiences, how it comes about and how it gives meaning to human life (Denzin & Lincoln 1994 cited in Streubert & Carpenter 2011:4). Qualitative research methodology, as such, attempts to describe and interpret perplexing human phenomena which are not easily quantifiable. Streubert and Carpenter (2011:23) assert that all qualitative approaches, apart from sharing the same goal and attributes concerning the discovery process, further seek to arrive at an understanding of a phenomenon from the perspective of those experiencing the phenomenon. Marshall and Rossman (2016:2) furthermore claim that qualitative research is pragmatic and anchored in lived experiences of people. Elaborating on the qualitative research paradigm, Polit and Beck (2017:13) indicate that researchers, using qualitative research methodologies, share overall goals and techniques and face similar challenges. Furthermore, the same authors argue that there are also a variety of theoretical and philosophical traditions that fall within the umbrella of qualitative research. Miles, Huberman and Saldana (2014:8), in support of the latter statement, assert that there are various ways in which to conduct qualitative research depending on the tradition followed. These traditional

approaches employ a variety of strategies and styles of collecting data, analysing data, and using appropriate language for specific approaches. The researcher implements all of these to attain the purpose of the study and comprehend the meaning of the findings of the study.

### 3.2.1 Characteristics of qualitative research

Hennink, Hunter and Bailey (2011:9) affirm that the main characteristics of a qualitative study are that, the researcher identifies issues from the perspectives of those who experience the phenomenon. The participants give verbal accounts of their experiences and allow the researcher to understand the meaning and interpretations that they give to behaviour, events, or objects. The interpretations of data given in qualitative research are dynamic and dialectic and attained through inductive reasoning (Grove et al 2013:24; Polit & Beck 2017:536). This means that the participants can shape and create their own experiences. Qualitative research is naturalistic and contextual as the investigation takes place in the setting where the phenomenon occurs (Miles et al 2014:9).

According to Creswell (2013:12) in qualitative studies, data are captured using in-depth interviews without formally structured instruments. The researcher uses him/herself as a data collecting instrument to generate rich information, and participants have control over the data provided. This is attained through non-obstructive interactions. Hence there is a need for the development of good rapport between the researcher and the participants to enhance a relaxed and atmosphere conducive to interaction (Holloway & Wheeler 2010:8; Streubert & Carpenter 2011:20).

Data in qualitative research are subjective, multi-dimensional, take the form of words (Miles et al 2014:10), and are analysed as individual responses, descriptive summaries, or both (Grove et al 2015:88-89). Miles et al (2014:10) further state that the standard way of analysing qualitative data is by sorting, sifting, and organising them, then identifying phrases, categories, and relationships amongst concepts and using such relational statements to develop theories. Researchers observe apparent differences between groups of data, and common patterns and sequences. Findings

from the study are unique and are not intended to be generalised (Streubert & Carpenter 2011:21). The details of these intricate processes and procedures are provided in subsection 3.12.1- 3.12.4.3 of this thesis.

### 3.2.2 Challenges of using qualitative methodology

Qualitative research poses challenges to researchers, because it employs different procedures, due to the difference in nature and assumptions regarding data and the questions to be answered (Hennink et al 2011:8-9). The effect of the investigator on the study, the principles, and the consequences of sampling as well as the processes of organising data during analysis could affect the research findings. Challenges are more pronounced in phenomenology than in many other methodologies because there are various schools of thought in phenomenology which practice different methods of data analysis. Compounding these challenges includes the fact that even exponents who come from the same school of thought propagate essential differences in their approaches to data analysis (Polit & Beck 2017:541).

#### 3.2.2.1 Challenges pertaining to data collection

The researcher acts as an instrument in collecting data and needs to create a good rapport between him/herself and the participants. Furthermore, the researcher engaged in the complex process of holistic analysis of elements of the phenomenon under study to arrive at the concrete understanding of all its parameters. Polit and Beck (2017:508) state that during the transcription of audio-tapes and field notes, there is a likelihood that the researcher can make mistakes. It is therefore, essential that, during this stage of data management, the researcher is careful in transcribing that information ensuring and managing the process accurately.

#### 3.2.2.2 Challenges pertaining to conducting interviews

Although only a few interviews might be conducted, qualitative research takes a long time, because the processes of data collection, massive amount of data collected,

processes of data analysis engaged in, and reporting findings are time-consuming (Polit & Beck 2017:46; 463).

Furthermore, managing, organising, and analysing data are complicated procedures that require an enormous amount of work, as indicated in Miles et al (2014:50-51). In the current study, the researcher used a grand tour question and started by doing one single interview. In doing so the researcher piloted the use of Grbich (2013:96-97) and Wertz et al's (2011:132-153) phenomenological method of analysing the data at idiographic and nomothetic levels. The rationale was to ensure that there is a clear understanding of this method, since it is complex as it utilises 11 operational methods and 4 procedures to complete data analysis of single case. Furthermore, some of these operations and procedures can be abstract and not easy to readily understand and apply. To prevent a situation where the researcher might fall short in understanding and applying them, the supervisor assisted by constantly checking the researcher's work and confirmed that the researcher had understood both all methods and their application as well. After that, the researcher went back to the participant before proceeding to the other individual interviews to verify if what she analysed and interpreted was what the participant had shared with her. Going forward, this is what was done with each subsequent individuals interviewed. Having completed the personal interviews, in the same manner, the researcher moved on to a general description of the phenomenon which is at a nomothetic level as according to Grbich 2013:96-97 Wertz et al (2011: 151-156) and these processes are given in the pages of these texts indicated in the previous subsection.

#### 3.2.2.3 Challenges pertaining to data analysis

Data analysis in a qualitative approach poses a challenge because it is complicated as there are no universal "rules" for analysing data and the absence of standard procedures makes it difficult (Polit & Beck 2017:530). Furthermore, Akinyode and Khan (2018:172) assert that different qualitative methods employ different steps of analysing data, however the point is to emphasise authenticity and acceptability of the collected and analysed data. These methods, especially the traditional ones, use what Polit and Beck (2017:539) refer to, as "fracturing" strategies which involve techniques that break down the data and re-arrange them into categories that enhance comparison across cases as is done in grounded theory. To reflect on the

complexity of data analysis, for instance, in the current phenomenological study, involved not only different steps that had to be followed, but the researcher also engaged in applying a series of attitudinal elements and procedures derived from Wertz 1983: and 1985 (in Wertz et al 2011:132-133). Qualitative researchers use an inductive, emic, subjective process-oriented approach to extract the meaning from data to understand, interpret, describe, and develop theory pertinent to a phenomenon and this is difficult to describe and illustrate (Polit & Beck 2017:550).

In the same vein, as purported by Lincoln and Guba (1985), cited by Streubert and Carpenter (2011:84), it is also difficult to guide the process of data interpretation as this is a complex process of uncovering the relationships and meanings that knowledge and context have for each other. This also depends on the approach of the research conducted. For instance, in qualitative descriptive studies, not based on any specific tradition, a researcher may engage in straightforward, simple content analysis (Polit & Beck 2017:479). In content analysis, the narrative data are analysed by breaking data into units, which are coded according to the content they represent to identify prominent themes and patterns.

### 3.3 PHENOMENOLOGY

The following sub-sections on phenomenology will illuminate the definition of phenomenology and phenomenological designs, as well as the rationale for choosing phenomenology as a methodology for the current study. The strands/streams of phenomenology will be briefly discussed to illustrate the meaning and the researcher's understanding of phenomenology.

Remler,and Van Ryzin (2015:565) define philosophy as a radical philosophy of subjective experience that strives to carefully describe and explain the structure and flow of consciousness. It means that it seeks to get to know about things in an expanded way.

According to Howit (2019:2020 phenomenology is a philosophical school of thought that attempts to describe how the establishment (constitution) of reality in the acts of our consciousness occurs and assists in giving broader understanding of humanity.

Furthermore, Husserl (2000 in Dahlberg 2006:18) refers to it as a description of direct "self-evidence." Wertz et al's (2011:125,126) definition of phenomenology aligns mostly with that of Moustakas (1994) as being descriptive, focusing on investigating individuals' ways of being-in-the-world, by conceptualising and emphasising the processes and structures of the "I" (ego or self).

According to Wertz et al (2011:124-125), phenomenology highlights how people perceive and meaningfully live in the situations as they experience them, to the point that they precisely describe them by neither "subtracting nor adding" anything to their experienced situations. This is what Husserl refers to as "returning to things themselves." Finlay (2009:6), focussing on psychological phenomenological approaches as engendered by Giorgi (1989), identified four core characteristics that occur in all variants of phenomenology. These core characteristics are:

- phenomenology as being descriptive,
- phenomenological research as using phenomenological reduction,
- phenomenology exploring intentional relationships between persons and situations, and
- phenomenology disclosing essences or structure of meaning emanating from human experiences using "imaginative variation."

### 3.4 PHENOMENOLOGY AS PHILOSOPHY

A philosophy, defined from a research point of view, is a paradigm constituting a set of interconnected assumptions that distinguish among different worldviews (Finlay & Ballinger 2006:16). As a philosophy, it has to do with explaining the way things are, with theories that enable one to explain things as they are for individuals (Tarozzi & Mortan 2010:13). Phenomenology, as a philosophy, puts essences back in experiences and requires an understanding of humankind and the world from the starting point of their "facticity**"** (Streubert & Carpenter 2011:73-74). Furthermore, these authors indicate that phenomenology is a philosophy for "which the world is there" before reflection begins and stems from the premise that "all consciousness, by its very nature, is consciousness of something and therefore has to describe things as they appear to consciousness" (Dupont 2013:53).

Yanow (2006:12 in Butler-Kisber 2010:51) asserts that in phenomenology, reality is the product resulting from insight gained through the interpretation of what we perceive, against the background of pre-existing conceptual categories derived from life experiences of interaction with others.

Grove, Gray and Burn (2015:191) furthermore, regard philosophy as a study, a search for wisdom, rational intellect and investigation of "trust or principles of being, knowledge or conduct" (William 2018:22; Jeniseck, 2018:13-14) define philosophy as including the elements of logic, epistemology, ontology, ethics and metaphysics. The latter refers to the study of the ultimate reality of all things, including the study of existence (ontology) and the study of the nature of things (epistemology). Streubert and Carpenter (2011:84) declare that applying philosophy in practice increases the understanding of a phenomenon and improves the scientific interpretation of the text or written words. The philosophical standpoint, grounded in phenomenology, is highlighted by Polit and Beck (2017:54), as not the work of Husserl only. Heidegger is yet another figure that featured in its further development. The focus of a phenomenological stance is the researcher's inquiry into the essence of phenomena under study as people experience it and depict its significance (Schram 2006 in De Vos, Strydom, Fouche & Delport 2011:316). This means that it does not end at merely providing findings in a descriptive format. It also affords interpretive descriptions. The difference is that some studies tend to focus more on one of the two forms. The current study's focus is in on both interpretive (hermeneutics) and descriptive phenomenology.

### 3.4.1 Classical transcendental phenomenology

Kafle (2011:185) states that classical or transcendental phenomenology represents the original form of phenomenological philosophy as conceptualised by Husserl (1859-1938) and that transcendental phenomenologists adhere to the fundamental premise that experience is to be transcended to discover reality. In classical phenomenology, Husserl highlighted how objects appear in pure consciousness; hence, he calls it the "science of consciousness." Intentionality, that at which the

mind directs itself, is a central concept in phenomenology and the essence on which the different strains of phenomenology articulate. As highlighted by Wertz et al (2011:126), intentionality represents all thinking, feeling, and acting and is always about things that we are constantly aware of or experience.

Through intentionality, one can reflect on and advance insight to describe what is experienced and how experiences are experienced (phenomena). According to Grbich (2013:93), intentionality is also how the researcher utilises (views, judges, and analyses) participants' experiences as these become the object of the intentionality of the researcher. Other key concepts in transcendental phenomenology are the epoch, eidetic reduction, and the constitution of meaning. Epoché is similar to bracketing; the putting aside of prior knowledge of the subject matter or scientific theories to focus on the pure phenomenon under investigation. The main difference is that 'bracketing' is more akin to the language of methodological behaviourists with epoché as the phenomenological counterpart (Giorgi 2011:64; Wertz in Wertz et al 2011:126). "Eidetic reduction", on the other hand, involves suspension of personal prejudices and opinions and all knowledge about the phenomenon so that "things themselves can be turned to;" a moment of withdrawal from the natural and everyday world towards the intersubjective level of the transcendental ego (Kafle 2011:182; Van Manen 2011:2). Furthermore, it means the way the researcher perceives and uses objects in the world and how these are analysed and judged (Grbich 2013:93) and how objects can be identified through the process of phenomenological reduction.

"Constitution of meaning" `is yet another aspect of phenomenology. It is how the researcher establishes the meaning of things and the images in his/her consciousness, to explain these images in the way they can be understood (Wertz et al 2011:125, Van Manen 2011:2). According to Holloway and Wheeler (2010:215) and Tassone (2017:2), Husserl's phenomenology also emphasises the concept of phenomenological intuition, which is increased insight (understanding) about a phenomenon. This means that, through this process, the core meaning of the experience of an individual can become apparent to the one who investigates the phenomenon because through eidetic reduction themes about a phenomenon can start to emerge (Van Manen 2011:2). Such emerging themes do not belong to any

known theories or conceptual abstractions. They are equally not part of the existing theories, philosophies, taxonomies, paradigms, or conceptual frameworks the researcher holds, but they are images of a phenomenon which make the investigated experience clear and well understood.

### 3.4.2 Hermeneutic phenomenology

According to Grbich (2013:99), the proponents of hermeneutic phenomenology include philosophers such as Martin Heidegger (1927-1976), Hans-George Gadermar (1900-2002), Paul Ricoeur (1913-2005), Max Van Manen (1942- 2017) and Amedeo Giorgi (1958- 2017). Spiegelberg (1982:344) refers to Heidegger's philosophy as representing "a rightful development of Husserl's phenomenology."

This form of phenomenology is applied when investigating the interpretive structures of experience of individuals or texts. A characteristic feature of the phenomenology of Heidegger is that it emphasises people's being in the world interacting with others. It is accomplished through the integration of external interpretation by the researcher, or from the inside by the participant who is experiencing the phenomenon. As such, it enhances the co-construction of data between the researcher and the participants through continuous conversation (Grbich: 2013:99). Heidegger and others fundamentally grounded their philosophical stance on the rejection of the idea of suspension of personal opinion (bracketing) and the adoption of interpretive narration to the description of experienced phenomena (Kafle 2011:186). Heidegger forged a new conception of phenomenology favouring interpretation "of being" which he believed as being more radical and transparent (Collins 2013:5).

### 3.4.3 Existential phenomenology

The proponents of existential phenomenology include Jean-Paul Sartre (1906-1975), Martin Heidegger (1889-1977), Maurice-Ponty (1908-1961), and Clark Moustakas (1923-2012) (Grbich 2013:98). Existential phenomenology marks the third phase in the development of the phenomenological movement. According to Streubert and

Carpenter (2011:77), the primary concepts developed during this phase are embodiment and “being-in-the-world.” The same authors indicate that these concepts propose that “all acts are constructed on a foundation of perception or original awareness of some phenomena.”

Through the meaning of these concepts, a person can experience something from the environment, and that further provides the meaning of such an experience. The proponents of this movement tend to differ with Husserl in conceptualising the meaning of experience as associated with consciousness and not with human experiences of everyday life (Grbich 2013:98). To them, consciousness is part of human existence, but a separate entity, especially where the body’s active roles, freedom of action and choice, are concerned (Grbich 2013:98). Furthermore, Heidegger and others perceive the individual as being inseparable from the world. Hence, they highlight existentialism as focusing on a person’s being-in-the-world, interacting with other people, having the ability to respond and to react to certain circumstances in the world. During such interaction, relationships are created. Furthermore, people make independent, dependent, and interdependent choices with other people. The time of the occurrence determines such choices, the context in which they occur, the physical location, emotional, social, and intellectual experiences of all involved (Grbich 2013:98).

## 3.5 PHENOMENOLOGY AS RESEARCH METHODOLOGY

Bowling (2014:141) and Polit and Beck (2017:470) highlight that phenomenologists probe the essence of the phenomena as people experience them and how they attach meaning to them. To attain this, the researcher, during the current research, involved in-depth interviews and in-depth involvement with both the participants and the data. The current study used these processes and the procedures in data gathering and analysis. The researcher discusses these processes pertinently at the relevant points in the study aligned with brief discussions of the proponents of these traditions of phenomenology.

The researcher found doing phenomenology, complicated, and not easy to readily understand due to discipline-specific terminology and a lot of contradictions and

controversies emanating from the various schools of thought and the views of respective proponents. However, on reading and rereading various sources on phenomenology, the researcher's understanding of the subject improved. Kvale (2000:55) declares that the development of contradictions is the "force of change" and further development in anything in which individuals become engaged.

Finlay (2009:6) echoes the concerns the researcher expressed regarding phenomenology. She further declares that, although phenomenological researchers concur that their chief interest in phenomenology is to return to embodied, experiential meanings aiming for fresh, complex, and rich descriptions of the phenomenon as it is concretely lived, there are, however, many debates when it comes to best ways of attaining this outcome**.** Such debates consequently lead to difficulty, frustration, and confusion, especially to novice researchers, when they must implement phenomenology as a research method. The confusion is further magnified by "extraordinary diverse interests" of phenomenological philosophers in their primary interest in interpreting the central issues of phenomenology, in their application of what they understand to be the phenomenological method (Neubauer, Witkop, & Varpio 2020:[Sa]., introduce new methods, ideas and, adhere to and debate historical trends of how should be revised and modified. Additionally, these authors indicate that the existing debates are there because, qualitative researchers have ventured to reflect on subtle and epistemological bases of qualitative research and further argue that some qualitative practices should come to an end.

Vagie (2016:65) agrees with the previous authors regarding the existing debates in phenomenological circles, about its use as a design or "method" by further highlighting that it is evident that no single method will be adequate for all inquiries. However, phenomenological researchers, from various fields, must reach a central agreement regarding the fundamental guidelines about doing phenomenology. Furthermore, several authors such as Crotty (1996); Giorgi (1994); Giorgi (1997); Pollio, Henley and Thompson (1997); Valle (1998); Valle and King (1978) and Van Manen (1990) are mentioned in Holroyd (2001:1) as having stated that the approach to phenomenology should be flexible and should be adapted to suit individual phenomena.

The researcher found phenomenology as a research method to be particularly appropriate for the current study. The researcher chose phenomenology because she envisaged it as being the best design to provide the answers to questions pertinent to the present study. In a case where the investigation is going to explore the lived experiences and feelings of individuals, phenomenology stands to be the preferred design of choice. Further, Chapter 2 reports on studies previously conducted on CS other than the experiences of newly qualified professional nurses doing CS in the ECP. With the background knowledge of phenomenology, described and explained in this chapter, the phenomenological design selected for this study has been discussed within the qualitative, descriptive, interpretive, and contextual paradigm. Thus, the design used in this study to explore the experiences of NQPNs doing CS, falls within that qualitative paradigm, because ultimately, this study obtained comprehensive and exhaustive descriptions emerging from the findings of the investigation, they would make contributions towards the scientific pool of knowledge of nursing at the descriptive and hermeneutic levels.

The researcher reflected on the processes derived from the western tradition of phenomenology to guide the study, which led her to provide a brief discussion of phenomenology under two headings as discussed next.

### 3.5.1 Phenomenology as “naturalistic” research

According to Fortune, Reid and Miller (2013:145), naturalistic investigation entails observing people as they engage in their everyday life activities and pursuing the sequences of actions in the contexts in which they naturally happen rather than in an artificially created situation like in a laboratory. However, these authors warn that during a naturalistic inquiry, because of the presence of the researcher, the events in the situation (context) can be affected. Furthermore, even the assumptions and the values of the researchers may influence the processes of data collection and analysis. To counteract this, the researcher needs to be reflective. The interviews in the current study took place mostly at clinics and hospitals. However, the researcher invited and interviewed three of the participants in her office. Furthermore, the

researcher decided on a “naturalistic” inquiry because of her interest in the context of the participants’ experiences.

Miles et al (2020:7) provide descriptors which distinguish the “naturalistic” nature of the qualitative research method, in that its data focuses on, “naturally occurring ordinary events, in the natural settings where researchers have strong management on “real life”. In line with Miles et al’s (2014:9) descriptors of naturalist inquiry, the researcher conducted the interviews in a non-manipulated setting which reflects the everyday life of the professional nurses in CS, at clinics and in hospitals. The researcher was also the main instrument in gathering data. This enabled her to gain a “holistic” overview of the context of the phenomenon under study, by adhering to the logistics of conducting a study through making appropriate arrangements with the participants and the managers at the respective sites. The researcher considered the relevant ethical principles and processes applied to interviewing the participants. As she was collecting data, she became mindful of the data analysis which occurs concurrently with data collection (Miles et al 2014:9).

## 3.6 RESEARCH METHODS

Privitera (2017:4) defines a research method as a set of systematic techniques used to acquire, modify, and integrate knowledge concerning observable and measurable phenomena. (Remler & Ryzin 2015:4) indicate that the research methods are the means or/ and procedures that are used to yield research evidence, such as sampling strategies, collecting data measurement instruments, data analysis planned, comparisons and statistical techniques. Whereas, Pattern and Newhart (2018:3) maintain that the research methods are building blocks of a scientific creativity and they inform the researcher how to go about developing scientific knowledge Furthermore, Polit and Beck (2017:743) indicate that the research method is essential for structuring a study to facilitate the gathering and analysis of data systematically. The following sections (3.7 through 3.12) address these aspects.

## 3.7 THE POPULATION

The population is the total number of possible units or elements that are included in a study and about whom to draw conclusions in the study; the entire aggregation of cases in which a researcher is interested and their number is indicated in 1.12.2 of this thesis. It sets boundaries on the study units, as it indicates the individuals in the universe who possess specific characteristics relevant to a study (De Vos et al 2011:223; Polit & Beck 2017:249; Babbie 2013:148). All NQPNs engaged in CS in SA, meeting the inclusion criteria for the current study at the time of participant sampling, constituted the population for this study. Those in the ECP, however, constituted the target population.

### 3.7.1 Target population

The target population is an aggregate of cases that meet the sampling criteria and about which the researcher would like to make generalisations (Grove et al 2015:250; de Vos et al 2011:110; Polit & Beck 2017:249). However, since this study is primarily phenomenological, the focus was not on generalisation per se, but on generating rich and in-depth information from appropriate participants who have experienced the lived experience of the phenomenon under study to describe and deeply understand the phenomenon. Parahoo (2014:13) explains further that defining the target population helps to provide practical means of selecting a study sample. The target population in this study were newly qualified professional nurses, who were doing CS from January 2012 to December 2015 residing in the ECP. The researcher obtained the target population from the graduates who were produced at an average rate of 295- 300 to 800 each year. These were from both the local nursing college and the university. The actual time for conducting the study depended on the progress of the study. The researcher obtained the target population of NQPNs at strategically selected health care centres in the ECP.

### 3.7.2 Accessible population

An accessible population constitutes a section of the target population to which the researcher has reasonable access and provides a sample of the study on which generalisations about the findings can be based (Grove et al 2015:250). Polit and Beck (2017:249) assert that an accessible population constitutes cases that are representative of the target population, who conform to the designated criteria and form a pool for inclusion in the study.

Mensah and Oteng-Abayie (2017:1614) state that an accessible population, within the context of qualitative phenomenological study constitutes a small group, requires consideration of the aims of the study and these should form a basis for determining inclusion and exclusion criteria of selecting participants. Further, geographic factors can influence the accessibility of participants (Remler & Ryzin 2015:142) (Also refer to Chapter 1 on the geography of the ECP).

During the current study, the researcher targeted the CS practitioners in areas where they were readily accessible. However, some of the participants were invited to the researcher's office since there was no suitable space in clinical units for conducting interviews without interruptions.

## 3.8 SAMPLING PROCESS

The following aspects relating to the sampling process were meticulously followed to ensure the success of the investigation undertaken.

### 3.8.1 Sampling.

The sampling process is an essential part of the research procedure where part of the population is chosen to participate in research to gather knowledge and information regarding the phenomenon under investigation (Holloway & Wheeler 2010:137). Moule and Goodman (2014:291) indicate that sampling in research

implies the process of choosing a portion of the population for the study as it would be unrealistic to conduct the study using the entire population. According to Richards and Morse (2013:221, in corroboration with Grove et al (2015:511) and De Vos et al (2011:391), the sampling process entails making decisions about which people, settings, elements, events, behaviours, and social processes to observe. In this study non-probability sampling with a purposive technique was used. The researcher targeted all those were known have the experience of the phenomenon under investigation. It was envisaged that they would give rich information on it.

### 3.8.2 Sample

A sample is a subset of the population, and ultimately the target population, of elements that can contribute to answering the research question (Polit & Beck 2017:250; Wilson & MacLean 2011:683) that a researcher selects to participate in the research project to ensure feasibility of the study (de Vos et al 2011:224). Its choice is guided by the design, which is used in that study (Brink et al. 2012: 142). The sample in this study was derived from the target population of NQPNs who were doing CS in the ECP during the time of collecting data. The researcher sampled about ten participants who were obtained from the allocation list of the nurses from the province's headquarters in Bisho.

### 3.8.3 Sample frame

Grove et al. (2015:511) and Bowling (2014:200) refer to the sampling frame as a means of accessing the participants for a study by obtaining lists of potential participants. This is accomplished by listing every member of the population and using the sampling criteria to define and determine membership. Privitera 2017:135) also indicates that a sample frame enhances clear and direct identification of portions of the accessible population. Mouton (2009:135) concurs with the previous authors, and further maintains that determining the rule of defining members, creates a complete list of cases that will fit a sample frame for a study. In this study, the researcher got hold of names of potential participants from the allocation list of

NQPNs in the Provincial Department of Health at the Directorate for Human Resource in Bisho (Head office town for the ECP).

These lists indicated the PHC centres and hospitals to which the potential participants of this study were allocated to do their CS. Where potential participants had already left a site of CS allocation, their areas of new employment could be traced through the same Department of Health's lists of appointments.

### 3.8.4 Site and participant sampling

Marshall and Ross (2016:106) assert that when conducting a study, it is often essential to give the details of a setting where the research is going to take place. It must be explicitly explained why such a setup is preferred rather than other sites. The researcher considered the following sampling processes.

#### 3.8.4.1 Site sampling

A research site can be defined based on the relative tradition of inquiry. In phenomenology, for instance, the concept of site selection refers to the fact that the participants selected for the study, could (although not necessarily) be in the same site and are likely to be individuals who have experienced the phenomenon under investigation. Such a site is usually in the field where the participants have life experiences. Streubert and Carpenter (2011:27), as described in section 3.5.2, assert that the reason for conducting data collection in the field is to maintain the natural setting where the experience of interest takes place.

To summarise what has been explicated in Chapter 1 of this thesis, the ECP is the third largest province in South Africa. The ECP comprises about 13.9% of the country's surface area (about 169,580 square kilometres). It has a population of 6,916,200 million, according to the 2017 statistics (Statistics South Africa 2017). About 88% of the population is black and lives in the former homelands of the Transkei and Ciskei, and 50% of the population resides in less than a third of the province's land. The province has 26 municipalities consisting of urban, semi-urban

and vast rural communities. It has 749 clinics, ten (10) health centres, 47 district hospitals, two regional hospitals, and three hospital complexes. These facilities include PHC clinics and hospitals where participants are doing CS.

The researcher chose sites where it was easy to access the target population because, in doing phenomenology, the researcher often must conduct more than one interview per participant. One might need to go back to the same participants to obtain more detailed information which might provide the opportunity for reflection on meaning and making "more intellectual and emotional connections" (Saldana 2013:[Sa]. On arriving at these sites, the researcher only selected and interviewed nurses that would be easily accessible, considering the geographic nature of the ECP.

The sites for data collection comprised of two hospitals and three clinics. Both hospitals are in urban areas. One clinic is in a township of East London, the second one is in a small town known as Stutterheim, and the third one is in the rural area which falls within the Buffalo Municipality, of the Amatole District. Due to the problems of interruption due to limited space in the clinical areas, after the researcher conducted the first two interviews, she resorted to requesting the participants to come to her office to continue with the subsequent interviews.

The researcher contacted the participants telephonically to arrange dates and times convenient to site managers and participants to conduct the interviews. This was done to avoid compromising time for patient care and interference with the off-duty breaks of the participants. The researcher convinced the participants that she would probably use some of their free time and patients' care time, as most of the interviews lasted 60 minutes or more. All these arrangements required appropriate and sensitive negotiations with the site managers and participants. At the end of each interview, the researcher decided with the respective site managers and participants on the date and time for a follow-up interview.

### 3.8.4.2 Participant sampling

Qualitative samples tend to be purposive, rather than random (Miles et al 2014:30). Thus, the researcher selected participants on the premise that they would most benefit the study (Polit & Beck 2017:493). It is on such a basis that Holloway and Wheeler (2010:137) and Streubert and Carpenter (2011:28) assert that purposeful sampling should be based on the judgment of the researcher or should be criterion-based. The knowledge that the participants have played a significant part in this as it supposedly would yield rich data based on their first-hand experiences of the CS phenomenon under investigation (Streubert & Carpenter 2011:28). According to Parahoo (2014:411), purposeful sampling proceeds according to the needs of the study and this is grounded in the researcher's knowledge on the topic. Accordingly, the researcher selects participants who fit the desirable criteria for the topic/experience under investigation.

In the case of the current study, the decision to select the participants purposefully stemmed from a desire to ensure the selection of participants that were doing CS or have done (experienced) CS in various locations such as urban, semi-rural and rural hospitals and PHC centres. The researcher envisaged gaining a variety of experiences from the participants from these centres which are in different geographic areas, in well-serviced and well-resourced regions, as well as from under-resourced and underserved institutions.

Getting participants from these different areas of the ECP was difficult because of the vastness of the province and its mostly rural character. Furthermore, the rural areas get more attention from the Provincial Government as it suffers more due to the shortage of staff. Although the prospective CS practitioners can select any five areas or locations to which they would like to be allocated, the Provincial Department of Health in the ECP does not always consider these. The needs of healthcare institutions guide NQPNs' CS allocations. Another factor, influencing selecting the participants in such areas, is that the shortage of nurses is something that is experienced by the entire province irrespective of the nature of the regions. It was possible to select the participants because the list of the allocation of NQPNs

obtained from the Department of Health specified the nature of the area of assignment as well as the type of services that each area provided.

#### 3.8.4.2.1 Sample size

Polit and Beck (2017:148) assert that qualitative researchers use small numbers of people to generate data. Grove et al (2015:274) also affirm that the focus in phenomenological studies, in particular, is not necessarily about the numbers, but concrete quality data about the lived experiences of the phenomenon under investigation where the researchers aim at gaining rich, in-depth information from the participants. Holloway and Wheeler (2010:145) affirm that qualitative studies require small numbers, especially if participants are homogenous. In conducting a qualitative study, Grove et al (2015:274); Streubert and Carpenter (2011:91) advise that predetermining the number of participants for any given study is not necessary, sometimes not possible, and not advisable. What happens is that data collection must continue until the researcher is sure that the data had been saturated. Data saturation happens when no new information transpires during the interviews, or themes and categories during data analysis (Remler & Van Ryzin 2015:78; Munhall 2012:519). Understanding this principle of data collection in qualitative phenomenological studies, led the researcher to continue collecting data until data saturation had been reached. After having interviewed six participants the data appeared to be saturated as no new information emerged. However, there were (11 interviews) conducted, because five of the six participants were interviews twice. The second interview aimed at going back to verify the accuracy of the information obtained from them during the first interview. The sixth interviewee was not available as was no longer around in the province. Table 3.1 displays some biographic details about the participants.

**TABLE: 3.1 Participants' biographic data:**

| No | Age | Gender | Level of professional education | Race | No of. interviews |
|---|---|---|---|---|---|
| 1. | 28 | F | BA Degree | Black | 2 |

| | | | | | |
|---|---|---|---|---|---|
| 2 | 32 | F | BA Degree | Black | 2 |
| 3 | 36 | F | BA Diploma | Coloure | 1 |
| 4 | 34 | M | BA Degree | d | 2 |
| 5 | 29 | M | BA Degree | Black | 2 |
| 6 | 27 | F | BA Degree | Black | 2 |
| | | | | Black | |

### 3.9. THE ROLE OF THE RESEARCHER

Based on the phenomenological notion of "being-in-the-world" the researcher considered her personal and professional qualities, issuing from her intersubjective phenomenological position, as crucial to qualitative research generally, and phenomenological research specifically.

According to Scott (2014:372), intersubjectivity is a term primarily used in "phenomenological sociology to refer to the mutual constitution of social relationships. It suggests that people can reach consensus about knowledge or about what they have experienced in their life-world at least as a working agreement if not a claim to objectivity." Blackburn (2016:249) corroborates this. However, Morris (2012:134) states that intersubjectivity represents "the quality that exists between people [that] permits them to share an understanding of the world. However, it does not necessarily correspond to the objective reality."

In the researcher's opinion, the entire process of phenomenological research articulates on the intersubjectivity of the researcher and his/her phenomenologically defined "objectivity;" a case of a subject-subject relationship as compared to the natural sciences' subject-object relationship.

#### 3.9.1 The researcher as the primary research instrument

Qualitative researchers function as instruments in data collection and thus become an integral part of the research process (Munhall 2014:236). As such, they become reflexive, implying that they reflect on precise self-aware analysis of their role as

indicated by Mortari (2015:1). This author asserts that by doing so the researcher allows self to be thoughtful about the 'real world' around her/ him so as to gain the crux of the people's experiences being investigated.

Streubert and Carpenter (2011:22), in concurring with the previous authors on the researcher as an instrument, further claim that this is one of the critical characteristics of qualitative studies. The researcher, therefore, serves the roles of being the observer, interviewer, or interpreter of various aspects of the inquiry. The researcher in fulfilling that role can assist in adding to the richness of data collection and data analysis. Cherry (2019:[Sa]) also indicate that the researcher, as an instrument of data collection. "becomes" the instrument of observation and "sees for herself" first-hand how people act in the specific setting. Munhall (2012:146) asserts that the researcher in qualitative phenomenological studies does not merely become a critical "instrument," but is a participant as well, who attempts to understand the meaning of experience through existential investigation. The use of "self" to collect data in qualitative studies, apart from enabling the researcher to gather rich descriptions of human experiences, further assists in establishing relationships during intensive and sensitive interviews with a small number of people (Polit & Beck 2017:533).

### 3.9.2 Reflexivity

Reflexivity is the process of critically reflecting on the "self" as a researcher, being aware that, one's social, professional background and identity, as well as one's values, may influence the process of data collection, analysis, and the interpretation of the findings of a study (Polit & Beck 2017:561; Grove et al 2013:707). Furthermore, Hennink et al (2011:49) affirm that reflexivity is a process that alerts researchers that they form part of the data and part of the setting or social context; as such, the social phenomenon under study.

It is under such circumstances that Streubert and Carpenter (2011:34) and Grove et al (2013:707) advise researchers to take responsibility to always explore their feelings, interests, assumptions, biases, areas of ignorance, and experiences and

endeavour to avoid these influencing their interpretations of data and other aspects of the research.

It is in this context that Hennink et al (2011:19) call upon researchers during reflexivity to engage in serious and conscious self-reflection to make clear their potential influence on all parts of their research. Richards (2011:49) also urges researchers to seriously take stock of their actions and personal roles in the research process. Polit and Beck (2017:561) also emphasise the fact that self-reflection enhances the quality of a study, as it allows the researcher to probe deeply to gain the best experiential information through “the lens” of the participants.

Researchers might take it too far with consciousness during self-reflection to the point where reflexivity becomes overindulged, thus compromising the validity of the study and potentially paralysing to the research process, hence Hennick et al (2011:21) warn about the extent to which researchers can uphold and practise reflexivity. These authors suggest that a balance needs to be struck between comprehensive reflexivity and becoming too analytic to prevent unduly privileging the researcher and blocking the voice of the participants.

In the current study, the researcher aligned herself with the process of reflexivity by creating a journal in which she documented all aspects she felt might occur in a particular manner that could impact on the operations of data collection and analysis. This enabled the researcher to keep in mind that she had previously been a teacher of some of the participants. The researcher considered that this might curb participants’ spontaneity. On the other hand, being no stranger to them might advance their openness and willingness to provide honest, in-depth information.

### 3.9.3 Creating data through transformative processes

The role of a researcher as an instrument is best illustrated by Reiharrz (1983 in Streubert and Carpenter 2011:88) as involving five steps that occur in phenomenological transformation as the investigator makes public, what was essentially private knowledge. The first step occurs as the individuals transform their experiences in a linguistic form (Reiharrz 1983 in Streubert & Carpenter 2011:88).

Through asking an initial “grand tour” question and subsequent probing questions, the researcher attained this transformation, from a felt internal, implicit experience of those doing CS to explicit linguistic descriptions of such CS experiences. The role of the researcher is primary as it is the researcher that elicits the verbalisation of participants’ experiences.

The second transformation occurs as the researcher transforms what is seen and heard into his/her understanding of the original experience (Reiharrz 1983 in Streubert & Carpenter 2011:88). During the current research, what happened during this transformation is that the researcher engaged in analysing the observed non-verbal cues and the verbal information obtained during data collection and data analysis. She further involved in interpretation and description of such information to give it a concrete meaning of the experiences of the newly qualified CS nurses. The descriptions she made led to a succinct understanding of the original descriptions of the participants.

In the third transformation, the researcher transformed what she understood about the phenomenon under study into conceptual categories that reflected the essences of the original experience (Reiharrz 1983 in Streubert & Carpenter 2011:89). In this role, during data analysis, categories evolved, presenting the essences of the original experiences of the participants. Some of the experiences reflected fear for their safety in townships, especially at night, because of the high incidence of crime that occurred in the environment surrounding the institutions. As participants found themselves far from home and allocated to institutions with people of diverse cultures, greatly influenced their experiences as well as the researcher’s interpretation thereof.

The fourth role entails documenting all the essences which the researcher considered to be relevant to the experiences of the participants. This documentation should reflect the participant’s descriptions and actions revealing their experiences (Reiharrz 1983 in Streubert & Carpenter 2011:88). In this final document, of which this thesis forms part, contains a detailed, comprehensive description of the phenomenon under study. The researcher then went back to the participants to verify if the information contained in the document was what they had shared. The

participants scrutinised the description to elicit anything that was omitted or added. The researcher engaged in this exercise to ensure that the final description of their experiences contain all that had been shared by them and that nothing had been added to what they had described initially. The final document aimed at synthesising and capturing the meaning of the participants' experiences into written form, from the very beginning of their experience of doing CS to the stage of the current investigation as the participants perceived it. The documentation thus contains rich information about the experiences identified throughout the study (Reiharrz 1983 in Streubert & Carpenter 2011:88).

### 3.9.4 Creating rapport

Rapport involves the extent of understanding, sense of trust, and respect between an interviewer and interviewee (Howtt 2019:61). Braun and Clarke (2013:10) indicate that rapport is an excellent interactional skill which enables the participants to feel at ease during interviews. Furthermore, it leads to the development of trust among individuals.

Polit and Beck (2017:515) emphasise the importance of the researcher in developing a close rapport with the interviewees as this provides an opportunity to gain rich information from the participants. Balls (2009:3) suggests that in phenomenology, the researcher should adopt the role of facilitator to encourage the participants to talk freely. This is so because participants are sometimes required to share confidential information about the studied phenomenon. They may also be nervous when the interview is tape-recorded. Hence it is essential to put them at ease. Ease may enhance the trust of interviewees in the researcher, enabling productive conversation and sharing of quality information about the phenomenon under investigation. It is in consideration of such that Polit and Beck (2017:515) specify that the participants should be comfortable at the onset of an interview. Streubert and Carpenter (2011:35) also suggest that it is essential for the researcher to take the time to establish rapport with participants if she/he wishes to solicit rich information.

In this regard, Whiting (2008 in Streubert & Carpenter 2011:35) advocates that an informal conversation should precede the actual interview to allow the interviewee to relax and bond with the interviewer.

Polit and Beck (2012:533) maintain that the trust and rapport displayed during an interview allow the interviewees to provide information about their inner world more readily. Interviewees further listen carefully and become the sound sources of detailed information, especially when the researcher skilfully asks probing questions. Saldana (2011:39) assert that it is essential to be calm, be settled and not be in a hurry, giving the participants the necessary attention, and being supportive when the need arises.

During the interviews of the current study, as the researcher went on with interviews from participant to participant, she observed that the interviewees looked tense and nervous initially. However, as the interview proceeded, the interviewees progressively became more comfortable and relaxed. The researcher also felt at ease and content at the realisation that she had established a significant degree of rapport between herself and the interviewees. To attain the needed information, the researcher won over interviewees' trust and established clear communication with them. These, consequently, allowed her to ask more probing questions about sensitive issues surfacing during the interviews, rendering rich and elaborate information.

### 3.9.5 Listening actively

According to Smith, Flowers and Larkin (2009:Loc1567), active listening is a phase of interviewing during which the researchers must pay full attention to the participants, by listening carefully to what the participants say. It is essential during this phase to engage the participants by interacting with them while also being mindful of providing them feedback during such engagements. This might also create a sense of trust with the interviewee that what they have to say is essential, thus further maintaining rapport. According to Leedy and Ormrod (2010:151), repetition of the participants' statements, reflective silences, and reinforcement of

their responses characterise active listening. Reflective silences allow the researcher to reflect on self and what she hears and observes from the participants' descriptions. The researchers must feel free and comfortable about reflective silences, as it enhances and re-enforces participants' description of the phenomenon.

Hennink et al (2011:129) suggest that the researcher should listen carefully to the description given by the participants and allow them to do more talking while guiding with succinct questions thus enhancing the telling of more in-depth stories about their experiences. Furthermore, utterances as "ah-ha" or "Okay" motivate participants as it shows active listening.

To adhere to the skills of interviewing, the researcher asked questions only when she required clarity in understanding when parts of the description lacked clarity. She also kept the interview on track by continually reminding herself and the interviewees of the interview question. Handwritten notes were also taken to augment the information gathered by the digital tape recorder as well as to note interesting aspects of the interview.

### 3.9.6 Involving participants actively

Streubert and Carpenter (2011:28) indicate that participants and the interviewee co-operate in the study and play an active rather than a passive role. In the researcher's opinion, the individuals' intersubjectivity accommodates this. The researcher actively involved participants in the current study by creating rapport, active listening, and responding via appropriate probing questioning as to what participants had told her.

### 3.9.7 Focusing on experiential details

In focusing on experiential detail, the researcher adhered pertinently to the principles of the in-depth phenomenological interview while collecting data. In addition to the researcher's responses to the cues, clues, and hints about experiential details, (Streubert & Carpenter 2011:90) the researcher also carefully applied the

phenomenological processes of bracketing, intuiting and phenomenological description.

As an example of focusing on experiential details during the current research, if a participant said something like “The experience was quite overwhelming,” the researcher would ask her exactly what she meant by “overwhelming” to arrive at a clear understanding of the quality of the experience.

### 3.9.8 Bracketing

Tufford and Newman (2012:[Sa]) state that the primary process of doing qualitative phenomenology is to mitigate the potential of preconceived ideas by “turning to the phenomenon itself” with an “abiding concern,” which requires the phenomenological process of bracketing. According to Leedy and Ormond (2019:233), bracketing is a process that describes how the researcher must take hold of the phenomenon and then place it outside of his or her knowledge about and experience of the phenomenon. Polit and Beck 2014:270; Leedy and Ormrod (2010:141; Grove, Gray and Burns 2015:69) further indicate that bracketing is the process that slates the researcher’s preconceived beliefs, knowledge, and opinions regarding the phenomenon under study so that these do not influence his or her understanding of the participants’ accounts of their experiences. Parahoo (2014:218) asserts that bracketing provides a means of scaling away strata of information when interpreting data. This assists in allowing the phenomenon to appear as experienced and not as the researcher perceives it. It is in this regard that Streubert and Carpenter (2011:83) highlight bracketing as being critical in the process of doing phenomenological research if the researcher is to attain a pure description of the phenomenon under investigation. This process allows the researcher to suspend any bias she/he might hold regarding the information obtained from the participants. It furthermore makes the researcher aware of the precariousness of personal claims to knowledge, something Spiegelberg (1975:70 in Streubert and Carpenter 2011:83) refers to as “ground epistemology humility.”

Butler-Kisber (2010:51) concur that bracketing is essential to approach the study with fresh eyes to grasp the uniqueness of the phenomenon under study, as well as to uncover the pure description of the phenomenon. During data collection and analysis, the researcher endeavoured to put in abeyance all the prior knowledge she had regarding the phenomenon under study to dwell and immerse in the data provided by the interviewees.  found that an exercise in reflexivity assisted in this. However, absolute bracketing is probably unattainable. The researcher acknowledged the extensive knowledge regarding the phenomenon, stemming from the involvement in guiding NQPNs doing CS as a nurse educator, and the preliminary literature review, that was conducted.

### 3.9.10 Intuiting

Intuiting is a second process in descriptive phenomenology which facilitates close observation and listening (Grbich 2013:95), implemented during the process of data collection and transcription as well as during the other operations in doing phenomenology as discussed under sub-section 3.9.8 of this thesis (Streubert & Carpenter 2011:81). According to Polit and Beck (2017:472) intuiting is a process in which the researcher becomes immersed in the phenomenon under study and remains open to the meanings attributed to the phenomenon to have a full understanding of the phenomenon as the participants describe it. Grbich (2013:95) asserts that intuiting should enable the essence of the phenomenon to become psychologically more visible, ensuring that the researcher builds up a picture over time regarding emerging patterns.

During this study, the researcher applied the intuiting process by using the self as the primary data collection instrument, where she listened attentively to individual descriptions of experiences of NQPNs doing CS. As part of intuiting, she studied the data while transcribing it and repeatedly reviewed what the participants had described as their lived experiences (Streubert & Carpenter 2011:81).

### 3.9.11 Describing

Describing in phenomenology refers to a situation where people relate their stories in their terms. Each participant narrates his or her stories from his or her unique perspective, which might lead to the uncovering of new information affording different meanings on a specific phenomenon as the individuals live it. Groenewald (2004:12) indicates that to enable the people (participants) to describe their stories explicitly, it is essential to focus on “what goes on within them” and make them narrate their lived experiences in language that is free from the constructs of the intellect and the society at large, as well as hypotheses and preconceptions

Finlay (2009:7) asserts that what counts for phenomenology is that for the research to be rigorously descriptive, it requires using phenomenological reduction to explore the intentional relationships between persons and situations, disclosing the essences or structures of meaning immanent in human experiences through the use of imaginative variation. Imaginative variation is the act of repeated reading of interviews to elicit the essence of the phenomenon as well as breaking data into segments that bear the same meaning and transcribing these into “themes” (Grbich 2013:97). Through this process too, the participants distinctly describe their lived experiences, highlighting the critical elements of the phenomenon (Streubert & Carpenter 2011:82). Furthermore, the crux of describing is to apprehend and understand the phenomenon in the “lived” context of the person living through the situation.

According to Grbich (2011:96), while describing, the researcher should reflect as closely as possible on the essence of an experience, to ensure that the description accurately reflects the experience. The same author indicated that, explicitly written descriptions enhance participants’ recognition of such descriptions as representing their own experiences, which also helps to strengthen the credibility of the study (Grbich 2013:96.

In the researcher’s understanding, all the processes and procedures in phenomenology, especially bracketing, imaginative variation and phenomenological reduction, have as a central aim the revelation of the eidos of the object of intention

(the phenomenon under investigation). Eidos refers to the “whatness” of the phenomenon (Van Manen 2014:228). In the present study, to adhere to the concepts of reduction, bracketing, and imaginative variation, the researcher, opened herself by engaging herself in relatively long interviews. These took between 60-90 minutes per participant. Concentrating and focusing on data were accomplished by reading and re-reading the data transcripts. Using the MSWord program to store, retrieve, and analyse the data, enabled the researcher to spent extended time with the data to acquaint herself thoroughly with it. Data “cleanliness” was attained by keeping in mind that which the researcher already knew about the phenomenon under investigation and consciously dispelling this from her mind, looking at the presented data in context (bracketing). The researcher thus also found the individual psychological descriptions of participants helpful. She mind-mapped each description to delineate its uniqueness and thus determining both its unique features and in what way invariance occurred.

## 3.10 DATA COLLECTION

Polit and Beck (2017:50), as well as Brink et al (2012:211), refer to data as pieces of information or facts; obtained during a study. Polit and Beck (2017:50) further indicate that in qualitative studies, researchers collect qualitative data in the form of narrative descriptions. Such narrative information can be generated by engaging in conversation with the participants by making detailed notes about people’s behaviour in naturalistic settings. In the context of the current study, the data generated were pieces of information obtained by asking an initial “grand tour question.” The researcher transcribed the responses to the questions as verbal text descriptions of the experiences of NQPNs doing CS in the ECP. Streubert and Carpenter (2011:33) indicate that there is a variety of strategies employed to collect data in qualitative studies. Polit and Beck (2017:506) further assert that often the manner of collecting data in qualitative studies is more fluid than in quantitative studies. Remler and van Ryzin (2015:61) argue that qualitative researcher encompasses various methods of inquiry and thus, collecting data in qualitative research differs from author to author. However, even if that is the case, phenomenological-oriented researchers believe that the subjective nature of data should be maintained intact and uncorrupted (Smith 2020:[Sa]). One way of doing this is by conducting an idiographic/individual

analysis first and after that nomothetic/grouped analysis as found in Wertz's earlier and later work as well as Grbich's 2013:96-97) work (Wertz et al 2011:134-156) Remler and Ryzin 2015:61). These authors, posit that phenomenological studies emphasise open-ended, unstructured, or in-depth interviews. The "grand tour question," that facilitated the open-ended, in-depth interviews during the current research, was followed by questions that sought to elucidate information about examples, experiences, and "insider" language and terminology provided by the interviewees.

### 3.10.1 Planning for data collection

In phenomenological research, several authors suggest that in conducting an in-depth interview, it is worthwhile to request a volunteer to interview and transcribe such an interview before going ahead with the first bona fide interview (Streubert & Carpenter (2011:190). This volunteer should be a person that can be trusted, who has experience in interviewing and somebody who can give honest and valuable feedback (Balls 2009:4). The information thus collected would provide an opportunity to pre-test the interview question and develop interviewing and transcription skills. It would further facilitate a realistic test for the appropriate use of the equipment and identify problems before data collection starts.

During the current study, the supervisor perused the interview guide and schedule. These contained the research question and other logistics of how the process of interviewing would be managed (See, G & H: E). The researcher also gave the same guide to another phenomenological researcher at the University of Fort Hare for comments. The purpose of seeking such comments was to see if the content of the question would make the participants respond within the context of the investigation.

### 3.10.2 The interview and interviewing

Polit and Beck (2017:506) indicate that phenomenological researchers use "self" (See Section 3.9 of this thesis) to collect data to obtain rich descriptions of human experiences in contexts. Researchers must develop smooth interrelationships with

participants while conducting intensive interviews with small groups of participants. On the first encounter with the interviewees, as advised by Holloway and Wheeler (2010:96), the researcher started the interviews asking some factual questions to facilitate participants' relaxation and their willingness to participate in the study. During this introduction, establishing rapport started, thus creating a suitable atmosphere to obtain informed consent, the signing of the consent form and further elaborating on how the interview would proceed and how long it might take. A specimen of the copy of the consent form is obtainable in Annexure E. The researcher asked permission from the participants to use a tape recorder and clearly explained to them the purpose of its use (Streubert & Carpenter 2011:91). The researcher assured the participants that the information on audiotape would be for the eyes and ears of the researcher only and would not be made available to any other individuals other than those officially involved in the researcher's reading for the D. Litt. et Phil. Degree. The researcher explained that notes would also be taken during the interview.

At the commencement of each interview, as it is typical for phenomenological interviews, the researcher started by engaging the participant in a general social conversation before asking the pertinent question. The social conversation aimed at creating a relaxed and trusting atmosphere, as Gill, Esson and Yuen (2016:54), recommend**.** She then, in a general discussion informed the participants why she developed an interest in exploring the phenomenon under investigation. This discussion also ensured capturing an opportunity to tell the participants about herself. She subsequently re-explained the purpose of the study and interview. Furthermore, the participants were provided with essential information by reflecting on aspects of ethical considerations as explained in section 3.13 of this chapter, for instance, aspects of voluntary participation, freedom to withdraw from the study if desired to do so, confidentiality and anonymity.

On starting the interview, the researcher engaged in "epoché" or "bracketing," and maintained it throughout data collection to facilitate concentration on the descriptions, of the daily experiences of the nurses doing CS (Polit & Beck 2017:471). Unstructured in-depth interviewing is a method of data collection which originates from perspectives such as phenomenology and narrative theory (Hansen

2020:10). Leedy and Ormrod (2019:229) indicates that the phenomenological interview involves informal, interactive processes via open-ended comments and questions. As indicated by Rawat (n.d Blog spot), in-depth phenomenological or qualitative interviews are one example of unstructured interviewing in the quest to understand other people's experiences and the meaning they attach to those experiences. Furthermore, these interviews are termed unstructured because the researchers prefer using a grand tour question and rarely conduct their research with a list of pre-determined interview questions (see section 3.10.3 of this chapter). Questions arise during an interview because of the conversation the researcher engages in with the participants (Breakwell et al 2009:237). These authors further explicate that in-depth interviews produce rich information based on the appreciation that the researcher has for the topic under study and the extent to which the researcher adequately questions interviewees.

The researcher chose the in-depth phenomenological interview for its potential to acquire information about NQPNs CS experiences effectively and accurately. According to Shirwise (2019:347), in-depth phenomenological interviews allow freedom regarding wording and explanation of questions to the participants, allowing the researcher to keep on rephrasing the question to obtain appropriate answers to the question. Furthermore, Streubert and Carpenter (2011:90) assert that the full concentration and rigorous participation of the interviewees during the interview process improve the accuracy, trustworthiness, and authenticity of data. In-depth interviews also have an additional advantage of yielding rich information, provided that they have taken place in a comfortable venue, place, and during a convenient time (Streubert & Carpenter 2011:36). This interview allows entrance into another person's world and is an excellent source of data collection (Streubert & Carpenter 2011:90). It allows the researcher to get the essence of the phenomenon under study by encouraging participants to describe their worlds in their terms and their own words (Anyansi-Archibong 2015:81; Seidman 2015:122), and to say as much as they can, while the researcher avoids imposing his/her ideas on participants (Holloway & Wheeler 2010:89).

### 3.10.3 The grand tour question

After initial acquainting herself with the interviewees, the researcher used a grand tour question to open the conversation and interaction between her and the participants (Grove et al 2015:302; Polit & Beck 2017:509). According to Polit and Beck (2017:509), a grand tour question is a broad question asked in an unstructured interview to gain a general overview of a phenomenon, about which more focused questions are subsequently asked. The grand tour question also allows for keeping the naturalness of the experience intact. Sensing (2011:86-87) asserts that the grand tour question should be a negotiated question by allowing the interviewee a "warm-up" conversation with a researcher in a relaxed atmosphere to reach an understanding of the research question. The grand tour question opens the conversation and interaction between the researcher and the participants (Grove et al 2015 83; Polit & Beck 2017:730).

The question used during the current research was entirely open-ended and not suggestive of any answers. The participants could reconstruct their experiences and narrate a range of constitutive events within the topic under discussion (Seidman 2006:15; Holloway & Wheeler 2010:88). The overall research question for the study was, *"What are your experiences of doing community service?"* Alternatively*, "How was it like doing CS?"* This question allowed a free dialogue between the researcher and the participants. Furthermore, the researcher reflected intensely on the experiences narrated by the participants as the act of reflection that denotes the importance of the researcher as an instrument in qualitative data collection. (Xu and Stor (2012:3) argue that in qualitative studies the researcher as an instrument is an accepted and acceptable position. This means that it is the qualitative researcher is obliged to be fully aware of "how his/her ontological and epistemological position supports the research conducted.

The participants could articulate their lived experiences and deeply felt emotions without asking "leading questions" (Onwuegbuzie, Leech & Collins (2010).[Sa] ). As the interviews progressed, the researcher merely gave guidance throughout the interview without unnecessary interference and conversation, to partly assist in maintaining the credibility of the data obtained. She guided the participants to give

clear and detailed verbal descriptions of their experiences which yielded intensive descriptions of the participants' lived experiences in CS (Polit & Beck 2017:509).

As advised by King and Horrocks (2010:48), the researcher kept the interview interactive rather than requiring participants to respond merely to an interrogation**.** The researcher requested the participants to explore their experiences by "reliving" the experiences in their minds, as indicated by Holloway and Wheeler (2010:398). To facilitate this, the researcher asked participants to recall specific experiences; to focus on these experiences thinking about it carefully, expressing their feelings about these experiences and what meaning it held for them honestly (Salmon 2015:Loc 199- 200)

Onwuegbuzie, Leech and Collins 2010:[Sa] also stress the importance of observing verbal and non-verbal behavioural cues while interacting with participants in a relaxed environment to develop stable relationships with them and to obtain deeper meaning of shared information. The observed behavioural clues include expressed feelings, preoccupation with the tape-recording process, and nervousness and other impressions like eagerness to share aspects of great concern about their experiences.

According to Warner's (2013:54) advice, listening attentively and carefully to participants encourages them to give rich and detailed accounts of the phenomenon under study. Such attentiveness facilitates capturing the meaning of an elaborate description obtained from the broad question asked initially. This rich description provided the researcher with a range of choices about what to follow up on and ask in subsequent interviews. As participants described their experiences during the current research, the researcher listened carefully and made specific observations that led her to notice hints, cues and clues that prompted her to aspire to get more information. Consequently, the researcher compiled follow-up probing questions in preparation for follow-up interviews to explore more information.

The researcher allowed the participants adequate time to share their lived experiences fully. The purpose of allowing participants additional time was to facilitate the careful reconstruction of their experience, putting it in context and

reflecting on its meaning (Seidman 2006:20). After that, the researcher transcribed the data verbatim, ensuring that it contained the details as the participants provided it (Polit & Beck 2017:517).

#### 3.10.3.1 Skill in posing the research question

As it is a frequent practice in phenomenological studies, the researcher negotiated the research question with the participants. In doing so, the researcher removed all ambiguity and ensured that the participants understood what the researcher required from them (Streubert & Carpenter 2011:91). This required from the researcher to formulate the question so that it spelt out precisely what the researcher wanted from the interviewees and that the interviewees understood what was required in answering the question. The researcher followed up the grand tour question with probing questions in response to the information the participants provided. By applying these probing questions, the researcher maximised her understanding of the interviewees' experiences. The researcher followed Maree's (2016:94) three examples of probing strategies, namely:

- **Detail-oriented probes** which aim at ensuring that the interviewer understands the who, what, where, when and how of the participants' answers.
- **Elaboration probes** which focus on obtaining the full picture of the described experience. These usually entail asking the participant to tell the interviewer, more about specific examples of the answers offered.
- **Clarifying probes** which aim at checking if the researcher's understanding of what has been said by the participant is accurate. This is achieved by paraphrasing the gist of what the interviewer heard and confirming this with the participant.

The three types of probes used will assist the researcher to get the indepth information that meets the process of getting qualitative data. The researcher attempted to get the thoughts and the feelings of NQPNs in their own natural environment.

### 3.10.3.2 Use of an interview guide and the rationale thereof

Polit and Beck (2017:514) indicate that although the researcher gathers data by engaging in a conversation with the participant, this does not mean that the researcher should get into a casual conversation. They need to plan and be clear as to what information they wish to elicit and how to go about doing so. Consequently, these authors assert that researchers should realise that interviews that are in the form of conversations are purposeful and require skills that go beyond those of an ordinary conversation, which compelled the researcher to careful preparation and practise before embarking on data collection (Polit & Beck 2017:515). The researcher also prepared broad questions for the interviews. Silverman (2010:194) advises that in qualitative studies, pre-prepared questions only serve as a guide during the interview, not as a formal, structured set of questions. Howitt (2016:63-4) also indicates that sometimes a general interview guide is used when the researcher's initial questions have not tapped into the lived experiences of interviewees qualitatively with sufficient meaning and depth. Harding (2013:36) assert that interview guides are essential even if the researcher is conducting qualitative research with a single overarching question. This assists in guiding and directing the conversation with the participants towards the topic and the phenomenon under investigation.

During the current study, the researcher also prepared an interview guide (see Annexure D) containing the "grand tour" question and possible subthemes, topics, and areas relating to the phenomenon under investigation. The guide helped to lay out the logistics of the interviews and allowed for its smooth flow in a logical sequence of activities. The logistics included, for instance, the introduction of the researcher, and an explanation of the purpose of the interviews and adherence to ethical principles. Furthermore, it directed the researcher to know what to ask the participants about, how to pose follow-up questions, what to say after the interviewees had answered the questions and how to move from the "conversational" questions to an interview guide as advised by (Howitt 2019:64).

### 3.10.4 Closing the interview

Hennink et al (2011:130) maintain that, in closing the interview, the researcher should not just end with one question which invites the participants to add more to the information but should gradually cut off the rapport which had been formed earlier by, for instance repeating what had been said earlier, concerning the output of an interview. This means that the end of the interview should not be abrupt, but "waned down gradually." Based on the previous advice, the researcher gradually rounded up each interview by asking each interviewee if he/she had any questions, offering them an opportunity to provide additional information if there was still anything that they needed to share. In some cases, the researcher noticed that interviewees shared vital information after the tape recorder had been switched off. Hennink et al (2011:130) suggest that such information should not be included as part of the study data but must be included in the field notes as it may turn out to be especially useful in data analysis. It was during this period that the researcher also added to her field notes aspects that she needed to take care of during subsequent interviews. She also took note of relevant aspects participants expressed, and her impressions of the interview as well as the feelings that were evoked during the interview as espoused by Marshall and Ross (2016:117-118).

At the end of the interview, the researcher thanked each participant and explained the necessity of further interviews. So, for each participant, the closure of the interview was tentative as she intended to go back to the participants. She also ensured that the participants had copies of the signed consent forms. The researcher drew the participants' attention to the fact that they could use her contact details provided on the copies of their informed consent forms, in case they had any questions or concerns (Hansen 2006:107). She also tried to summarise the significant points that emanated during the interviews. After that, she ended the interview by thanking participants once more for their participation and informing them about the availability of the final research report.

## 3.11 EXPERIENCES OF THE RESEARCHER RELATING TO DATA COLLECTION

In line with the experiential nature of phenomenology, the researcher thought it appropriate to mention some of her experiences during data collection (interviewing) at this point.

### 3.11.1 Arrangements for the interviews

According to Streubert and Carpenter (2011:90), once the participants have consented to participate in a study, it is essential to prepare them for the actual interview. This allows for an opportunity to ask questions about all that pertains to the interview before interviews commence. In planning for the interviews in this study, the researcher ensured that she obtained the contact details of the participants as well as the information regarding the centres at which they gained CS experiences. Since participants were allocated in various hospitals and PHC clinics, they were contacted through e-mail and telephone two weeks before the actual data collection to request their participation in the interviews.

Prospective participants could contact the researcher about any questions they had concerning their participation. The researcher addressed all queries to make participants fully understand the process of data collection before it commenced. Hennink et al (2011:120) stress that making appointments with interviewees before actual data collection is necessary because this facilitates choosing a suitable location for the interview. Venues were considered to make the interviewees feel comfortable and at ease in sharing their personal experiences freely. Furthermore, the researcher made these prior arrangements to secure convenient dates and times for the interviews to ensure that interviewees arranged for the necessary time required for the interviews since in-depth interviews could last 60-90 minutes. The arrangements the researcher made, aimed at preventing compromising patient care time and forging negotiations for the use of the participants' break time as much as possible since the researcher realised that conducting these interviews would interfere with participants official duties. Before the actual dates of data collection,

the researcher, once more, through telephone conversations, reminded the participants about the previously secured interview appointments.

### 3.11.2 Venue for the interview

Loopez and Whitefield (2016:129) suggest that the researcher should create a comfortable environment which is encompassed with high degree of privacy during an interview to make the participant feel relaxed. In that regard the researcher requested the site managers to provide private rooms with no distractions during the interview as suitable venues for conducting the interviews. Distractions and interruptions were minimised, by putting up a note on the door indicating that an interview was in progress and not to be disturbed and telephones were diverted from the venue. The participants' and the researcher's cell phones were switched off. In reality, this is not what occurred in these settings. In most areas, the duty rooms and boardrooms were provided for the interviews. However, in some instances, the researcher was frustrated, because of the interruptions experienced during the interviews where people would ignore the sign on the door and just come in to look for aspects of their routine activities. This left the researcher with an impression that the seriousness of conducting research in general and interviews specifically was not earnestly heeded.

### 3.11.3 Some experiences in the field

The researcher had to consider the information she shared with the personnel from clinical areas regarding the performance of the NQPNs in CS. The comments made by some senior staff regarding the fact that the researcher was conducting the study in their clinical areas were also in her mind. These included the utterances like she might have come to spy on how the senior professional nurses were treating the NQPNs as well as the conditions of CS in their clinical areas.

As a professional nurse and a citizen of the country, it is the researcher's wish to hear the participant contents with CS, because it helps to get extra hands in the clinical areas where there is a shortage of healthcare professionals, and particularly nurses, in South African health care clinical areas. To the researcher, this is what

would make the services to the clients better than it has been the case in recent years. Furthermore, as a lecturer especially when the researcher interviewed graduates from the university where she works, she aspired to hear them indicating that they had attained more knowledge, skills, and “soft skills” than what they had learned during their education and training. There was a wish to hear them articulating that there was a minimum need to refine their skills to reach the level of experienced professional nurses.

### 3.11.4 Culture and language

Cultural factors pertained mostly to the issues of the language used by the participants to narrate their experiences of CS**.** Even though they had completed their tertiary education, some of them struggled to express themselves in English. Consequently, some of the participants could not describe their experiences eloquently as they would go around in circles repeating the same information. However, the researcher endeavoured to gather rich information using various ways of questioning participants and altering them to different ways in which she interpreted the information given.

## 3.12 DATA ANALYSIS

According to Holloway and Wheeler (2010:282), qualitative data analysis is a complex, nonlinear process; however, systematic, orderly, and structured. Miles et al (2020:62) indicate that analysis in qualitative research is an on-going process, which is comprehensive, emerging, and iterative, and elicits meaning from data systematically and rigorously. Butler-Kisber (2010:30) in agreement with the latter authors, further asserts that data analysis is an iterative process in the sense that the researchers move back and forth from collection to analysis, and then back again, refining the questions they ask from data. Furthermore, data analysis also depends on what the researcher brings to the inquiry, what the researcher concentrates on and selects from what she hears, sees, and records on audiotape and records in field notes (Butler-Kisber 2010:30). Streubert and Carpenter (2011:47) claim that regardless of the methodological approach used, the goal of data analysis is to

illuminate the experiences of those who have lived them by sharing the richness of lived experiences and cultures.

Holloway and Wheeler (2010:281) maintain that qualitative researchers usually collect and analyse data simultaneously, and as Saldana (2011:95) points out, preliminary data analysis of most data follows as segments become available to summarise emerging issues and identify further questions that the researcher needs to ask to attain a holistic perspective on the data. Furthermore, Miles et al (2014:12) assert that data analysis of most qualitative research entails "data condensation, data display, and verification of conclusions." These authors explicate data condensation as a process which occurs continuously throughout the life of any qualitative oriented investigation and is a process of selecting, focusing, conceptualising, simplifying, and transforming the data that appear in written up field notes or transcriptions.

Holloway and Wheeler (2010:281) point out that not all forms of qualitative inquiry take the same approach to data analysis. In this regard, phenomenology, and grounded theory, in particular, have very distinct ways of data collection and analysis. According to Grbich (2013:96-97) phenomenology employs explicitly ideographic and nomothetic analysis processes. Using Giorgi's method of data analysis too, necessitated the researcher to analyse at such levels. Before getting to the details of analysing data at these levels, the researcher engaged in preparatory operations as proposed by Wertz (2005:172; Wertz et al 2011:132-133; Grbich 2013:96-97). After engaging in the preliminary operations of data analysis, the researcher in phenomenological data analysis embarks on some more specialised procedures. Wertz (1983:206) describes these operations as only distinguishable theoretically. In practising research, they overlap quite a deal, and they mutually implicate that they constitute an inextricable unity. Ideally, all these activities, either successively, in combinations, or all in one stream (stroke), are projected on every statement in the Individual Phenomenological Descriptions (IPD). The following subsections summarise these aspects.

### 3. 12.1 The preparatory operations for phenomenological data analysis

To accomplish data analysis in phenomenology, the researcher must firstly engage in preparatory operations for such analysis (Wertz 2011:132). Secondly, researchers engage in analysing individual cases (idiographic analysis) to understand the individual phenomenological structure(s) (IPS). Subsequently to that, data analysis aims at attaining a general psychological picture of the phenomenon under investigation. The researcher adhered to the attitudinal constituents and procedures as proposed in Wertz (2011:132, 1983:204-210: 1985:168-174), streamlined in Grbich (2013:96-97). These attitudinal constituents and operative procedures at this level of data analysis include:

- describing the emphatic immersion in the situation,
- slowing down and dwelling in each moment of the experience,
- magnification and amplification of the situation as experienced, and
- suspension of belief and employment of intense interest in experiential details (Wertz 2011:132).

The researcher studied the active operations and procedures for achieving general findings as suggested by Wertz (2011:132; 1983:201-210); 1985:168-173) and Grbich 2013:96-97). Applying these engaged and illuminated the researchers psychological (mental) insights systematically during the current investigation (Wertz 1983:204; Wertz et al 2011:132-133). At the end of the analysis, the researcher understood the experience of individual participants fully and consequently managed to explicitly describe the overall experience of the newly qualified nurses doing CS in the ECP.

### 3.12.2 Organising data for analysis

Wertz et al (2011:136) assert that the best way of organising phenomenological data for analysis is to integrate each participant's written description and the interview material into a "first-person" master narrative. As the researcher did so, she adhered to what Grbich (2013:96) refers to as the "ideographic mode," which means gathering closely related words, ideas or concepts from each transcript and translating these into paragraphs which constitute the narratives of each participant

Wertz et al (2011:136); Hycrner (1985:282) and Wertz (1985:172) declare that focusing on reading every word, sentence, and paragraph; paying attention to significant non-verbal communication reported in the field notes, enhances picking up and grasping the participants' exact expressions and meanings in their broadest extent. Furthermore, Wertz et al (2011:125) state that embarking on a procedure of seriously reflecting on attaining insight into and describing the "how" and the "what" of the experience makes the researcher understand the "world" in which the participants live. Such reflection made the current researcher think and create a mental picture of what the descriptions meant, so that when she expressed them, she did so, in a manner that revealed the most relevant and significant aspects of each case. The whole idea of engaging in this exercise was to ensure that once the researcher fully understood the data, it would be adopted Wertz's (2013:136, 137) suggestion to organise the narrative of each participant, into paragraphs which contain unit meanings of varying content and length. In line with this suggestion, she then segregated phrases that bore common meanings, which Grbich (2013:97) refer to as "natural meaning units."

Once the researcher had a clear picture of the emerging units or meaning units, she created a research key as advised by Grbich (2013:96). Such a key enabled her to group meaning units into categories according to how they related to one another. Similarly, she delineated the sub-categories that fitted well with each category. She reflected on previously formed constructs (ideas) to identify the key themes related to the research question, and that proved crucial to the experiences of participants. Furthermore, the researcher wrote the phenomenological comments on each theme, and finally, wrote a clear and precise sub-narrative of the individual's experience that related to the interpretive themes the researcher had constructed. Going through this exercise at this level of data analysis, enhanced understanding of the phenomenon of interest as the experiences of the participants started to evolve and became distinctly based on the everyday life of the participants in CS.

### 3.12.3 Actual data analysis procedures

#### 3.12.3.1 Individual Phenomenological Description (IPD)

The researcher commenced the process of data analysis by immersing herself in the descriptive data, by reading it a couple of times as suggested by Wertz et al

(2011:136). In line with the principles of interpretive phenomenology, she avoided contaminating the data by engaging herself with the "texts and the transcripts" (Willig 2008:57). Rather than trying to bracket all the knowledge the researcher had about the CS processes and policy and the information she attained from literature about the implementation of CS, she adopted a stance of adhering to a more reflexive view of interpretive phenomenological analysis. Thereby, the researcher aimed at observing Heidegger's criticism of Husserl's phenomenological approach that it is not possible to achieve total bracketing; one can only opt for optimal bracketing of what one knows (Langdridge & Hagger-Johnson 2013:438). What was more important to the researcher in this regard, was to reacquaint and remind self what she was known about the phenomenon under investigation including the researchers feelings and attitude towards it, and to keep this as a backdrop against which she interrogated her interpretation of data units for "an authentic" original representation. Thus, in line with Wertz's (1983:204) advice, the researcher refrained from engaging in this analysis as a spectator, by having allowed herself to "experience[d] the joys and the pains of the participants" in full. The researcher entered the participants' situations and reflected and thought about where the participants were, how they got there, and what it meant to be there, as Wertz (1983:205) suggests.

The Individual Phenomenological Description (IPD) level of data analysis, "eidetic" analysis starts with focusing on analysing individual cases of the experience under investigation, before attempting to generalise cases (Wertz 2005:172; Wertz et al 2011:127). On accomplishing these two procedures, (IPD and imaginative variation), the researcher moved to "intentional analysis with its emphasis on the *how* and the *what* of experiences (Wertz 2011:126). These procedures aim at reflecting on participants' mental processes to determine the essence of experiences emanating from interactive engagement with other people in their lifeworlds (doing CS) (Wertz et al 2011:136).

As emphasized by (1983:207), during reflection, the researcher continually judge statements in the IPDs for its relevance to the phenomenon under study. The researcher must grasp the essence of each meaning unit in context and its relation to other units and the entire experience (Wertz et al 2011:138). During the current study, the researcher compelled herself to reflect on each statement to judge its relevance. Her self-interrogation contributed to the successful outcome of these reflections.

Contexts like family and culture, which initially appeared remote to the experiences of the participants, were crucial in compiling IPDs of the phenomenon under study as these appeared significant existential baseline experiences of some of the participants (Wertz et al 2011:137). For instance, one participant, although admitting that she liked working at the site of allocation, also expressed looking forward to the end of the period of her stay at that facility as she was not comfortable with being there. On probing her about the apparent contradiction in this statement, she said that it was because she was far from home. Furthermore, she had a language barrier with the colleagues who tended mostly to express themselves in their native vernacular. She could also not communicate effectively with the patients as she was Afrikaans speaking, and the colleagues and patients were Xhosa-speaking.

### 3.12.3.2 Magnification and amplification of the situation

As Wertz (1983:205) advocates, when the researcher stops and lingers with each description, its significance becomes magnified or intensified. Furthermore, the researcher must go beyond taking for granted participants' expressions. The researcher observed a fitting example with one of the participants in support of what Wertz (1983:205) indicated in the previous paragraph. This participant shared that she was troubled by "ill-health" since she started CS. Observing her and listening to her utterances, the researcher picked up that she was angry and frustrated about the treatment she received at her area of allocation. She found herself in an environment where she was not allowed to practice in certain areas, which she felt was crucial for her development. She was concerned about the few outstanding months before completing her CS practice and an imminent lack in her experience due to not being allocated to those units. Looking frustrated and angry, she indicated that

> *… when it suits the senior professional nurses, we are independent practitioners, and they would leave us to run the wards…* when it suits *them (senior professional nurses) … again, we are not good enough to be allocated to areas where we would like to be allocated to gain certain experiences important for our development*.

Even though the participant did not seem to associate her "ill health" with her experience at that particular facility, the researcher regarded the illness as a means

of avoiding being in an environment that frustrated her because she indicated that she has never experienced ill-health before. She also complained that the period for sick leave afforded them was too short. Thus, what could be unrelated (minor) to the participant became vitally important to the researcher By noting the possible relationship between the two experiences presented to her as not relating and as individual experiences, the researcher thus magnified the situation.

As suggested by Wertz et al (2011:132), the procedures used in data analysis are essential to reach "intense interest in experiential detail and turning from object to their personal and relational significance." During this attitudinal stance of phenomenological reflection, as Wertz et al (2011:138) postulate, the researcher concentrated and engrossed herself in what the experiences of the participants during the process of doing CS revealed. Furthermore, based on Wertz et al's (2011:138) assertion, she focused on and mind-mapped the meaning units of the IPDs so that she could understand the context in which these experiences occurred. She further tried to grasp how each meaning unit related to one another, as well as to the entire experience which made her perceive the situation as the participants experienced it and what it meant to the participants. It became evident to the researcher, as she reflected that the participants were *partly disappointed*, *angry,* and *discontent* about the act of being mishandled by the senior professional nurses and by what turned out not to be the fulfilment of their expectations. They perceived their treatment as merely a way to achieve the needs of the government by placing them in clinical areas promptly after their training and education. They expressed that since they were doing CS for further refinement of their competencies, they anticipated better management, support, mentoring, and nurturing by senior professional nurses. However, much to their dismay, they found themselves working alone to curtail the staff shortages in some wards and without supervision. Against such a background, the NQPNs regarded themselves as the victims of exploitation by the government and senior professional nurses.

#### 3.12.3.3 Interrogating opacity

The interrogation of opacity involves extending and acknowledging the limits of understanding. When analysing a transcript of an interview, there are often some vague areas which make the researcher wonder what is going on. Wertz (1983:209)

asserts that a sense of those areas is obtained by dwelling with particular persistence in those areas and interrogating their contexts. In one case, the researcher analysed, the participant said something contradictory to what she was experiencing. This participant said when she got to the institution, she was well accepted and were happy working there. At the same time, the participant indicated that she would like to go back to her community. The researcher realised that something was missing here, which she did not pronounce. Upon probing further, the researcher discovered that she missed home. The reason was that people of colour in the ECP, more so where this lady resided, do not mix with the other ethnic groups. She thus found herself isolated. Not being able to express her feelings in the language of the patients and that of her colleagues magnified her problem. Dwelling with the transcripts, involving in reiterative reading, and returning to the participants were the only ways open to the researcher to illuminate and opacity.

#### 3.12.3.4 Thematising recurrent experience, meanings, or motifs

Having engaged in reflection using various analysis procedures, the researcher came up with the summated integrative version of the "individual phenomenological structures" (Wertz et al 2011:142). As she did so, following Wertz's (1983:209) suggestion, she looked for the unity and consistency in the diverse experiences of NQPNs doing CS. Different forms of the phenomenon thus emerged, which led the researcher to identify categories, subcategories, and themes. The emergence of these themes assisted in the development of essential aspects of the experience under investigation (Wertz1983:28).

Furthermore, in line with Grbich's (2013:97) suggestion, the researcher wrote a concise sub-narrative of examples of the individuals' experiences of the phenomenon and related them to the interpretive themes selected**.** A distinctively phenomenological characteristic at this level is that the researcher attempts to grasp the essence of life experiences (Wertz 2011:127). For example, the researcher identified a theme of "exploitation by others," as it figured in the senior professional nurses' actions and the government policy/system; such as the perceived contradiction of the purpose of the government of utilising CS nurses as part of the workforces and not primarily to improve their skills capacity. The reverse side of the

coin is that some senior professional nurses “well-received and oriented nurses into the service,” and “creating a relaxed environment conducive to learning.”

#### 3.12.3.5 Languaging

According to Wertz (1983:210), languaging pertains to the researcher’s attempts to express the sense she/he makes of the analysis of a single case. Themes, phrases, distinctions, and relations are all named and expressed to reveal significant aspects of the descriptions. The results hereof are strictly speaking no longer represented in the participant’s language, but in that of the researcher, as it is the researcher’s psychological reflection that the description articulates. In this regard, Wertz (1983:210) points out that the transformation into psychological language is not a mere translation into, or replacement with, abstract words, but it entails or represents the original spoken word on the part of the researcher as she/he has had contact with the participants. Given the descriptions in the previous paragraphs, the researcher reflected on the knowledge she gathered as she uncovered the psychology of each case. It is important to note that the language used in this phase contains words often used in daily conversations, but the words used are made exclusive to convey precisely participants’ participation and the situation as “meant” by the participants (Wertz 1983:210). For instance, in some cases, the researcher used words like “distraught,” “abusive” and “overwhelmed” to describe certain moments of the participants’ experience.

#### 3.12.3.6 Verification, modification, and reformulation of findings

Wertz (1983:210) asserts that whenever there is an expression of mentally perceived experiences, there is a significant possibility that participants may not express all there is to such experiences. Grbich (2013:96) thus asserts that researchers should ascertain that the description and interpretation of such experience reflect as narrowly as possible the “true” essences of the experiences and avoid losing contact with the participants’ lived experiences. To ensure adherence to this during this operation, the researcher constantly returned to the original descriptions with the reflective statements to verify, modify, or negate the newly emerging reflections in her mind. She also persistently interrogated herself to check if what she described came from the participants’ descriptions and not from her mind. She furthermore

verified whether everything in the concluding descriptions was what participants had in mind and whether she perceived it as the participants intended. To be satisfied that she did not alter what each participant said, the researcher went back to the participants to verify if she had captured what they shared with her as their experiences in doing CS correctly.

The following is an example of an Individual Psychological Structure (IPS) analysis following Wertz's (2011:134) and Grbich's (2013:96-97) modes of idiographic/ideographic data analysis, respectively. The researcher named this Case A in the transcript.

**TABLE 4.2: An individual phenomenological description**

| ***The individual's description*** | ***Psychological reflection*** |
|---|---|
| *I can say that my experience of doing CS was positive at first, but later, I had a bad experience. I started doing CS at the … clinic. There, I was comfortable because I was doing it like a real Intern. I was mentored, and I learnt a lot there. After six months, I was asked to come here because they were short-staffed and the person who was here had trained in the 1970s.*<br>*When I was asked to come here, this in the first place was not the choice I made. I was brought here to a place where I did not even have a place to stay. I had to look for accommodation for myself. The ones that brought me here did not even care how I got here and what challenges I faced. You know I was faced with a lot of challenges* | *"I was comfortable because I was doing it like the real intern … was being mentored and learned a lot."* This resembles the same structure as in the adjacent block. This was before the participant encountered some frustrations. Here the participant was living comfortably in an environment conducive to working and career development, so there was comfort, personal happiness, and contentment. Then, when having had moved away from this choice clinical placement, she became frustrated, distraught and disappointed by those who exposed her to such a situation. |

**How the researcher refers to the experience:** Ambition for perfected professional career coupled with frustration, exploitation, and abuse, yet marked with hope for future success
**What the experience looks like:**
Diagrammatic reconstruction of the experience:
Starting with the aspiration for career attainment and having a desire to be a successful nurse professional
**Distal background:**
Constant supervision yielding comfort because of support and guidance
**Proximal background:**
Initiation of CS: marked with comfort: afforded warm welcome and proper orientation to the clinical units
**Dawning reality:** Lacking direct and constant supervision; Lack of rotation to desired clinical units
**The actualisation of experience expressed with mixed feelings:** On a negative note feels frustrated; exploited and abused; while on the positive note being left alone to practice provides an opportunity to develop the required personal and professional independence.
Confronted by challenges and gaining the opportunity for independence, self-confidence, competence, as well as personal and professional growth

**Box 2.1: An example of a single case**

### 3.12.4. Data analysis at the nomothetic level

As Wertz (1983:228; Wertz et al 2011:150) explains, the nomothetic level of analysis departs from the integration of the attitudes and the operations as well as the achievements attained in the ideographic/idiographic level of analysis. Wertz (1983:227; Wertz et al 2011:150) justify nomothetic analysis, as Individual Psychological Structures (IPS) have some limitations such as that it reflects only an individual instance of a phenomenon – an individual's experience of a phenomenon. It was, therefore, essential to move to the nomothetic level of analysis, a form of general thematic analysis in phenomenological research (Grbich 2013:97). Wertz et al (2011:150) claim that the aim of the nomothetic analysis is essentially to arrive at a "General Psychological Structure" (GPS) of the phenomenon under investigation. Such a structure stems from the analysis of varying individual phenomenal descriptions (IPS), to yield a general understanding and knowledge of experiences. Wertz et al (2011:150) further maintain that through the process of "eidetic seeing," a researcher can establish the concrete qualities found in some, many or all individual experiences of the phenomenon under investigation. This kind of analysis derives from the procedure of "free imaginative variation," where a researcher delineates features that are common in different single descriptions and those that are invariant. In this phase, researchers strive to achieve an understanding of the whole phenomenon as derived from the analyses of several single cases. The researcher, at this point, seeks to move from the baseline information achieved through the different cases analysed to an understanding of the diversity presented by individual cases.

The procedures in the nomothetic analysis also do not happen distinctly from one another but tend to occur in an overlapping manner (Wertz 1983:228).

In dealing with the analysis of the procedure under discussion, the researcher made notes as she listened to different individuals' descriptions of their experiences and realised that the imminent meaning and structural relations of some statements could be true in the general context, others could not. She regarded the others still as unclear, requiring further reflection. However, engaging in this exercise made her start identifying the potentially general insights of the experience as Wertz (1983:228), and Wertz et al (2011:151) maintain. Most of the participants had to

move from simulated clinical situations in simulation laboratories that made them feel comfortable and secure. When they started working in the clinical areas, some of them continued experiencing working with ease and maintained comfort as they were well received and offered good orientation in some of the clinical areas. However, later, they got to the "struggles of the real world of their experience." Such a moment of "change" (realisation) occurred for some as they experienced a language barrier (iSiXhosa versus Afrikaans and English). Those who did not understand the vernacular could not adequately reach out to their patients or colleagues. Their colleagues, at times, tended to use the local language even when they executed professional responsibilities, thus further isolating colleagues who did not speak or understand their language. Adding to the struggles they faced was being overwhelmed by the burden of having to run a unit with people who had slightly out-of-date information about recent nursing practices.

#### 3.12.4.1 Comparing individual examples of the experience

This phase entails a complicated process, in which researchers, through continuous reflections and interrogation of original descriptions, strive for the most specific and accurate general insights (Wertz 1983:229) through the identification of general, even if implicit, invariant characteristics. As Wertz et al (2011:133, 152) suggest, the current researcher considered case by case to identify features of the experience that emerged as general. The researcher made a comparison of the cases to see what themes "emerged" from them, giving her potential general insights into individual structures. Grbich (2013:96) maintains that this exercise facilitates the identification of commonalities of meaning units and the delineation of emergent meta-themes and through the clustering of themes in order of their importance.

As the researcher went through this phase of data analysis, she continued with a comparison of individual experiences to attain insight in the general structure of the experience, even when she found implicit information of individual experiences. Such a comparison did not only enhance the convergences/commonalities of experiences (Wertz 1983:230) but also highlighted the divergent, typical or distinctive structural features of the individual IPSs for the researcher. Wertz (1983:229) emphasises the notion that, rather than uncritically assuming any statement in the Individual Psychological Structure is true for all, the researcher must find it in all the individual ones available.

In further analysing the data through this procedure of comparing her insights, the researcher discovered that for all the cases described, the participants view doing CS as an extension of their professional development to refine their competencies in various discipline-specific areas. She then stated in understandable language, the similarities which re-emerged as general (common) statements from the General Psychological Structures of the phenomenon.

As the researcher is also allowed the freedom to reflect on Individual Phenomenal Descriptions (IPDs) during this phase, the researcher discovered features of one IPD in other IPDs (Following Wertz 1983:230). The researcher, was thus able to penetrate the IPSs deeper to find common features as well as uncommon features that are sometimes highly implicit, thereby gaining valuable and trustworthy insights into the phenomenon under investigation.

As an example, most of the participants voiced that when they were students, they carried out nursing care activities without supervision. When this happened late during their CS period, they felt that this assisted them in developing professional independence. However, other participants felt neglected to have to do CS without close supervision, especially in the early stage of CS.

### 3.12.4.2 Imaginative variation of individual examples to identify invariant features and organisations

Imaginative variation is a process in the nomothetic analysis of data employed to achieve the desired generality, beyond the actual cases which are accessed through the researcher's initial descriptions (Wertz 1883:231). Langdridge and Hagger-Johnson (2013:439) indicate that imaginative variation is "a process of approaching the phenomenon experienced from different perspectives through imaginatively ingeniously varying the features of a phenomenon." According to Wertz et al (2011:151) and Grbich (2013:97), this can be accomplished by reading and re-reading the individual psychological structure of single cases or interviews to gain the general insights of the phenomenon under investigation. This process makes for a description of the characteristics essential to the phenomenon in such a manner that one does not leave out or factor in any changes that will alter the meaning of the phenomenon under investigation.

Furthermore, Langdrige and Hagger-Johnson (2013:239) claim that imaginative variation is "potentially a very powerful technique through which we can uncover the layers of meaning and invariant properties of an experience," which Wertz et al (2011:151) refer to, as the "seeing of essences." To achieve imaginative variation of any experience the identity or structure of the phenomenon is attained by considering both the descriptions of the experience which stand out and those which are implicit, while also discerning the invariants. An example pertains to the various aspects which frustrated participants; for instance, the researcher realised that much as these are different, they add up "negative experiences" or "frustrations". For example:

- one participant was frustrated by doing night duty at a place where she did not know anyone and had to travel by taxi even at late hours of the evening in a township with a high crime rate;
- another participant was without decent accommodation as the assigned clinic was close to an informal settlement where the participant had to stay;
- another participant felt victimised by a nurse who was in charge of a psychiatric hospital;
- several participants got bored with being allocated to similar wards while there were wards from which they would gain more experience making one participant spending a couple of weeks at home "being sick;"
- one participant was homesick, due to frustration with the language barrier that existed; and
- one had a feeling of being undermined by the lower categories of nurses because she felt that doing CS did not make them see themselves as professional nurses and thus not afforded them that status.

During this phase, the use of free imaginative variation, and identification of invariant features, as proposed by Wertz et al (2011:133) enabled the researcher to achieve generalisation and identification of knowledge statements which Wertz (2005:173) refers to as "explicative themes." Such themes are evident in more than one case, which makes it "general" but not true for all cases. The researcher furthermore organised concise sub-narratives and interpretive themes and drew concept maps to place the interpretive themes into related "fields," indicating interconnections around the phenomenon as Grbich (2013:97) advises. This resulted in concept maps and

the interconnections lead to the identification of further general meanings, constituencies, themes, psychological processes, and organisational features relating to the phenomenon under investigation. These interconnections also allow for the formulation of hypotheses for further research.

#### 3.12.4.3 Explicit description of general psychological structure(s) (GPS)

Wertz (1983:235) highlights that during this phase, researchers must document the general truths they observe. In the present section, the researcher formulated the essential themes, by taking into consideration the necessary and sufficient conditions, constituents, and the structural relations which constituted the phenomena in general. These must be inclusive of all instances of the phenomenon under study. Chapter 5 displays these as the final reconstruction of the phenomenon of interest, the experience of doing CS.

The research needs to involve creative writing through free imaginative variation to attain explicit descriptions of the phenomenon under investigation (Grbich 2013:97). Creative writing involves the embodied experiences of the phenomenon, together with information from the literature that enhances the phenomenological description of interpretive themes fundamental to the phenomenon (Grbich 2013:97). Wertz et al (2011:133) assert that finally there will be fine-tuning of explicative themes into one final phenomenological description to form the conclusion of the research; a definitive description of the general phenomenological structure.

During the phase of data analysis under discussion, profound psychological insights evolved (Wertz 1983:204; Wertz 2011:132-133). At the end of the analysis, the researcher was able to understand the experience of individual participants fully, and she consequently managed to explicitly describe the overall experience of the NQPNs doing CS in the ECP. At the end of all understanding of the phenomenon under investigation, the participants were on a professional journey, transiting from being an NQPN to a fully-fledged successful professional nurse. However, it became apparent that both positive and negative experiences marked their journey, as discussed in sections 5.4.1 through 5.5 of this thesis. To attain their goal of success in doing CS, participants needed to adapt to various situations during their tenure in CS, as discussed in chapters 5 and 6 of this thesis.

From analysis of data in this thesis, the details of findings which evolved as categories, subcategories and themes are evolved from data are explicitly described and presented in chapter five.

### 3.11.1 Development of guidelines

The qualitative phenomenological study conducted for the purposes of exploring the experiences of the newly qualified professional nurses doing community service in the Eastern Cape in this thesis, provided findings on which the guidelines were developed. The guidelines developed were to assist the NQPN to adjust to the community service, to understand the structure and meaning of the immediately lived experiences and the professional socialisation potential of CS into the nursing profession.

## 3.13 ETHICAL CONSIDERATIONS

According to Ezzy (2011:52-53), ethics in research deals with the moral conduct of researchers in addressing aspects of research. Ethical reviews that ethics committees conduct, reflect on how the researchers managed the procedures of informed consent, data collection, and the analysis and interpretation of the data. Saldana (2011:24) refers to ethics in research as “moral and legal codes,” which require adherence to care (caring) afforded those who participate in research studies. Langdridge and Hagger-Johnson (2013:544) indicate that ethics in research generally refer to a system of moral principles that need the serious consideration of all researchers engaged in any scientific investigation. As such, values involved in the research must be identified and meticulously explicated in terms of the research setting. Streubert and Carpenter (2011:60) allude that when conducting qualitative research, the qualitative researcher needs to be mindful of the fact that the qualitative investigation is dynamic. Consequently, during the application of its processes, unanticipated ethical concerns may arise. The same authors also point out that there can be ethical dilemmas associated with issues like informed consent, anonymity, confidentiality, and investigation. Hence it is crucial to adhere to ethical standards in planning to conduct research and working throughout the project. It is equally important to consider various principles in dealing with human subjects such as the participants, institution, and scientific integrity of the research and the

researcher. However, this does not mean that it is without associated problems as participants, for instance, may suffer emotional trauma. Given the highlighted significance of observing the ethical standards in conducting research, the following ethical principles were taken into consideration during the current study.

### 3.13.1 Consideration regarding the institution (data collection site)

It is not only the participants the researcher needs to consider when preparing for collecting data, but also the areas in which they live their lives, the research sites. Hence the researcher considered the following aspects relating to the institutions at which participants were doing CS. Obtaining permission to conduct the study at any institution is essential as indicated by Van der Wal (2011:336) who declares that "it is imperative that the institution is treated as a person." As part of the ethical consideration, therefore, the research proposal was presented to the Ethics Committee of the University of South Africa for evaluation and approval. The researcher sought permission to conduct the study with the NQPNs from the Department of Research, Epidemiology, and Surveillance of the ECP to enable the researcher to access the institutions where the participants were doing CS. The Directorate of Human Resources at the Department of Health of the ECP approved the researcher's request to access a list of CS approved institutions. Letters to obtain permission to collect data from the participants at these clinical sites were also submitted to site managers. Annexure B contains copies of the letters that granted the researcher permission to conduct the study.

#### 3.13.1.1 The autonomy of the institution

Van der Wal (2011:336) advises that the researcher must respect the autonomy of the institution throughout a study. In this regard, the researcher provided each institution where she collected data, with an abridged research proposal, a copy of the ethical clearance certificate from the University of South Africa (Annexure A), and the permission letter she obtained from the Department of Health of the ECP. She assured the institutional authorities that she did not anticipate any ethical issues that would negatively affect the participants, as the research did not deal with sensitive

personal information. However, aspects of CS and CS certified institutions might come under fire. About the latter, no information that directly identifies these institutions appears in this research report.

#### 3.13.1.2 Anonymity of the institution

The researcher secured the anonymity of the institutions by preventing any possibility of relating data to a specific person in an institution (Van der Wal 2011:336). The researcher used pseudonyms in the place of the names of institutions to ensure the anonymity of participants and institutions.

### 3.13.2 Ethical issues concerning participants

The data collection phase is a critical period during which to consider ethical considerations as researchers are actively interacting with the participants during this period (Van der Wal 2011:326) that can elicit a range of actions and reactions. Miles et al (2020:54; Schwert 2012:21) also advocate for the maintenance of self- respect and dignity of participants, especially respecting that they offer their time and provide information required by researchers voluntarily. The participants are most vulnerable as the interview might interfere with their privacy, autonomy, dignity, and anonymity.

It became essential to the researcher to prevent the possibility of causing psychological harm to the participants. Since there was no experiment and no treatment given to the participants, she prevented harm indicated by protecting the information given by the participants. The researcher achieved this by keeping in confidence all information given, adequately informing the participants about the nature of the study, thus reducing the risk of exploitation of participants. She prevented exploitation, for instance, by not promising any incentives for participation.

#### 3.13.1.2 Autonomy

The autonomy of participants is an essential ethical aspect of research. All other elements relating to the individual interviews are central to the autonomy of

participants. According to Hammersley (2014:1) autonomy is one of the philosophical principles applied to determine whether research is ethical, and should be used to guide the behaviour of social researchers to respect it. It is a principle aimed at treating humans as self-directed agents capable of controlling their activities (Polit & Beck 2017:144). The participants had a right to withdraw from participating in the research at any time without risking any penalty. By this, the researcher showed her commitment to the principle of respecting the participants' autonomy. She equally informed the participants that they could share information freely as wished; however, if they did not feel comfortable with this, they had the right to withhold such information.

#### 3.13.2.2 Informed consent

Privitera (2017:75) asserts that it is ethically essential to obtain informed consent from all the participants when conducting research by providing them with adequate information about the study and with an informed consent form on which they must indicate their uncoerced willingness to participate in the study. The researcher must ensure that participants understand the information and that they have the power of free choice (autonomy), enabling them to consent to or decline participation (Polit & Beck 2017:145). (See Annexure E).

Kadam (2017:107) concurs with Brynard, Hanekom and Brynard 2012:96) that it is the prerogative of the researcher to ensure that the standard components of consent receive careful attention as it is crucial in ethics when conducting clinical research. These include the provision of appropriate information, participants' competence and understanding and voluntariness to participate and their freedom to decline and withdraw, in writing, at any time after the study has started (Miles et al 2014:59; Streubert & Carpenter 2011:61). Van der Wal (2011:333-334), citing Brink (2006:36-7), suggests that the language used with each participant should be understandable, to the point and unambiguous, and should meet the intellectual ability of each participant to enhance their understanding.

Before prospective participants' decision to join the current research, the researcher fully informed them about the purpose of the study, its significance, its benefits and risks, their role in data collection, what the data collection strategies entailed, and the time of commitment at each point of contact. Furthermore, she informed the participants about the purpose of the research, research procedures, duration of the study, and how she would disseminate the results of the investigation. The researcher also avoided unnecessary scientific terminology which could comprise jargon.

Phenomenological studies have a unique manner of managing the issue of informed consent when dealing with participants. Participants are consulted, recruited, and oriented about the research project well ahead of their actual participation, to answer any preliminary questions they might have and to prepare them for their contribution (Streubert & Carpenter 2007:90). The current researcher also adhered to this principle.

#### 3.13.2.3 Protection from harm

Miles et al (2020:55; Parahoo 2014:102) advocate that researchers should endeavour to avoid the likelihood of harm in conducting qualitative studies.

The researcher ensured the protection of participants against psychological and physical harm throughout the study (Breakwell, Smith and Wright (2012:12). To protect the participant from psychological harm, the researcher did not coerce participants to participate in the study against their will and refrained from asking questions not related to the study. As indicated by Brynard, Hanekom and Brynard (2014:96) the researcher, gave a proper explanation of the entire research process in a manner that facilitated a full understanding of the process and which alleviated participants' tension. Also, the researcher endeavoured to create rapport with all the participants to ensure that they felt comfortable and relaxed and experience the research as interesting (Holloway & Wheeler 2010:8). Since no treatment was given to the participants in this study, there was no possibility of any physical harm, thus also upholding the principles of beneficence (doing well) and non-maleficence (preventing inflicting harm). The participants were respected, and their dignity maintained throughout the process of conducting the study (Schweigert 2012:21).

### 3.13.2.4 Anonymity and confidentiality

Anonymity and confidentiality are two of the essential aspects of conducting research, and these require to be upheld by the researcher. Anonymity is a process of concealing the identity of the participants from all people throughout the study (Privitera 2017:82), such that, in the end, even the researcher cannot link the individuals with the information provided (Grove et al 2013:172; Streubert & Carpenter 2011:64). In this regard, Braun and Clarke (2013:63) warn that while participants' anonymity can be protected, it can also take away the voice of participants, and this might conflict with social justice goals. However, Israel (2015:104) asserts that it is not possible at times to ensure the absolute anonymity of participants.

Confidentiality entails the protection of study participants where the researcher does not divulge information they provide during the research (Van der Wal 2011:335), except if participants agree, such as in a thesis (Silverman 2010:155). According to Privitera (2017:83), confidentiality stems from the premises that people who accept the information in confidence must ensure that they protect the information from being seen by people other than the researcher(s). Van der Wal (2011:335) states that upholding anonymity depends on upholding confidentiality. At the time of negotiating with participants to participate in the current study, while preparing to obtain informed consent, the researcher indicated how confidentiality and anonymity would be secured. Keeping anonymity and confidentiality, regarding information collected from the participants, was guaranteed by reassuring the participants that information obtained would be used in such a manner that no one else, except the researcher, knows the source.

Furthermore, in the present study, the anonymity of all information obtained from the participants was ensured using codes in the form of alphabetic letters. The researcher then kept the list of names of the participants under lock and key, separately from data she collected to prevent persons other than herself from gaining access to those names and being to associate the data with specific

participants. In addition, all electronic files on the researcher's computer were protected by an access code which only the researcher knew.

Although precautions to ensure anonymity were adhered to, it was difficult to exclusively hide the identity of the participants, because data generation involved face-to-face and in-depth interviews. Furthermore, the number of participants selected was small as data saturation surfaced on having interviewed only six participants.

#### 3.13.2.5. Privacy

Privacy during the research process is of prime importance and is an individual's right because of the unpredictability of what could happen during interviews (Streubert & Carpenter 2011:66). Privacy must be considered once confidentiality and anonymity, and the nature and extent of invasion of participants' horizons have been secured (Grove et al 2015:105). It is also essential to clarify the extent to which to disclose the information provided and the conditions under which information would be shared (Van der Wal 2011:154). The researcher requested a private room at the sites where the interviews were conducted to uphold privacy.

#### 3.13.2.6 The scientific integrity of the researcher

Scientific integrity refers to the researcher 's competence in conducting a scientific investigation and the way the researcher adheres to the ethical implications of every step of the research process. Van der Wal (2011:340) emphasises the importance of researchers maintaining personal and scientific integrity while conducting research. Mouton (2008:240), asserts that the researchers should strive towards adhering to the highest possible technical standards in their research. Furthermore, the researchers should avoid all kinds of plagiarism by acknowledging the use of other person's ideas, models, or theories used for designing their frameworks and diagrams.

The Higher Degrees Committee (Ethical Clearance) of the Department of Health Studies of the University of South Africa confirmed the researcher was competent to conduct the study when the research proposal was scrutinised and approved. A copy of the ethical clearance certificate appears in Annexure A. Furthermore, to support the principle of integrity, this thesis is the researcher's original work. It is not a study that someone else conducted somewhere else. She steadily improved her competence through the guidance she received from her supervisor.

To maintain beneficence, nonmaleficence, and justice towards self, whenever the researcher had moments of frustration about the progress of the study, she would share this with caring and sensitive colleagues, her academic supervisor and the Head of the Departmental where she worked. The words of encouragement they provided, gave her courage that she would manage to understand areas that posed problems for her and that she would be able to complete the study.

## 3.14 TRUSTWORTHINESS OF THE STUDY

Van der Wal (2011:340-341) suggests that establishing and maintaining the trustworthiness of the research also reflects the scientific integrity of the researcher. Trustworthiness in qualitative research is the counterpart of validity and reliability in quantitative research. According to Giorgi (1975:96 in Grbich 2013:379): "The key criterion for trustworthiness in phenomenology overall, lies in whether a reader in adopting the same viewpoints articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it." Different strategies or sets of criteria served to enhance the trustworthiness of the research, as outlined in de Vos et al 2011:420-421; Miles et al (2020:306-307 and reiterated in Streubert and Carpenter (2011:47).

### 3.14.1 Credibility

Credibility in qualitative studies refers to the confidence in the truth of the data and interpretation thereof (Brink et al 2012:171; Polit & Beck 2017:559). Miles et al (2014:312), in support of these authors, emphasise that the findings of a study must make sense to the researcher as well as the readers by truthfully evidencing the data

the researcher gathered as well as how the researcher obtained the evidence (data). Furthermore, Grove et al 2015:392: Leedy & Ormrod 2019:239) indicate that the research results should be convincing and believable to those exposed to the findings and should reflect the views of the participants

To ensure credibility, the researcher gave the participants clear explanations about the study, to enable them to provide appropriate answers when they responded to the main question and ensuing probing questions**.** According to Streubert and Carpenter (2011:48), one of the best ways of checking the credibility of the findings of the study is through prolonged engagement with the subject matter. The researcher achieved prolonged engagement with the subject matter by reading literature about the process of phenomenological research. Extensive reading about the design of choice, meticulous data analysis, returning the researcher's interpretations to the participants, and constant refining of the discussions in all the chapters of the thesis, enhanced the credibility of the results of this study.

Another way of ensuring the credibility of the study was to stay with the data up to the point of data saturation. The duration of the interviews (60 minutes and longer) allowed the researcher to observe the reactions of participants and interrogate what they said. The period of transcription allowed her to immerse in the data during data analysis and interrogate data to gain maximum understanding of what the data meant. Further, towards ensuring the credibility of the research, the researcher conducted member checking having returned to the participants to verify the findings of the researcher as their actual experiences (Young & Stewin 1988 cited in Streubert & Carpenter 2011:48). The researcher found doing this possible with five of the six NQPNs whom she interviewed. Five of them work where the researcher was able to contact them. The sixth participants could only be reached with difficulty by telephone as she worked some distance from the researcher.

Furthermore, to enhance credibility, colleagues who had experience in qualitative research, and specifically in using the phenomenological design, affirm the results that assures credibility of the findings of the study as advised by Saldana in Miles et al (2020:306). Furthermore, the researcher used her experience gained during a previous qualitative study as well. The researcher also consulted her supervisor from

time to time as the processes of data collection and analysis progressed to discuss the process and the results of the analysis.

### 3.14.2 Confirmability

Confirmability refers to the extent to which the research results are outcomes of the focus of the study, based on the actual data obtained and data analysis processes considered, not the biases of the researcher (Leedy &Ormrod 2019: 240). According to de Vos et al (2011:421), confirmability means being able to reaffirm what the researcher has heard, seen, or experienced concerning the phenomena under study. The objective of confirmability is to illustrate as precisely as possible the evidence and thoughts that led to the conclusions and findings (Streubert & Carpenter 2011:49). To achieve confirmability, the researcher adhered to:

- bracketing, which assisted in keeping in abeyance biases on the part of the researcher that could have been created by her pre-knowledge about the phenomenon under study,
- using a digital audio-tape recorder during data collection and transcribing interview information verbatim,
- returning transcripts, analysis, findings, and conclusions to participants,
- comprehensive note-keeping of observations made during data collection,
- interpreting the data collected from the participants in detail and accurately (Miles et al 2014:311), and
- providing an unambiguous description of data collection and analysis processes (Brackwell et al 2009:317).

### 3.14.3 Transferability

According to Miles, Huberman and Saldana (2020:306) transferability refers to whether findings from a qualitative study can be applied to another similar context or situation and still preserve the meanings, interpretations, and inferences of the completed research ( Polit & Beck 2017:164; Braun & Clarke 2013:280). In this regard, Streubert and Carpenter (2011:49 citing Green 1990, Lincoln and Guba 1985, and Sandelowski 1986), assert that the expectation for determining whether

the findings are transferable or not depends on the potential users of the results and not on the researcher.

To ensure the possibility of transferability of the findings of this study, the researcher provided an in-depth description of the purpose of qualitative and phenomenological research (see sections 3.2, 3.3, and 3.4 of this thesis) as well as a definition of the "naturalistic setting" of the research in Chapter 1. The researcher further used purposive sampling, which enhanced in-depth discussion during data collection and gave a detailed description of the setting and the context of the research to strengthen transferability.

### 3.13.4 Dependability

According to Streubert and Carpenter (2011:49), dependability is a criterion met once the researchers have demonstrated the credibility of the findings. Dependability refers to the extent to which another researcher might come to similar findings should he/she repeat the research and establish that their convictions about the study findings converge. (Miles et al 2020:306). The question that the researcher must ask him-/herself is: "How dependable are the results?" de Vos et al (2011:420-421; Streubert and Carpenter 2011:316), on the other hand, describe dependability as a process of detailing reasonable consistency of findings over time and convergence over time across methods such as observations, participants, context, data quality checks, audits and peer reviews of coded information.

The researcher described the research methodology of the current study in detail, and this may assist the emergence of comparable results if repeated in a similar situation. Chapter 4 describes the process of data analysis clearly. The supervisor checked the data analysis process through samples that had been sent to him on which he gave valuable feedback. Integrated analysed data are available in Chapter 5.

As advised by Munhall (2012:320), to ensure the dependability of the findings of a study, written field notes, transcribed interviews, coding schemes, the structure of

categories and themes and the findings of the study were open for audit trials. Furthermore, the data collection processes and analysis protocol were developed by following the technique/strategies recommended in the methods of data analysis in phenomenology. The researcher regularly sent her work to her supervisor. She considered his comments and suggestions to improve the value of processes of the data collection, analysis, and interpretation thereof.

## 3.14 CONCLUSION

This chapter gives a detailed explanation of the application of the phenomenological approach to qualitative research and alludes to sampling and data gathering methods, the ethics involved in the research as well as the trustworthiness of the findings of the study. The contents of this chapter convinced the researcher that the methodology she had chosen was the most fitting to answer the research question and to attain the research objectives. Chapter four which is on the framework that guides this study follows this chapter.

## CHAPTER 4

## CONCEPTUAL FRAMEWORK: THEORY OF TRANSITION

### 4.1 INTRODUCTION

This conceptual framework is designed to guide the current study which sought to uncover the experiences of NQPNs doing community service and consequently, based on the findings of the study advanced to development of guidelines intended to produce information that might assist the NQPNs to adjust in the clinical areas. A primary purpose of the current study was to understand how NQPNs experience their CS exposure to immediate enviromet and to develop guidelines on how they adjust thereof. According to the present study, the journey (exposure) of these NQPNs marked both positive experiences that made the journey enjoyable and treasured and negative experiences that adversely affected their personal and professional growth and their love for the chosen profession as their career, hence a need to develop guidelines to assist them to adjust so that they can begin to implement their professional responsibility and leave the clinical areas at the end of CS period being fully responsible and accountable for their professional roles.

To develop this study the researcher, concentrated mainly on the readings of Wertz (1983:204-210 and 1985:157-175), Wertz et al (2011:134-156) and Duchscher 2008:441-448, 2009:1103-1113 and 2012:120).These authors refer to writings; mainly about experiences concerning the theory of research and research conducted on experiences of an array of phenomena. The researcher equally perused several articles on the transition of newly graduated nurses to professional nurses. Also, the researcher considered looking at the available theories in the discipline of nursing that relate to the construct of adaptation/ sdjustment and related constructs emanating from the findings of the current study. “Eidetic seeing” guided the scrutiny of the analysed data of individual cases (Wertz et al 2011:150) and led to the prediction of specific characteristics of the phenomenon under investigation; the “experiences of NQPNs doing community service in the ECP.” Subsequently, the researcher compared all attributes of all the cases that participated in the study to uncover the General Structural Phenomenal Description (GSPD) obtained through

continuous free imaginative variation. This showed that the NQPNs traverse a journey during their one year period of doing CS from “being a novice to being experts” - to borrow from Benner’s theory title (2013).

A concept that crystallised as crucial and positive to the participants is the concept of “adaptation,” an evolving experiential concept that allowed participants to grow and attain the much-needed competencies for their professional roles. Participants viewed “adapting” to the environment as instrumental in enabling them to adjust to community service and focus on the rendering of effective and efficient patient care.

In developing the conceptual framework to guide the development of guidelines to assist the newly qualified nurses to adjust/ adapt to doing community service, and to better understand the structure and meaning of their immediate enviroment, the reseacher regarded Duchscher’s (2008) Theory as relevant, because it relates closely to concept ‘adjustment/adaptation which was emergent key concept (construct) that evolved from the findings of this study. This concept describes the elements of behaviours of newly qualified nurses in the clinical area during a year period of their allocation in community service. The identified theory, explicates therefore, phases and processes of transition during which the newly graduated nurses experience development and encounter some challenges for a period of one year post- registration.

The researcher’s intention was not merely to expand the description of the concept of adaptation, but also to assess the fit of the current study’s findings with that of existing nursing thought and to develop guidelines to assist the newly qualified nurses to adjust to community service whilst they understand the structure and the meaning their experiences within the immediate enviroment. The literature review too, in association to the application of adjustment/ adaptation concept, specifically in health care is also presented.

## 4.2 DEFINITION OF TERMS

After continued contemplation about and dwelling on the research findings and theoretical constructs, relating to the emergent concepts, especially the concept of

adaptation, the researcher realised that the concepts of “traverse” and “transition” accompany the concept of adaptation. Duchscher’s (2008) theory served as a main framework for the discussion of the current study’s findings and as an alternative reconstruction of the phenomenon under investigation.

### 4.2.1 Definition of the term “traverse/ traversing”

The Oxford English Dictionary (2010:1300) defines “traverse” as “travelling” across or through something or moving upward and downward in time, resulting in a non-linear movement.” The participants’ lived experiences revealed that their transition from being NQPNs at the commencement of their one year of CS was not a linear progression, nor was it always smooth. It was also “steep and sloppy at times” that the transition demanded some negotiation.

### 4.2.2 Definition of “transition”

Duchscher (2008:442) defines the term “transition” as the movement from one state, condition or place to another. Duchscher (2001:428) refers to transition within the nursing context as “a period [when] a new nurse undergoes a process of learning and adjustment to acquire the skills, attitudes, and values required to become an effective member of the health care team. Furthermore, Larner (2014:714) states that transision is a multidimenssional process where, in the context of people, an individual passages from one state or condition to another over a period of time. Jonczyk, Lee, Galunic, and Bensaou, (2016:978) assert that during such a period an individual becomes deeply engrossed in the new role and has to disengage from the previous one.

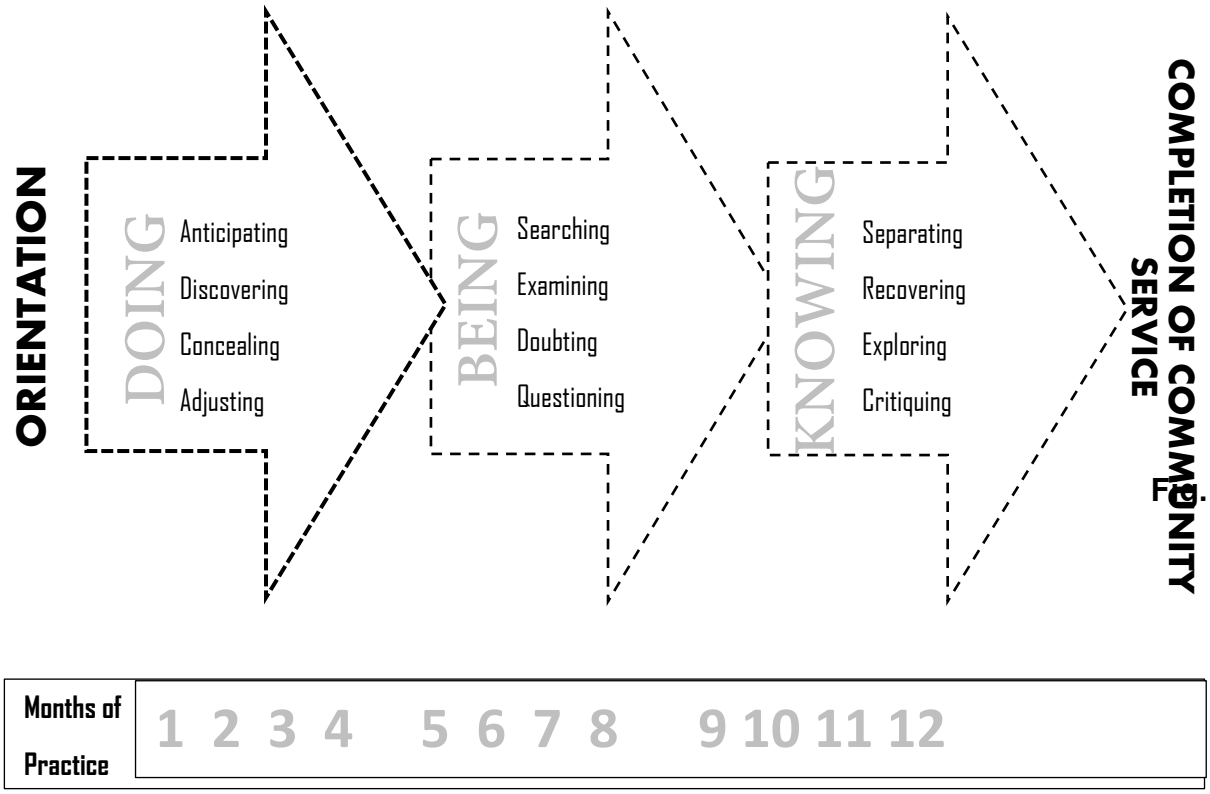
### 4.2.3 Definition of “adaptation.”

According to Roy (1984) in George (2002:313), “adaptation is a process and outcome which people consciously chose to use when they think and feel as individuals and groups, to create human and environmental integration.” Eyzaguirre and Warren (2015:258) indicate that adaptation entails considerations and decisions

that are adopted when a change is required in practice which will need implementation of actions. Lee and Lee (2019:[Sa]) referring to adaptation in a career, indicate that it is a process of accepting the values, norms and policy of the organisation wherein the individual gain work related knowledge , skills, support and attainment of interpersonal relationships.

### 4.3 Duchscher's (2008) Theory of Transition

Figure 4.1 depicts the different stages of Duchscher's (2008) Theory of Transition.




**4.1: Graphic representation of Duchscher's (2008) Theory of Transition** (Adapted from Duchscher 2008:443)

### 4.3.1 Rationale for choosing Duchscher's (2008) Theory of Transition

The researcher chose Duchscher's (2008) Theory of Transition as the main framework
within which to discuss the emergent constructs of the current study. The experiences of the NQPNs, who did CS and participated in the present study, have much in common with Duchscher's (2008) theory. Hence the researcher chose to use the latter as a framework for discussing the constructs (adaptation/ adjustment) that emerged during the current study. This concept has been used in developing guidelines as are presented in chapter 6 of this thesis.

Duchscher's (2008) study presents a theory emanating from a study she conducted on experiences of NQPNs, from the commencement of their placement in the clinical areas up to 12 months in the clinical field. Duchscher (2008:444) refers to the initial 12 months of transition from being a student to being a professional nurse in the clinical area as "a process of becoming." She terms the process of transition of these NQPNs as the process of becoming, which is accomplished through three stages, namely; the stages of Doing**,** Being and Knowing. Furthermore, the same author indicates that the entire journey of transition entails going through a process of anticipation, learning, performance, concealment, adjustment, questioning, revelation, separation, rediscovery, exploration and engagement.

During these first 12 months, the participants in her study had not written their "full registered nurse" examinations qualifying them as professionals. They worked under the title of "probationary nurses." In the case of the participants of the current study, although they were working under the title of a CS practitioner, they had already passed their qualifying examinations allowing them to be registered as professional nurses with the SANC once they had completed their community service. However, some participants in the current study shared that, having the title of a "CS Practitioner" created some challenges for them. Some senior professional nurses did not completely understand their position. Their position was even worse concerning the sub-categories of nurses who merely regarded them as their equals or as having

a status inferior to theirs; regarding NQPNs as “children” or still as “student nurses.” Hence, they were, at times, not allocated responsibilities appropriately. In some units, they would be used as messengers to be sent from ward to ward, or the pharmacy or X-ray departments to collect items appointed porters can do as well. Such practices could lead to the improper development of knowledge and skills of the CS nurses impeding their personal and professional development, leaving their confidence impaired.

Duchscher (2008:442) reports that the journey of the transition of newly graduated nurses to professional nurse practitioners is not linear, but evolutionary and transformative; constituting successes and challenges. Nonetheless, such a journey of transition is instrumental in adjusting to changing personal and professional roles. Additionally, it is a process during which the NQPN goes through the processes of emotional and intellectual development. As their experiential and knowledge levels escalate, it broadens their professional skills and relationships which contribute further to their personal and professional growth.

Roziers, Kyriascos and Ramugondo (2014:95);Duchscher (2009:1104) share that the participants in their study entered into the practice field with some excitement about meeting certain set expectations and responsibilities and moving forward with their personal and professional development. However, challenges in the clinical field soon led to the realisation that things were not as they had anticipated. Such challenges included aspects of their personal and professional lives. As they commenced their clinical practice, they had to deal with professional role responsibilities and workload, which they were not prepared to tackle (Duchscher 2009:1105).

In line with the current study’s findings, comparing the implicitly and explicitly identified characteristics of the experience of navigating their transition from being NQPNs to becoming successful professional nurses, participants did not perceive or experience their contexts in the same manner. In line with the expectations, set by phenomenology as philosophy, each newly graduated nurse presented a unique experience. There were similar experiences and varying ways of experiencing CS. Some participants were allocated to the same facility and exposed to the same

context, but still, shared different opinions about their exposures. For example, some participants voiced having a problem of working without being allocated a supervisor to work with them, and this frustrated them as they felt they were not ready to function independently. For other participants working alone, without an allocated supervisor, was a golden opportunity to develop a sense of independence, self-confidence, growth, and responsibility, because it gave them a chance to take independent decisions. Participants, who regarded working alone as being positive, posited that it reinforced their development. This started when, as students, their superiors would delegate tasks to them either in the classroom or in the clinical field.

Duchscher (2008:443) emphasises that much as the NQPNs might have had remarkable successes in the clinical areas, they still encountered some challenges, especially during the first 12 months of their clinical practice. Examples of these challenges include, “a lack of clinical knowledge and confidence in skills performance, relationships with colleagues, workload demands, organisation and prioritising relating to decision making and direct care decisions and communication with physicians”

These examples of challenges, cited by Duchscher (2008:444; Matlhaba 2019:[Sa]; Govender et al 2015:18; Obiodun, Daniels, Pimmer,and Chips 2019 :12); Halpin, Terry and Curzio 2017:[Sa]), are similar to the challenges mentioned by participants in the current study. Participants pointed out that they experienced a lack of clinical knowledge. These related to limited time during their exposure to some clinical areas while they were students**.** In other instances, they were not even allocated to certain areas, for example, operating theatres and intensive care units, which contributed to wavering confidence in performing skills, thus leaving a gap in their professional armour. Workload demands also posed a challenge. Interpersonal relationships with peers posed some problems, and senior professional nurses, at times, were not good. In some instances, some CS nurses encountered language barriers as a challenge, especially in cases where colleagues chose to use their traditional language when dealing with patient care matters in the presence of foreign colleagues. Some of the participants expressed that they were not supported most of the time due to a shortage of senior staff members. Also, they felt not acquainted and comfortable to directly communicate with physicians or making judgements and decisions about patients’ conditions.

### 4.3.2 Stage 1: The orientation period and doing stage of transition

The “doing” stage occurs during the first 3-4 months of NQPNs’ professional experience in the clinical field. Duchscher (2008:443) argues that during the first three months of allocation in clinical practice, NQPNs go through the process of adjustment to their new roles and responsibilities which are enhanced by the process of orientation to which they had previously been exposed. They begin to accept and realise the differences between the theoretical orientation attained during their education and the practical focus of their professional work. They also become aware that the emphasis in the clinical area is on teamwork rather than on the provision of care by single individuals. The participants in the current study indicated that they became involved in teamwork as senior professionals, doctors, sub-categories of nurses, allied professionals, and the NGOs in the field coached them.

The first stage of entry into professional practice is significantly marked by an extensive range of fluctuations of emotions as newly graduated nurses go through the processes of anticipating, discovering, learning, performing, concealing, adjusting and accommodating (Duchscher 2008:444). These nurses have some expectations regarding the clinical area, of which some occur according to their anticipation, while others do not. They discover, amongst other things, that there is a huge responsibility to shoulder as has been reported in Matlhaba, Pienaar and Seholare’s (2019:6) study where the NQPNs would be left alone to take all the responsibility and accountability of the units. In some instances they would be left in specialised units like martenity and intensive care , yet they lack competences for such units.

It also dawns on them that they are still in the process of continuous learning and have to perform skills in which they are either competent or not yet competent. They also realise that they need to acclimatise to experiences, whether positive and challenging or negative and frustrating. Mabusela and Ramukumba (2021:[Sa]) further affirm that the NQPNs, in this stage of their transition, encounter numerous challenges about their personal and professional lives as they become aware of their inadequate preparedness for their professional roles (Obiodun, Daniels, Pimmer and Chipps 2019:[Sa]). Furthermore, they face a functional workload unfamiliar to them,

as students as well as the expected level of performing nursing and non-nursing tasks.

According to Duchscher's (2008:444) Theory of Transition, most of the newly graduated nurses commence their transitional journey with idealistic expectations and anticipations of what is supposed to happen in the practice field. To them, the reality of the situation is a shock as they are expected to handle full patient loads equivalent to those of the senior professional nurses. They then start blaming their previous educational preparation for the discrepancies between what they anticipated, regarding their roles as nurses, and what they are expected to do in the clinical field. Despite their immense responsibility, they receive neither mentoring nor counselling nor support. This makes them realise that their contributions to the institutional operations are undermined

#### 4.3.2.1 Anticipating

The word "anticipation" comes from the Latin word "anticipate" meaning an expectation or prediction that something (Oxford South African Pocket Dictionary 2014:33), especially something pleasant, will happen and as such one expects it to happen.

According to Roziers, Kyrioacos and Ramubunda (2014:95), NQPNs join the clinical practice field with excitement; convinced that they will cope with the transition from student nurses to professional nurses. Furthermore, excitement was incited by the thought that they would work independently with less monitoring as opposed to their student days. They expected to work on equal basis with the senior professional nurses, and had hoped to be able to manage professional responsibilities and challenges (Thrysoe, Hounsedgaard,Dohn & Wagner 2011:16)

Aligned with the process of anticipation postulated by Duchscher's (2008:444) Theory of Transition, the newly qualified professional nurses in the current study expressed an array of expectations as indicated in sections 5.3.2 and 5.5.5 of this thesis. These ranged from the expectation to be orientated to the expectation to be rotated from unit to unit, allocated alongside senior professional nurses, treated like professional nurses as well as having the departmental officials coming to monitor

and evaluate their progress while doing CS. Moreover, they anticipated to be sent for in-service training sessions as a means of supporting, augmenting, and refining their competences, and to be recognised, primarily by the sub-categories of nurses, as senior personnel. Some expected to be provided rural incentives as is the case when working at the rural clinics.

Contrary to Duchscher' theory (2008:444), in the current study, participants did not explicitly indicate that they felt unprepared for their responsibilities and the workload they had to face in their new roles. What they did mention, relating to the current point of discussion was that when they identified any gaps in their functional responsibilities, they often had to consult their prescribed books. For instance, they used the Essential Drug List Books ( EDLs) or had to go on the Internet as professional nurses often refused to assist them or could not do so because of their lack of knowledge. It was a sobering concern for the researcher to have established from some of the respondents, that since they were not orientated and did not have constant supervision, they would carry out their responsibilities through "trial and error" implying that patients might not be safe under such circumstances.

The participants in Duchscher's (2008:444) study attributed the gaps in their competency to performing clinical practice responsibilities, to a lack of their educational preparations. Additionally, those who participated in Safazadeh, Irajpour, Alimohammad and Hag 2018:[Sa];Salifu,Gross,Salifu and Ninnoni 2018: [Sa]; Salar, Aljerjawy and Salama 2019:4) pointed out that, educational system and design they were exposed to, did not support their skills development and their acquisition. However, those who participated in the current research associated the theory to clinical practice gaps with inadequate exposure to the clinical field during their student days. They were content that they had a satisfactory theoretical background to make them competent, only if they spent sufficient time and had sufficient exposure to different clinical areas.

#### 4.3.2.2 Discovery and concealment

These two sections must be read in conjunction with each other. If not, discovery might imply the gaining of clinical expertise only. However, discovery has much to do with unravelling that which is concealed in the clinical area.

##### 4.3.2.2.1 Discovery

To discover is to "become aware of a situation" (Oxford South African Concise Dictionary 2010:333). Fowler's Concise English Dictionary (2016:179) refers to discovery as finding something previously not known, or to have an encounter and learn about something for the first time (Collins English Dictionary 2011:478).
Regarding the discoveries and the hidden realities of what is happening in the clinical areas, the researcher realised that there is a lot in this study that aligns with Duchscher's (2008) Theory of Transition, regarding the experiences of the NQPNs during the stage and processes of discovery and concealing.

Duchscher's (2008:444) theory postulates that NQPNs expect to function at the professional level, allowing them to learn (discover) a lot; to the extent that they feel "*flooded with information and expected to perform accordingly."* NQPNs discover during this phase that what they experience is not what they expected, for instance, to be flooded with additional learning and consequently being expected to perform accordingly. Consequently, their inability to apply information is also a concern because their seniors depict them as being incompetent. They lack a sense of identity and experience a sense of self-doubt and anxiety and become "stressed about everything." (Duchscher 2009:1105) Their inability to perform procedures of which they have limited, or no knowledge, trigger their anxiety, and their fear of harming patients unintentionally further escalates their anxiety. Problem-solving, management of complex situations, and clinical judgement are also challenging encounters. In line with these findings the newly qualified nurses in a study conducted by Kreedi, Brown, Marsh, and Roger's (2021:101) study, also affirmed that they found themselves lacking soft skills like decision making, critical thinking and making clinical judgements.The rigid and outdated ways senior professional nurses adopt in their work was equally problematic.

While senior professional nurses in the current study, expected the NQPNs to carry out their professional roles, there was minimal support and teaching provided by senior professional nurses in most clinical sites where the participants did their community service. Instead, they had to work alone most of the time. In some instances, even if the senior professional nurses were around and the CSNPs needed assistance regarding aspects they did not quite understand, they referred them to consult their prescribed books for the information they wanted. The experiences the NQPNs in the current study had are similar to those in Duchscher's study. (2008:444;Thrysoe et al 2011:16; Walker, Costa, Fosta, and de Bruin 2016:510 ; Scheeper and Bell's 2020:15) studies, where the participants confirmed that they were expected to perform work that was way above their level of competency and experiences as the newly qualified nurses. For instance, it did not dawn on the present respondents that they would be expected to perform like fully-fledged nurses soon after they qualified as was the case at the CS sites. Correspondingly, their experiences were anxiety-provoking due to the abusive manner with which some of the professional nurses treated them. Anxiety also arose as a result of an inability to perform specific procedures they never had adequate time to practice while still students and the workload was a problem as there were staff shortages in some instances.

Similarly, some participants expressed being overwhelmed by anxiety during the execution of their responsibilities, in specific areas, such as nursing premature babies in intensive care (ICU) units; an especially anxiety escalating experience. Likewise, nurses in Kreedi's et al (2021;101) study articulated the same experience of being overwhelmed, stressed and unscertain about what to do when confronted with dealing with very patients in the ICU units. They feared to harm the patients. Some participants in the current study, also experienced such anxiety when they had to carry out responsibilities that fell outside their scope of practice, such as those that required doctors' expertise. However, none of them ever explicitly expressed any self-doubt in their clinical practice. This emanated from the fact that it was found to be a common practice for most of them to be left to do work on their own as students. They grew accustomed to trial and error, thus concealing any feelings of inadequacy.

As indicated, some of the participants experienced (discovered) that the clinical field could be a harsh experience due to the unprofessional behaviour of some senior professional nurses. They had to bear being untrusted and undermined by senior professional nurses when it was convenient for those senior professional nurses to do so. For instance, when it suited them, the senior professional nurses would allow respondents to keep the keys to the drug cupboard. Usually, professional nurses will not allow this. Also, following Duchscher's study (2008:444), senior professional nurses reprimanded NQPNS, much against their expectations, in the presence of others. Although not reprimanded for the same reasons, participants discovered that reprimands by those in authority are something that is there and is "the order of the day." To them, it was a revelation that all is not exciting and pleasurable in the clinical setting, which was contrary to the excitement and joy they had and expected to find in their placement sites.

#### 4.3.2.2.2 Concealing process

"To conceal," in comparison with discovery, means hide  means not allowing to be seen (Oxford South African Pocket Dictionary 2014:177). Online Longman's Dictionary of Contemporary English (2021:[Sa]) refers to conceal as hiding real feelings or the truth. According to Duchscher's (2008) theory, this process involves the question as to on whom to rely. New graduates have a strong desire or need for someone to look up to and to lean on. However, they often hide their feelings from their colleagues and strive to disguise any feelings of inadequacy (Duchscher 2008:444; Duchscher 2009:1108). Although NQPNs have advanced skills and knowledge, these are often camouflaged by "their wavering confidence, their limited experience with the application of that skill and lack of predictability of and familiarity with many variations in clinical contexts" as according to Duchscher's theory of transition (2008:444). This concealing process escalates anxiety resulting in high levels of discomfort to newly graduate nurses as they fear being portrayed as incompetent, which might subsequently reduce their credibility in the eyes of their colleagues.

The current study yielded evidence in support of Duchscher's (2008:444) study and resulting theory. For instance, in the case where the reprimands levelled against respondents in the current study, they hid their feelings, acted humbly, and kept quiet, realising that they were there to accomplish the aim of their career advancement and patient care. One of them even indicated that she needed to "hold back" her feelings based on her principles of professionalism by abstaining from arguing with a senior professional nurse during a misunderstanding and heated argument between them. One other manner of hiding the feelings, against the rude behaviour of the senior professional nurses, was trying to work harder by concentrating on patient care and, during quiet periods at night, keeping herself busy on her laptop, not socialising with senior members of staff, thus concealing herself.

#### 4.3.2.3 Adjustment

The word "adjusting" means "to adapt to, or to get used to a new situation" (Oxford South African Concise Dictionary 2015:18). Furthermore, it is an act of gradually becoming familiar with a new situation, and as such, one settles in (Longman's Dictionary of Contemporary English:nd). The Collins English Dictionary (2011:20) refers to adjustment as "adapting to a new environment."

During this stage pertaining to Duchscher's theory (Duchscher 2008:445), during the newly graduated nurses go through the process of adjustment to a range of professional attributes, for instance, to new roles, responsibilities, relationships, sociocultural and personal and professional attributes. At the same time, they grapple with adjusting to daunting degrees of clinical duties, establishing new professional associations and ceasing holding on long-standing relationships formed during their student days. Consequently, they have to navigate through adjusting to the culture of nursing practice, which they mostly find prescriptive, tradition-bound, emphasising adherence to a hierarchical stance of doing things. They also have to adjust to day and night shifts, which place severe physical demands on them. For instance, it is exhausting and leads to sleeplessness, especially during the day. Even so, they are expected to be alert at work at night. They also needed to adjust to making decisions, and judgements and accepting full responsibility for their professional actions although they feel they lacked the expertise for that.

In the course of  the initial stages, discussed by Duchscher (2008:445) in her theory of Transision, the newly qualified nurses were also overwhelmed by having to nurse double the number of patients they expected to nurse and having to care for patients who have unstable conditions as well as having to multi-task. Such experiences lead to added stress. Stress is also caused by having to delegate responsibilities to licenced and unlicensed personnel who are older than they are with vast experience in the clinical field (Duchscher 2009: 1109).

As in the case of Duchscher's (2008:445) study, the NQPNs in the current study also faced having to nurse large numbers of patients, at times alone, due to a shortage of staff as well as a high rate of absenteeism among senior professional nurses who were often booked off sick. They also had to multi-task and maintain responsible actions. It was common practice for them sometimes to become involved in responsibilities that did not fall within their scope of practice; like prescribing medication for some patients, dealing with head injuries and exercising judgment about what to do with the patients as the doctors would not always be readily available, especially in smaller hospitals in the rural areas. Similarly, the NQPNs in the current study reported that they had to deal with seriously ill patients, especially those in intensive care units, including caring for critically ill premature babies. As well, nurses in Duchscher's study (2009:1019), self-reported working in situations that made them feel uncomfortable.

Having to deal with the sub-professional categories of nurses was a daunting responsibility because, as participants stated, some were much older than themselves with vast nursing experiences. To make things worse, they did not even understand their status as so-called "CS practitioners," a slightly ill descriptive title leaving sub-categories of nurses regarding CS nurses as being inferior to the other subcategories of nurses.

However, although the nurses in the current study also faced making decisions about patients' conditions, they did not struggle much about that. They indicated that they got acquainted with doing so while they were still students. They maintained that while they were still students, it was common practice for them to work

independently. Nevertheless, some of them were sceptical about making decisions on their own about patients' conditions, without the support of a senior professional nurse, lest they might put these patients' lives at risk. Equally, as in the case of Duchscher's (2008:445) study, the newly qualified CS nurses were detached from old relationships and had to adjust to new relationships formed between peers and the senior professional nurses.

#### 4.3.2.4 Accommodating

Accommodating is an adaptation in which psychological structures are modified to fit into the changing demands or processes of the environment or change as a result of the new experience (Cherry 2018:[Sa] ). Accommodation means to adapt, change, settle, adjust, transform, comply, conform, alter and change a the behaviour so as to fit into the new situation (Oxford advanced Learners Dictionary 2014:8). In the researcher's understanding, it also involves "making place for."

Duchscher's (2008:445) newly graduated nurses found that some nursing procedures were, at times, not executed as expected. So, they decided to do things the way they were told to do them without questioning their exactness. The rigid ways and authoritarian nature of handling issues in the clinical field, as they experienced and observed senior professional nurses doing these, resulted in their capitulation to accommodating practices they did not believe were exact. This was confirmed by one nurse in Duchscher (2008:445) study who voiced that her earlier clinical practice was just like "*being in a little bubble and things were going all around her/him and could not hear or see them*." The capitulation further frustrated them and contributed to a lack of experiencing professional fulfilment in the execution of their professional roles. Equally in a study conducted by Mishra, 2015:[Sa] newly qualified nurses experienced very rigid traditional practices which made them uncomfortable and insercure. There was also excessive emphasis put on hierachical status that made them to feel inferior to a point that they felt were even pushed to "working class status".

In the current study, some of the NQPNs ignored the abusive behaviour of some of the senior professional nurses. They rationalised this by realising that they would be

in precisely the same situation for a significant part of their professional development and patient care. So, they decided that the best they could do was to endure the rude behaviour of some of their seniors.

In summary, the nurses in Duchscher's (2008:444) study also, expressed a desire to belong, but were uncertain as to whom to trust in the environment in which they found themselves. They experienced some difficulties because they felt incompetent as a lot of what they had to do was new to them. The CS nurses in the current study also expressed a need to belong, however some missed feeling that they belonged due to ill-treatment, language barriers between them and patients and between them and senior professional nurses and peers who decided to express themselves in a vernacular that cut other nurses from their "world."

### 4.3.3 Stage 2: The "being stage" of transition

This period of transition as stated by Duchscher (2008:445) commences after the orientation and doing stage between the 5$^{th}$ to 7th months of NQPNs' experience in the clinical field (Duchscher 2008:442). During this time, there is a significant change in the newly graduated professionals' perceptions of their experience, which takes them to a stage where they consolidate occurrences and derive meanings. This stage signals a remarkable development in their levels of knowledge, skills competencies, and cognitive skills. The dominant processes at this stage, include searching, examining, doubting, questioning, revealing, and recovering. During the processes occurring at this stage, the transition characterises disengaging, questioning, recovering, accepting, and finally re-engaging with their chosen career on their terms.

Duchscher (2008:442) also claims that at this stage of transition to professional nurses there is a significant change in the newly graduated nurses' perceptions of their experience which allows them to consolidate occurrences and develop an understanding and grasp meanings. In the current study, the development of the newly qualified CS nurses was not observed strictly by delineating it in association with the different months of practice during their year of allocation in CS clinical practice environments. However, the participants, in line with Juliff's (2017:97),

findings expressed the emotional impact of lived experiences coupled with their ability to advance through the different stages of transition. Sections 5.4.1 and 5.5.3 discuss examples of such emotional impacts which transition had on the newly qualified CS nurses/participants. These allowed them to focus on patient care and their professional development

#### 4.3.3.1 Searching and examination processes.

The term “searching” means to critically analyse and carefully seek to find out the truth about something (Online Cambridge Advanced Learner’s Dictionary 2021:[Sa]). Furthermore, it indicates to “examine or scrutinise thoroughly to find something, especially in a disconcerting situation” (Oxford South African Pocket Dictionary 2014:810).

The term “examining” refers to” look for something carefully and thoroughly because one wants to find out more about it” ( Online Longman’s Dictionary of Contemporary English for Advanced Learners:nd). Examining also pertains to investigating something in detail (Oxford South African Concise Dictionary (2010:406).
It is reported in Duchscher’s (2008:446) study that the frustration of NQPNs about issues at work continued as in the first stage of their transition; however, transition continued at a slower pace. To cope with their work, some of the participants directed their focus towards their personal lives and tended to draw away from the work environment as they would refuse, for instance, to work overtime. In some instances, they even avoided spending time with their colleagues. In the current study also, respondents expressed their frustrations within a few months of their arrival at their workplaces. Whenever they experienced frustration, they instantly shared it with the researcher (who was also a lecturer to some of the participants) as well as the coping mechanisms they implemented to shun away from whatever frustrated them.

As indicated in Duchscher’s (2008:446) theory of transition, at this level of NQPNs’ trajectory, the newly graduated nurses already developed a heightened level of whom they are as professionals, and they begin to compare their professional roles

with those of other healthcare professionals. They also seek to balance their personal and professional lives during this phase of transition, as the NQPNs become content with their professional roles and responsibilities The comfort and contentment of newly graduated nurses allow them to begin rigorously examining the underlying rationale for nursing and medical interventions as well as the relevance and value of the health care system. In the current study, the participants were aware of their gradual development as professional nurses. However, they based the comparisons they made between themselves and senior professional nurses on the difference in the recency of exposure to current knowledge. They argued that having had exposure to new developments in some aspects of health care systems in their training rendered some senior professional nurses' knowledge obsolete. This was especially noticeable in the area of HIV and Aids and integrated neonatal and child health care. The participants equally alluded to the sense of contentment about their experiences at all levels of transition. However, this depended on individual participants and the situations in which they had found themselves.

#### 4.3.3.2 Doubting process

"Doubting" entails "a feeling of uncertainty or lacking conviction or a state of questioning the truth of something" (Merriam- Webster Online Dictionary 2021:[Sa]). Doubting also means being unsure, wavering, questioning, fearful, suspicious, sceptical, or being in a dilemma (Thesaurus, 2012:170).

Duchscher (2008:445) asserts that although participants indicate personal and professional growth during this stage, they still worry about and doubt their professional identity. The views they hold about themselves and the nursing profession impact such doubts. They also have concerns about the discrepancies and inadequacies they still encounter and experience in the health care system. In the current study, the participants did not emphasise much concern about the gaps they had in their practical abilities. Mostly, they expressed zeal to have the opportunity to bridge the gaps they identified in their practices by committing themselves to their development and coming forward and asking for help when needed.

#### 4.3.3.3 Questioning process

"Questioning" refers to "the rising of doubt or concern on an issue for further consideration or discussion" (Oxford South African Concise Dictionary (2015:1201). Questioning can also mean "to check the value of something or doubt the value of something" (Oxford South African Pocket Dictionary 2014:731).

Duchscher (2008:446) states that during this process, newly graduated nurses reported feeling that they were at a "turning point," realising that they have to commit themselves "to be real nurses." They reflected on their student days and questioned their decision to leave that comfort zone to face the overwhelming responsibilities that "*made them continuously feeling incompetent, inadequate, exhausted, disappointed, devalued, frustrated and powerless*". The newly graduated nurses have an array of questions while grappling with their responsibilities as nurses. However, they cherish the environment in which they have to adjust and accept it passionately. The newly graduated nurses in the current study also appreciated the opportunity CS offered them irrespective of the nature of their lived experiences. However, one participant reflected and commented on the comfort she enjoyed as a student, realising that most of the time as a CS nurse she worked without constant supervision whereas, during her student days, a clinical facilitator was always at hand so that she could depend on such support all the time.

#### 4.3.3.4 Revealing/Recovering process

The term "reveal" refers to "allowing being seen" (Oxford South African Pocket Dictionary 2014:768). To reveal is to "let something interesting and significant be or surprising about a situation be known" (Oxford Advanced Learners Dictionary 2015:1266 ). According to Duchscher (2008:447), during this revealing/recovering process of transition, NQPNs reported that they tended to recover the sense of control over their lives by engaging in protective withdrawal from their surroundings. They expressed a strong desire to work in areas that offered stable situations where familiarity, consistency, and predictability surrounded them.

In the initial phase, their judgement of self-trust was weak, and they sought validation of their decision making and confirmation of clinical judgement from senior co-workers who had attained a level of practice the NQPNs admired and respected. More importantly, the participants asked for clarification and confirmation of their thoughts and actions. They started to appreciate the situation in which they found themselves (professional clinical practice), thus becoming more comfortable and content, and increasingly confident in carrying out their nursing care responsibilities. Furthermore, they were put in positions to teach students and to orientate new members of staff. However, they regarded this as unsafe and inappropriate as they were concerned about their lack of knowledge, clinical competencies, and experiences in their area of allocation.

In the current study, the participants also encountered challenging experiences. These made them recognise that adjusting quickly to the situation might not be that easy. To cope, they rationalised about the situation, thus allowing themselves a chance to take control of the environment. Such rationalisations allowed them to pursue the principal aims of doing CS. The following expressions attest to that:

*When the problems came, we had to deal with them." " I do not want to frustrate myself, so I would go away to the ward to keep myself busy." "No, I should hold back because I am still a junior, and she is a senior and older person. I kept quiet … she felt she was right because she is old in the profession.*

The decision to use coping mechanisms assisted the NQPNs doing CS to "withdraw" from unfavourable conditions and protect themselves from situations that could retard the pace and extent of adjustment to the situation or interfere with their goal to attain specific cognitive, psychomotor, and affective skills within the one year of CS.

#### 4.3.3.5 Recovery process

Recovery means returning to the normal state of health or mind or regaining control (Oxford Advanced Learner's dictionary 2015:1015). According to the Longman Dictionary of Contemporary English for Advanced Learners (2012:1457), recovery means to return to a healthy condition after a period of trouble or difficulty.

Duchscher (2008:447) indicates that when NQPNs commence their clinical practice, they are motivated and excited and aspire to execute their responsibilities as professional nurses. However, such aspirations are interrupted by their focus on their personal and professional growth, the challenges of which they might find overwhelming. So, during the latter part of this phase of the second stage of the transition theory, the NQPNs begin to reacquaint themselves with their initially held aspirations. They experience that they require less physical, emotional, and cognitive energy to handle the situations within which they are executing their role responsibilities.

The NQPNs in the current study similarly expressed some aspiration and motivation to carry out their responsibilities to the best of their abilities. The researcher also found no evidence of a dampening of such aspirations resulting from the challenges they encountered. Instead, some of the participants asserted that the challenges motivated them to work harder to achieve the purposes of their allocation to CS clinical areas.

#### 4.3.3.6 Adjusting and accepting

The word “adjust” means “to adapt or get used to a new situation” or a process of change that enables a person to better or wwork better in a new situation” (Online Oxford advanced American Dictionary 2021:[Sa]) . “Accepting,” as a partial synonym to adjusting, refers to “regarding something as favourable or with approval” (Oxford South African Concise Dictionary 2010:7).

Duchscher (2008:447) states that during this process of the second stage of the Theory of Transition the newly graduated nurses are, according to her theory, familiar with the environment, and as such, they experience fewer struggles to accomplish their responsibilities. They are now free to adjust, accept, and enjoy the changes to their personal and work-related programmes (Duchscher 2008:447). They have reached a positive outlook about their experiences in the practice field, and thus, more zeal to do their work becomes evident. The newly graduated nurses are more confident about their knowledge and practical skills.

Furthermore, the same author asserts that during the processes of adjusting and accepting the spirits of the NQPNs are invigorated to venture into their nursing roles, and their aspirations are rekindled to think critically and make decisions independently when facing challenges. Challenging situations also become more manageable. Their relaxation within the practice environment culminates in having opportunities to think about their long-term career goals.

In the current study, some of the NQPNs felt a sense of personal and professional growth; hence, they began to feel relaxed and enjoyed their CS practice at their placement areas. They expressed that they had developed adequate competence in clinical skills as they had practised in different nursing units. They experienced continued development of their management skills and independent and individual decision-making. However, they also indicated that they confirmed such decisions with the senior professional nurses that were available.

On the other hand, in contrast to Duchscher's (2008:445) transision theory, it was quite disturbing when one of the participants articulated that they were still learning and doing so "through trial and error" because some of them were neither orientated nor allocated senior personnel to supervise, guide and mentor them.

### 4.3.4 Stage 3: The knowing stage of transition

This is the last stage of newly graduated nurses' transition, which falls within the first twelve months of their professional role practice. According to Duchscher (2008:447), this last stage of transition theory constitutes separation, recovery, critiquing, and accepting processes.

#### P4.3.4.1 Separation process

The word "separate" means "to detach, to view as a unit apart from, or by itself, not joined or united with others or stop living together as parties" (Oxford South African Dictionary 2010:538). "Separation" also refers to a period of time people move apart and away from one another in different directions (Oxford Advanced Learner's Dictionary 2015:1333).

Duchscher's (2008:447) theory, states that the knowledge base of the NQPNs substantially increases during this phase, and the NQPNs feel much more relaxed and free to execute their professional responsibilities. During the process of separation, they aspire to associate with the broader community of professionals that are in the practice field rather than with only those within their terrain or former group. However, much as this was the case, some of the participants in Ebrahimi, Hassankhani, Gillispie and Azizi's (2016:[Sa]); Kuruman and Carney 2014:5; Spacirno 2016:1) studies, reported that they still experienced anxiety about moving from the status of maintaining a learner role towards assuming their professional roles with higher expectations and reduced tolerance to making errors.

Regarding the findings of the current study, the NQPNs had some moments of relaxation during CS. They realised the huge responsibility resting upon them regarding executing their professional responsibilities. There was not much emphasis on them of having anxiety because of the responsibilities expected of them. They verbalised their concerns about having to do almost everything themselves but also felt they had to face this head-on because they regarded doing CS as a way towards their successful growth as professional nurses within the career of their choice. Unlike the participants in Duchscher's (2008) study, none of the participants in the current study verbalised concern about separating from their peers. There was neither any indicated aspiration nor excitement about joining the expanded health professionals' community. However, what became obvious, in this regard, is the appreciation other health professionals had for the NQPNs' contributions and these NQPNs' appreciation of the contributions made towards their development. The resulting assumption is that this appreciation might ease the uptake of these NQPNs into the existing health professionals' corps.

#### 4.3.4.2 Recovery process

The definition of recovery appears under section 6.3.3.5 of this thesis. "Recovery" means "returning to the normal state of health or mind or regaining control" (Oxford South African Concise Dictionary 2010:498). According to the Longman Dictionary of

Contemporary English for Advanced Learners (2012:1457), recovery means to return to a normal condition after a period of trouble or difficulty.

Duchscher (2008:447) affirms that during this process of transition, which is at the end of the 12 months of professional nurses' first year in the clinical field, the newly graduated nurses at this stage reveal steady recovery which they have started in the second stage. They focus more on supportive relationships with their co-workers and colleagues rather than from friends or family.argues that the drive to focus on their work becomes more pronounced. The newly graduated nurses, at this point of transition, better comprehend verbal communication and what they observe. Working in the clinical field becomes a pleasure, and they do not complain about much. This signifies a gradual and balanced development in their professional lives.

In the current study, the NQPNs displayed a varied pattern of experiences regarding wishing to attract more supportive relationships from family members. Only one of the six participants longed for family support. The other participants desired more support from their colleagues and senior professional nurses. Some participants never even mentioned that they desired any such support. Their cultural background and their previous experiences influenced their independent behaviour in this regard. Some of them grew accustomed to fumbling alone to get to know what to do in the practice environment. The one that yearned for family support faced a language barrier between herself the patients and other nurses who did not belong to her racial and language group.

Recovering towards nursing and the nursing profession involves seeing the profession in a more positive light. The current study's participants indicated their better understanding of what they learned during CS and their wish to be excellent practitioners in specific areas. Hence the aspirations to advance their career in the fields of nursing education, midwifery, and community health.

#### 4.3.4.3 Exploring and critiquing process

The word "critiquing" refers to looking at the value of something in a detailed and analytic way (Oxford South African Concise Dictionary 2010:275). The term

“exploring” is contained in this definition of the term “critiquing.” On the other hand, critiquing indicates how appropriate or inappropriate (clear) a set of ideas are Oxford Advanced Learner’s Dictionary (2015:349), clarity one can only arrive at after proper exploration. Oxford South African Pockert Dictionary (2014:205) defines explore as “to examine or investigate, esp. [especially] systematically” or to go through an unfamiliar area with an intention to learn and know more about it.

As indicated in Duchscher’s (2008:447) Transition Theory, these processes occur mainly during the latter half of Stage 3, the knowing stage of transition. During this time, the newly graduated professionals devote much time focusing on exploring and critiquing their new professional set up. At this stage, they have reached a stable level of comfort and confidence in their role responsibilities and routines. However, they still experience moderate frustration and stress, which focus mostly on the healthcare system rather than on their capacity to cope with their roles and professional responsibilities. They are quite concerned about NQPNs being “at the bottom of the hierarchy” of power and authority in comparison to other members of the multi-disciplinary team. “Being devalued” leaves them with the anticipation that it might affect their growth pace in the profession and thus could leave them with less motivation to advance in their profession.

The current study’s findings revealed that the NQPNs attained comfort and confidence at different phases during their CS allocations. Participants based this on the fact that some of them received support in the units from the onset of their assignment to these units and thus adapted sooner to the environment with a better chance of learning, developing and gaining comfort and confidence. Others barely received any orientation and proper guidance with the associated adverse effects resulting from this. All of their transitions marked their placement at the bottom of the staff hierarchy not knowing to which nurse category they belonged since they appeared to be inferior, even to sub-professional categories of nurses, and yet, they were introduced as professional nurses. This probably emanated from the title ascribed to them, namely that of “Community Service Practitioners” (CSPs). Although the participants in this study realised their devalued status, they did not utter any concern about a slow pace of optimal professional growth and also did not indicate that their hierarchical placement might demotivate them to advance in their careers.

#### 4.3.4.4 Accepting process

The term “accepting” means “to regard something as favourable; to approve of it, tolerate it, believed in its validity, to be correct, or to submit to it” (Oxford South African Concise Dictionary 2010:4). “To accept” further implies “to agree, take on, or face-up” (Chambers Paper Thesaurus 2012:6).

This process becomes more pronounced during the 12th month of transition towards being fully professional nurses (Duchscher 2008:447). This is the period of becoming aware of signs of progress of one’s professional growth. At this stage, NQPNs can distinguish between their skills and knowledge and those of the newer qualified nurses who joined the professional practice environment at later stages. Their skills and cognitive capacities have risen to conspicuous levels, and they can now respond to questions rather than asking questions about issues.

Furthermore, they are capable of assisting newer nurses in carrying out their workloads. They appreciate the advancement in their professional organisation and their ability to prioritise skills associated with patient care as well as the capacity to cope with an array of situations within the practice field. According to the participants in Duchschers’s (2008:447) study, they were delighted at the end of 12 months as they noticed the change in their professional behaviour which occurred to be better without them realising it.

In the current study, the participants achieved professional growth gradually at various levels during the year of doing CS. Some of them observed notable growth by the end of one year. Others, although they had realised some personal and professional growth, still felt that they needed more experience in preparation for assuming a fully-fledged professional nurse status. One participant commented that she felt that the one year of doing CS was not enough as there was a lot that they needed to learn in a short space of time. University educated and trained NQPNs especially mentioned the shortness of time, probably because their education and training involved less clinical exposure than diploma courses. All the participants, however, appreciated the opportunity afforded them to do CS. They reported a noticeable change in their capacity to carry out their roles and responsibilities as

professional nurses at the end of their CS time. Unlike, the findings of Duchscher's (2008:447) study, where the participants revealed that they performed better than the more recently qualified nurses, in the current study, participants were not able to comment about comparing themselves to more recent additions to the CS clinical field. Some of them would not be in a position to do so, because they left before the allocation of newly graduated nurses to the site where they did CS. Nonetheless, the participants in the current study realised progress in meeting one of the main objectives of doing CS namely the refinement of their competencies.

## 4.4 CONCLUSION

This chapter serves as the theoretical framework that guides the conduction of the phenomenological study which sought to explore the experiences of NQPNs doing community service in the EC. Duchscher's (2008) theory of the transition of NQPNs to professional nurses has been mainly utilised to form a framework that guided the discussions of the emergent constructs like the process of adaptation/adjustment. Furthermore, this chapter discusses the processes of transition which are closely associated with experiences of the NQPNs as they adjut or not adjust well to the clinical areas due to the demands of professional responsibility. This framework therefore, also befits the intentions of developing the guidelines which might assit the newly qualified nurses to adjust into the clinical areas which are discussed in chapter six of this thesis. The following chapter has given the presentation and discussion of the findings of the current study.

# CHAPTER 5

# PRESENTATION OF DATA:

# THEMES AND CATEGORIES WITH EMPIRICAL EVIDENCE

## 5.1 INTRODUCTION

This chapter presents the findings on the experiences of newly qualified professional nurses who had done or were still doing compulsory CS at the time of data collection. The CS policy, according to section 40 (1) of the South African Nursing Act (Act No 33, 2005) indicates that any South African citizen intending to register for the first time to practice as a professional nurse in a prescribed category must perform remunerated community service (CS) for one year in a public health facility (South Africa 2005:s 40(1)). The experiences of NQPNs in fulfiling this legal requirement became the topic of interest of the researcher. In addition to the experiences of the NQPNs are findings obtained from the views of the nurse educators and the site managers in which some of the newly qualified nurses were allocated. The nurse educators that provided information work at the universities and at the Eastern Cape Provincial College and managers are at hospitals and community healthcare centers. The information gathered from these health care professionals was on their views regarding the factors that might influence the adjustment of the newly qualified nurses doing community service in the province. The endevour to interview the indicated senior professionals above, emanated from the idea of developing the guidelines on adjustment of NQPNs into thepractice enviroment.

## 5.2 DEFINITION OF THE CONCEPT OF “EXPERIENCE”

The concept experience entails personally encountered knowledge and understanding through practical involvement in, or a lived through exposure to an activity, event, or reality that the individual observes first-hand (Yogapaedia, Online Dictionary**)**. Experience refers to knowledge or skills attained through exposure over

time of practically doing something, especially within a particular profession (Oxford Online Dictionaries).
Section 1.11.5 of this thesis defines the term experience in detail. Various authors refer to it as a real-life occurrence, - thus, lived, true, and historical, with some individual existential meaning attached to it (Brink et al 2012:122; Schwandt 2007:102; Streubert & Carpenter 2011:74). A researcher has certain expectations of what might be encounter during a study. The acceptable accounts of experiences in doing CS included experiences participants expressed as self-experienced as these are best known by the person who experienced it (Streubert & Carpenter 2011:74; Schwandt 2007:102).

The lived experience, which was the focus of the current investigation, was that of the newly qualified professional nurses during their post-registration period following on either a degree or a diploma programme. These nurses, according to the reviewed literature, are in the process of transition from being students to being professional nurses (Burton & Ormrod 2011:1; Chandler 2012:1; Duchscher 2009:1105; Doody, Tuohy & Deasy 2012:684). During this transition, the NQPNs might require 1, 2-4, 5-12, or 12-24 months to complete this transition. In the process of navigation, they encounter different levels of knowledge and an extended scope of practice. This allows them the opportunity to contribute to their ongoing personal and professional development.

In the case of the current study, doing CS was accomplished by clinical placement of the NQPNs in “practice platforms” (a venue where skills, knowledge, and attitudes developed in the theoretical part of the curriculum are applied, advanced and integrated (Newton, Jolly, Ockerby, & Gross (2010:66), at a range of institutions the participants had chosen. Most of the time, the participants chose the clinical field to which they preferred to be allocated. However, they were often allocated to clinical places/institutions as determined by the needs of particular institutions (Duchscher 2008:441) and not according to their choice.

As indicated in the introduction of this thesis, the areas to which the NQPNs were allocated for clinical practice differed regarding the resources available in those clinical areas, the nature of the clinical area (that is rural, urban or semi-urban) and

the experience they gathered. So, doing CS was not perceived in the same manner by different participants. As a result of that, they provided convergent and divergent views about the experience of doing CS.

In some instances, even if they were in the same institution, they never came up with similar experiences. This affirms what is indicated by Polit and Beck (2017:8), that no two individuals can experience and perceive the same objective event in the same way. Duschcher (2012:20) also asserts that in the literature she had examined, the extent and the similarity of experience of NQPNs are not expressed in the same way. Furthermore, their personal history, coping mechanisms, support systems, co-existing issues, and stress resilience influence their adjustment to situations. In the current study, the location of the site for implementation of CS, the personalities of people they worked with, the size of the institution, the nature of the patients they nursed, and the available resources and equipment influenced their adjustments. In some instances, they would be in the same institution, but the attitudes and the treatment of the different people they encountered at those institutions still made their experiences varied.

This chapter presents the themes, categories, and sub-categories which emanated from the analysed data and these depict a variation of how lived experiences were expressed by the NQPNs who had done or were doing compulsory CS. Data from participants were initially analysed ideographically (individually) and subsequently analysed nomothetically (generally or holistically). The themes and accompanying categories, subcategories, and sub-sub-categories constitute the following: -

- 5 Main themes
- 8 Categories
- 16 Sub-categories
- 12 Sub-sub-categories

The statements (empirical data statements/evidence) represent the voices of participants that support these findings.

Fig. 5.1 presents the overall themes, categories, and subcategories. Furthermore, the verbatim accounts of the participants offered as evidence or empirical data, affirm the relationships among themes, categories, and subcategories. Also, the

researcher used available literature, relevant to the findings, to further discuss (support or refute) the findings of the current study.

There were, however, few themes that evolved from the educators and site managers. Most of them were similar with those emergent from the NQPNs. Only two of there were unique which were highlighted as being perceived as might not easily lead to adjustment of the newly qualified nurses, for instance, lack of taking up of responsibility by the NQPNs and lack of skills competency noted from those nurses who received their education and training from the universities due to the limited number of hours they spent in the clinical areas. These themes are presented at the end of discussion of themes emanating from the data produced by the NQPNs.

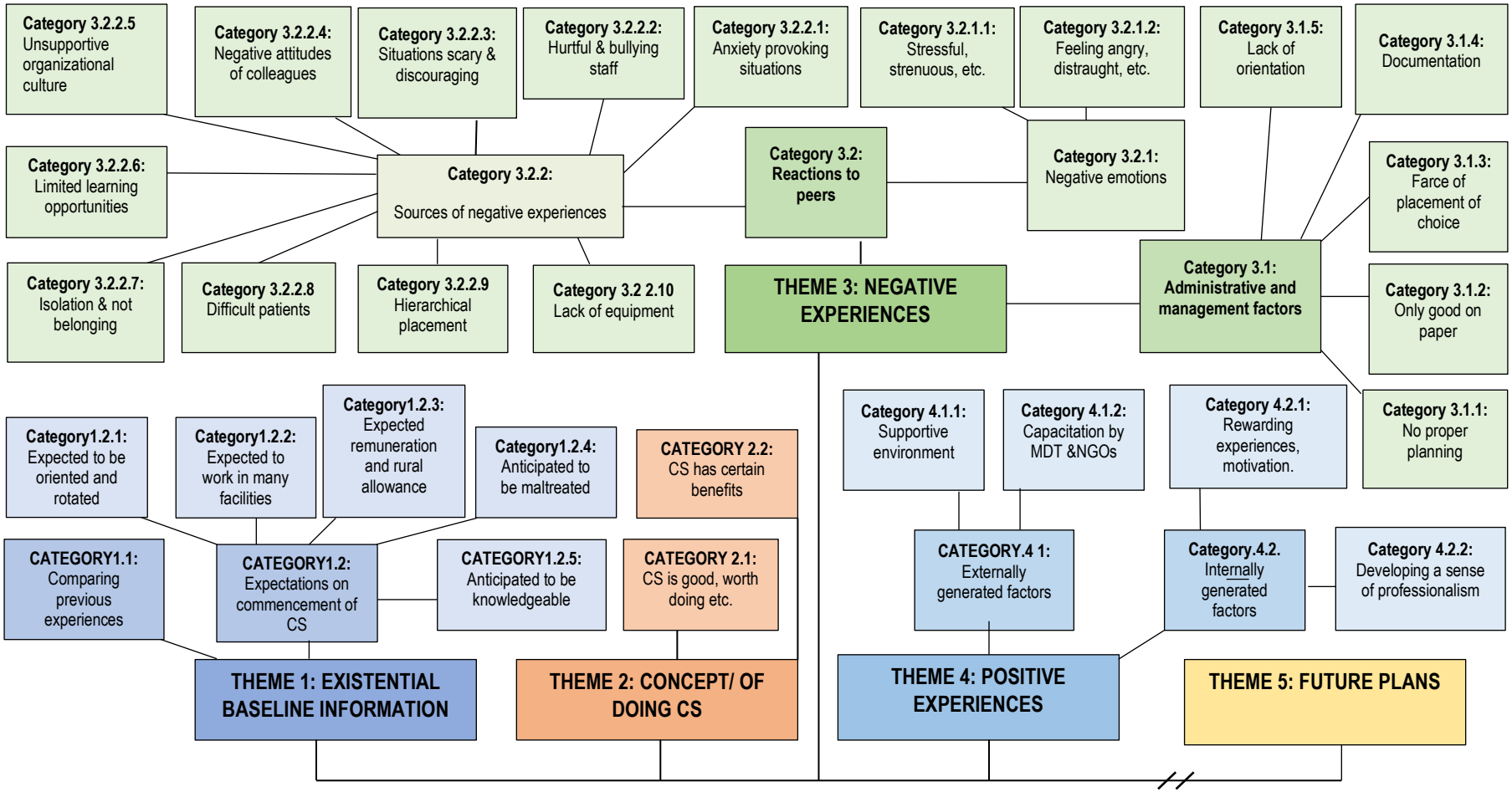



**Fig. 5.1: The experiences of NQNs doing CS**

## 5.3 THEME 1: THE EXISTENTIAL BASELINE OF NQPNS DOING CS

According to Wertz (1983:207; 1985:175), the norms of psychological existence, typical of everyday life in which the phenomenon under study is not profoundly present or in which others predominate, are implicit in the researcher's mind. Thus, the phenomenon under investigation is not an independent entity but a variation of other phenomena that stands out against this background. It is the researcher's understanding that this is also true for the research participants' psychological existence; that expectations, knowledge, skills, and experiences immediately define the familiar and the unfamiliar in the clinical field for CS nurses. The existential baseline for the current study was thus the context of being a student nurse merged with the professional sphere of nursing.

### 5.3.1 THEME 1: Category 1.1: Reflection on previous experiences and making comparisons

Under this subsection, the researcher discusses concepts that emerged from the reflections on the participants' lived experiences of their training compared to the lived experiences encountered during CS, including:

- *Students used to work alone*
- *Students learned to be independent*
- *Attaining current knowledge on aspects such as HIV and AIDS and facilitated teaching, even to senior professional nurses.*

The first theme of the experience revealed a concept of the utilisation of existential baseline information: which according to Wertz (1983:207) is something that serves as the basis upon which the phenomenon under investigation stands out allowing for identification as a phenomenological object. In this study, the existential baseline became evident after reflection of the newly qualified professionals on the fact that they were able to perform some responsibilities and attain specific competencies due to the experiences they had through their learning while they were still students. One participant articulated that:

> *I remember the other time we were doing third, yes the third year I think, in the clinic. We had to consult the patients alone and use the EDL book, so we had to know the symptoms, as in some cases, the symptoms are alike. We had to really know the …the condition from which the patients were suffering so that you give the best medication*

*which is relevant to the condition of the patient. So, they were giving us independence. You had to be independent.*

Based on such experience as students, for some of the CS practitioners working alone to render services to the clients during a period of doing CS was not a problem. According to Mullings (2015:1), independent learning is crucial for those in the learning process because it enhances collaboration of their activities with those with whom they associate, and also provides an opportunity for self-monitoring. However, this author advises that it is beneficial to receive feedback on the progress when one operates alone as this encourages the development of confidence. The participants also echoed this sentiment.

- *Applying theory/knowledge acquired previously in CS knowledge attained during students' days-*
- *Applying theory/ knowledge to practice during CS com-service*

As part of baseline information, the participants in this study articulated that they were still applying the theory they learned as students while doing CS, to develop their nursing practice foundation. Khaphangawani and Useh (2013:182), state that learning occurs when what has been learned in class is applied in the reality of nursing practice. Tucker (2014:1) confirms that this assists in generating further knowledge and indicates in which direction nursing should develop in the future.

Furthermore, applying theory learned about nursing practice enhances good patient care, improves personal and professional development, and also forms the basis for research and further education. Gumuhey, Kalolo, Mirisho, Chipwaza and Nyangena (2019:1) affirm that applying knowledge learned in class enables the learners to appreciate the value of learning theoretical information as this develops their confidence and effectiveness, makes them competent and adapt in the execution of their responsibilities. The NQPNs, who participated in the current study, pronounced that applying the previously attained knowledge as students during CS helped them to develop more skills. They furthermore indicated that they not only applied such theory. However, they also taught some of the staff members about current knowledge gained from their training. This was the case because senior professional nurses lacked recent knowledge on some aspects of nursing practice, primarily in the area of HIV and Aids-related aspects.

### 5.3.2 THEME 1: Category 1.2: Expectations of CS practitioners on commencement of CS

The NQPNs, on commencement of their CS, had some expectations including:

- *Expected to be allocated to the clinical areas of their own choice*
- *Expected to be rotated to many units of the facility*
- *Expected remuneration to be augmented with rural allowances*
- *Anticipated to be maltreated, according to peers' previous experience*
- *Expected to be knowledgeable about what they had learned from previous training*

Burton and Ormrod (2011:1) state that becoming a nurse is quite an achievement and something satisfying. This is supported by the findings of the study conducted by Roziers et al. (2014:91) where it was reported that all participants in their study expressed a feeling of joy about their achievement to complete their training and education. Nevertheless, when they came to the workplace as newly qualified professionals, they experienced some complexities and tensions. Some of these include challenges, expectations, roles, and responsibilities, as well as accountability (Nursing Essays 2020:1). Hardacre and Hayes (2016:32) indicate that the NQPNs get to clinical practice expecting to apply their cognitive skills into practice to enhance their personal and professional growth to attain improvement in practice. In the current study, the participants expected to be allocated to the clinical CS areas of their choice. However, according to Reid et al' (2019:744, 745) research study on medical practitioners, superiors did not adhere to allocating health professionals to the clinical sites of their choice at all times, as some would be allocated to rural areas, yet having preferred urban placement. In some instances these health professionals would remain in allotment areas beyond the one year obligatory period. These authors regarded such allocations to short-staffed areas as being unfair as it ignored participants' requests in favour of the needs of the government.

#### 5.3.2.1 THEME 1: subcategory 1.2.1: Oriented and rotated

According to the Collins English Dictionary (2011:1168), orientation is a process of adjusting or alignment of oneself to the surroundings or circumstances. Chacko (2016:8) defines orientation as a complex process that uses organisational resources to train staff to attain the strategic goals of the organisation. Riegel (2013:461) states that, through

orientation, the NQPNs are introduced into the world of nursing, which prospectively influences the novice nurses as well as patients' outcomes. According to Matlhaba et al (2019:13) orientation provides an opportunity for NQPNs to become acclimated to their new environment and makes them to be well conversant in what happens in their work expectations on a daily basis.

On the other hand, Charleston, Hayman-White, Ryan and Happell (2014:1) maintain that orientation heightens the development of knowledge and skills of new graduates through enhancing the integration of theory and practice in the clinical areas, thus facilitating a smooth transition from university life to clinical practice. Chackco 2016:1) asserts that the goal of orientation is not to educate per se but to help the nurses to adjust to their working environment and apply their knowledge. In association with the benefits of orientation, Solem, Tammy and Stuart (2012:105) affirm that the orientation of newly qualified graduate nurses helps them to relax, feel secure, and learn more. Furthermore, it leads to the gradual acquisition of skills and knowledge, and it familiarises the NQPNS with the culture of the organisation, and also it influences effective healthcare outcomes. It is under the above indicated benefits of orientation that Wranz, Klop and Bezuidenhout (2011:36) argue that orientation and staffing issues are critical when posting the newly qualified to CS. In the same vein, the same authors claim that information provided during orientation informs the candidates about the organisational units' expectations which they would need to meet when they get to CS. Participants in Beyers and Jooste's (2013:34) study highlighted that they found it helpful to adjust to their new placement areas, because of the orientation they were exposed to.

The current study's findings revealed that in some areas of placement, the NQPNs were given proper orientation when they assumed their responsibilities when they voiced that:

*We were given good orientation…and were introduced to the other members of staff.*

In line with the findings of the current study concerning orientation, many authors explicate what orientation is and how valuable it is if implemented when the NQPNs arrive at their new places of employment. Even in the findings of the current study, some participants emphasised how orientation had helped them to adapt to the new sites of doing CS and how its assistance was cherished. Some participants applied their knowledge to practice and acquired the required competencies and then adopted the

values of their profession. The facilitation of learning, ensured by proper comprehensive orientation, was instrumental in making the NQPNs develop personally and professionally. It became apparent that, literature worldwide, emphasises the importance of orientating NQPNs when they resume their clinical responsibilities. This should provide them with opportunities to refine their skills. In this regard, some of the current study's participants reported that they were not orientated at the institutions where they had been placed:

> *The sad thing in the hospital where I did CS they never orientated us that was the sad thing. We came the first day, which was during the Morning Prayer, and they told us that we are going to work in maternity, in paediatrics and outpatients. That was the end. Then we went to the wards thinking that they would orientate us. When we went to the ward, they did not orientate us. We would ask ourselves … Where are the needles, where this is and that thing, even in maternity? We never experienced that as student nurses when we were students, they would orientate us, but here we were not orientated.*

However, although, orientation is regarded as an important issue for the nurses when they get into the new environment, and although some of the participants enjoyed it in some units, other NQPNs did not get the opportunity to be oriented where they commenced their CS. The findings of the current study, regarding the lack of orientation of NQPNs, corroborate with those of Ndaba and Nkosi (2013:45) maintaining that participants reported little or no orientation in some of the units where they worked. Orientation was only provided after an incident had occurred. The lack of orientation, as articulated by these researchers, was attributed to a lack of time and increased workloads associated with a shortage of staff. Regarding orientation, Lindfors, Kaunonen, Huhtala and Paavainen (2021:9) indicate that, although orientation is crucial to be offered at commencement of professional responsibilities and throughout the life practice of nurses, the participants in their study reported that not all the NQPNs received organised and satisfactory orientation in their new clinical environment.

Some of the current study's participants (NQPNs doing CS) expressed that they expected to be allocated to work alongside senior professional nurses so that they could be supported, guided, and be mentored. Wong et al (2018:34) reported that the participants in their study reported they preferred to have support and mentoring from the supervisors

/ preceptors to strengthen development of their skills and self- confidence in preparation to give proficient care in the clinical areas even though the support is often not provided at times. In the same vein, Burton and Ormrod (2011:2, 4) emphasise a need to mentor and supervise the NQPNs to equip them with knowledge and skills and thus enhance their successful transition to professional practice. Some of them articulated that they were not allocated anyone to work with them according to their expectation. The participants associated the inability of senior professional nurses to provide preceptorship to the NQPNs to a shortage of staff, the attitudes of some of the senior professional nurses towards the newly qualified and the non-existence of a structured orientation programme. Yearning for support testifies that the nurses in this study wished to adapt to the clinical areas so that they could provide efficient patient care.

#### 5.3.2.2 THEME 1: Subcategory 1.2.2: Rotated to many units of the facility

Participants expected to be rotated to many different clinical sections during CS. According to Dinis and Fronteira (2015:18), rotation is a process of transferring employees from one unit to another to improve their credentials in an array of aspects. It is done to promote the attainment of new skills and thus productivity, as well as motivating the nurses to achieve higher performance levels, allowing continuous growth and development of new knowledge and skills. Rotation of the employees within the organisation improves their skills, gives them a sense of growth, and provides them with a better understanding of what is happening in the organisation (Coy 2013:2). Furthermore, it offers an opportunity for expanding the skills base of the NQPN, because as a student it is not possible to be adequately exposed to all learning and practice areas and thus be able to learn about everything and to be prepared for future professional nurse roles (Govender et al 2017:19). The NQPNs in a study conducted by Zaayman and Daniels (2016:48) experienced rotation as a worthwhile exercise because exposure to a range of experiences leads to the acquisition of new skills and assists in developing confidence.

Regarding participants in the current study's expectation to be rotated to all the facilities in the field, some participants considered themselves lucky to have been rotated to different units of the institution/department. They envisaged that rotation to different units of the institution would ensure the expansion of their experiences as they were thus exposed to

a range of clinical experiences. This further affirmed that they were accomplishing the purpose of doing a year of compulsory CS, which is to refine their competencies.

Dinis and Fronteira (2015:18) emphasise the importance of having a well-planned rotational programme within institutions. Robert 2016:[Sa] echoes the idea of well - designed rotational programmes at institutions because these do not only benefit the employees, they also benefit the institutions, because employees' experiences and skills are enhanced, and so are their work outputs. In a study conducted by Butterworth, Rajuphadhya, Gongal, Manca, Ross, and Nichols, (2019:6), it evolved that rotation was perceived as essential for the participants as it exposed them to a range of experiences that enhance their personal and professional development. However, not all the participants were exposed to satisfactory rotational programmes/ systems which offer the opportunity to redress the limitation of clinical experience, which are caused by failure to rotate the NQPNs during their placements.

Emerging from the current study, is that some participants were rotated to a range of units. However, one participant expressed that she stayed for only one month in each unit and she regarded this as being inadequate to acquire adequate competencies. On the other hand, some of the current study's participants were denied the opportunity of being rotated and were concerned about such a lack of exposure to varied learning opportunities that might influence their skills needed for their future practice as professional nurses.

#### 5.3.2.3 THEME 1: Subcategory 1.2.3: Remuneration and rural allowances

According to the Nursing Act, 2005 (Act no 33 2005: s 2.1), CS practitioners earn a salary. This kind of remuneration was implemented in 2008 when the newly qualified graduates commenced CS (Nursing Strategy for South Africa 2008:27). Attaining a qualification was highly appreciated by the NQPNs who had completed their course. This excitement was expressed by some participants who qualified from the university who, during their last four years, never enjoyed even getting a stipend, unlike their counterparts at nursing colleges. In support of this notion, Roziers et al (2014:95) reported that the participants in their study on the transition to professional nurses and doing CS had rewarding situations and earning a salary was cited as one such rewarding factor.

Additionally, Hatcher, Only, Kornik, Peacocke and Reid (2014:[Sa]) commenting from their study conducted on medical doctors doing CS, indicated that they were delighted to earn a salary which they often received on time. However, one participant in the current study indicated that, when they commenced CS, she did not get paid due to a lack of information regarding the kind of forms they needed to complete, to receive their salaries timeously. Over and above that, the same participant shared that they expected to receive rural allowance irrespective of where they were allocated as that is the practice in the ECP when NQPNs do CS, especially if assigned to clinics. Dissatisfaction about salaries also evolved from the reports of some authors such as Andren and Hammami (2011:10) who reported that the participants in their study were dissatisfied with the discrepancies they noticed in the salaries received. Such inequalities in salary were between those who qualified at universities and nursing colleges. Interestingly, the NQPNs from universities expected to get more money than those from nursing colleges as they financed themselves during their education and training. Their perception was that doing CS served as a sort of payback money offered to cover their previous university studies. Some further complained about the amount of work they had to perform, which did not compare to the meagre salary they received during CS.

Furthermore, according to Govender et al's (2017:19) findings, the newly graduated nurses felt cheated because they carried out responsibilities at the level of senior professional nurses and yet earned low salaries designated for the CS practitioners. It is evident from the results of this study that participants were even called during their off-duty time to be at work. Others worked much longer than the regular eight-hour shifts.

#### 5.3.2.4 THEME 1: Subcategory 1.2.4: Anticipated to be maltreated

Maltreatment by the peers, professional nurses, and doctors were cited as a troublesome issue by some participants of the current study. They voiced this as one of the problems they anticipated to encounter when they assumed their role as newly qualified professional nurses. They expected this to happen, based on the information they gathered from their peers who had experienced such problems during their allocation to the practice environment. Indeed, some of the participants reported maltreatment by senior professional nurses and some of their peers, who displayed an inexplicable unpleasant attitude towards them. Such an experience is similar to the experiences

encountered by NQPNs who participated in a study conducted by Gadieja, Strumpher and Williams (2014:47) who voiced that they felt exploited by the abusive conduct they had to face from the senior professional nurses supervising them and from the doctors who treated them as being subservient. It was a common practice that the NQPNs had to endure the humiliation that happened at times in front of the patients and other colleagues (Gadieja et al 2014:47).

Duchscher (2008:443) affirms various aspects that are problematic to NQPNs when they undertake their professional roles in clinical areas. However, there is no explanation as to what precipitates or facilitates the resolution of these problems.
Maltreatment of NQPNs by those in the clinical areas was accordingly reported by Solem et al (2012:105) and Vogelpohl (2011:133). NQPNs experienced some humiliation, making them feel like outsiders, and they did not have anyone to consult if they needed assistance. In some instances, NQPNs were mocked, bullied, persistently criticised, their mistakes emphasised, given trivial tasks, and ignored (Solem et al 2012:105). Being intimidated at the workplace was also echoed by NQPNs who participated in Chandlers' (2012:106) study, which pronounced that they worked in an environment that was discouraging, competitive, and bullying. Moreover, whenever they were approached for anything, the senior professional nurses would be hostile to them. Hazaveh, Rafii, Khosrav, and Seyedfatemi (2014:203) attest that some senior nurses had unfriendly confrontational kinds of behaviour when dealing with newly graduated nurses. Also, the same authors confirm that they would show improper and unprofessional conduct when communicating with NQPNs. Furthermore, the senior professional nurses commonly humiliated, bullied, exploited, and discriminated against NQPNs and denied them opportunities for obtaining support.

In the current study, some participants shared experiences of being ill-treated in some areas where they were allocated. They indicated that sometimes, senior nurses were so hostile to them and as a result they cried at work.

To confirm the maltreatment in the workplace, the newly qualified professional nurses uttered the following statements:

> *If you tell the sisters that you do not know something, they would ask you what did your Brunner tell you? (*Brunner is one of the authors of Medical and Surgery Textbook often

prescribed for nurses*) … You would be told to go to your books, yet you need to know something there to help the patient.*

Another participant shared the following*:*

> *They would make us work long hour… then promise to pay us back those hours. I can remember I had about 12 to 18 hours that I was owed. I requested back the hours they owed me. However, … Yhoo … Mam! … The way the sister was harsh, in the ward, she was angry; I just did not know where that attitude came from. I did not know whether it was stress from her home. I thought she would just indicate when I should take the hours. Yhoo … instead, she was so angry. I ended up not taking those hours. I just felt like I did not have the right to take those hours, but yet it is my right to work for a certain number of hours.*

Another participant pronounced that she had to work for long hours, for instance, she stated that she was on day duty and the same day had to go on night duty. Such changes were made to accommodate senior professional nurses (Gadieja et al 2014:51).

Sometimes the pronounced maltreatment of the NQPNs made them feel bitter, hurt, discouraged, and tearful at work. The CS nurses who had experienced such injustice could not report them, because they feared that they might make the conditions worse for themselves. Much as they were victims of abuse, they decided not to reveal that to site managers lest they would suffer more. The only thing that sustained them was the realisation of the purpose of them being there, that of serving patients. The following extract supports this.

> *There was a time I felt bad, I felt like crying I feel I must take this thing out. There were times when I felt like crying, but hid, because I did not want to be seen as somebody who needs attention, and people feel pity for. I felt at that time hurt and discouraged. At times you hide that you are hurting. At times while crying, you remind yourself about who you are … that you are a nurse. You have to realise that you are at work and at work you do not need to make friends. You have to remember why you are there. So, Mam, those are the challenges that you come across with, and you have to manage them. When we were treated badly, we did not tell anyone*

In corroboration with the findings of the current study concerning the maltreatment of CS nurses, Gadieja et al (2014:51, 60) state that the CS nurses were hesitant and reluctant

to report the bullying by senior professional nurses because they were scared as to how the senior nurses would react. These nurses were scared of being victimised.

According to the findings of the current study, the newly qualified CS nurses reacted in different ways to encountered maltreatment, and they found ways of being resilient towards it as some expressed that they were forced to suppress their feelings or decided to 'play humble' and instead focus on patient care and their growth. In some instances, they felt that if they complained, the senior professional nurses would be of the impression that they displayed a kind of a superiority complex towards the senior professional nurses, hence the following excerpt:

> *I felt that I should just hold back my feelings even if she is walking all over me, I realised that well, I am here because I want to grow, … so I have to keep quiet because I am growing if I say anything it will hinder me from growing… felt I must accept that I am wrong even if I am not.*
> *I decided to play humble, to keep quiet and know what I have to do; I do for patients.*
> *I felt if I commented would be seen as making self-better than operational managers.*

#### 5.3.2.4 THEME 1: Subcategory 1.2.5: Expected to be knowledgeable

The newly qualified CS nurses were expected to be knowledgeable about what they had learned during their training. Such expectations were from both themselves and the other multi-disciplinary team members. One participant indicated that even though some professional nurses volunteered to assist her, she chose not to consult, but to carry out most of her professional roles by herself. She believed that she had attained adequate knowledge from what she expressed proper training. She maintained that she wanted to be independent, work hard, make independent decisions, implement and develop unit management skills as well as advancing her critical analytic skills about patients' issues; hence she uttered the following:

> *…you have to be knowledgeable about the work and about what you are doing and nursing… sometimes there is no senior nurse to ask from.*

Reports in Nursing Essays (2020:1) also reported that the newly qualified nurses are expected to be knowledgeable about all the work in the working environment and be able to do everything after qualifying is quite daunting and unfair. It leads to frustration. The NQPNs become overwhelmed and cannot cope with their responsibilities and

accountability. Failure and the inability to meet the professional obligations and standards breed self-blame.

## 5.4 THEME 2: NQPN'S EXPERIENCES OF DOING CS

### 5.4.1 THEME 2: Category 2.1: Doing community service as something good, worth-doing, tremendous and excellent experience

The following segments of data illustrate the feelings of excitement and joy some participants experienced during CS. They expressed such sentiments in slightly different terms, implying more or less the same experiences such as that CS was:

- *Something good; as it reinforced what students learned*
- *Something worth doing and makes one feel good about it*
- *It was something wonderful or wonderful and nice experience*
- *It was a great experience and made me feel great*
- *Enabled one to work hard is awesome*
- *It was a great experience*

Some participants in the current study perceived CS as being something good, because of the warm welcome by unit members and their introduction to all members of the units to which they had been allocated. The participants also highlighted that they were made aware of the expectations of what to do and what not to do in those units. This facilitated a sense of comfort and readiness to be involved in the activities that were in line with the fulfilment of the objectives of doing CS.

One participant (in the current study) indicated that her lived experience had been remarkable. It made her feel great and satisfied because she realised that with these experiences, she would, in due course, be able to manage a clinic alone without any supervision. Furthermore, she indicated that she was able to develop the soft skills required by her professional role. Reportedly, the senior professional nurses at the clinic offered the newly qualified CS nurses a chance to try and assess what they had mastered to do and when to do it. Hence this particular participant indicated that:

> *The experience was great; the independence they gave us was fine because we would know what to do and when to do it.*

Yet another participant asserted that doing CS is a lived experience that was great, enjoyable, and fulfilling. The participants specified that she was in a unit in which the senior professional nurses made them work independently. The participant viewed this as an opportunity offered so that they could develop confidence in performing their professional roles. This particular participant, who appreciated her experiences, was allowed to critically look at the condition and treatment of patients and forecast the progress of the patients' conditions. The participant was allowed to give medication and to modify treatment. Once decided on the modified treatment, the participant consulted the senior professional nurse and discussed her views about the change of treatment. The consulted nurses usually supported her decisions, and this excited her. Hence the participant said.

> *I remember the patient was presenting with hypertension for the fourth time, I thought I had to start the patient on treatment ….the patient was on modification therapy, but …the patient's BP was still high; So, I decided… the patient needed to be started on treatment. I did not do it alone. I went to the sister…. would not just give the treatment, … I looked on the past history of the patient, what is wrong with the patient, the patient is coming for the third time or fourth time, so I had to see what the problem is. So they gave us independence.*

Another participant (in the current study) confirmed that she had remarkable experiences because no one despised her when she displayed deficits in performing some procedures. Instead, those who had more experience taught her and developed her confidence in her work performance. Getting expertise in exercising control over the other members of the nursing team was a great experience. Hence, she expressed that:

> *When I started, I was nervous and anxious; working with people who have experience, they teach me… I am confident about the procedures that are done here… I gained confidence. My anxiety has now gone down*.

It also emerged that doing CS is something that every nurse who qualifies should go through. Regarding the feelings expressed by the participants, it is evident that newly qualified CS nurses perceived CS as something that is gratifying and worthwhile. These findings concur with those of participants in Kumaran and Carney (2014:3) study where participants expressed that doing CS was exciting, made them happy, delighted, proud and had feelings of growth and achievement. St Clair and Morin (2013:79) too, reported

that participants in their study regarded CS as an exciting experience, through which they learned a lot. Likewise, Roziers et al (2014:95) indicated that the newly qualified CS nurses perceived it as something that is worthwhile, incites joy, sense of development and confidence as the participants in their study pronounced that they found it rewarding, because they received praise, positive feedback about their practices and acknowledgement from staff as well as even earning a salary. It assisted them in developing the sense of confidence and achievement especially in carrying out management responsibilities like organisation, prioritising responsibilities and prioritising.

Likewise, a participant in the study also highlighted that the teaching methods utilised at her previous training institution contributed towards making her perceive CS as being a pleasant experience. Even though they did not receive constant support during their CS, it was not a problem because they were accustomed to doing work on their own as their method of learning was the integration of Problem based Learning (PBL) and Community Based Education (CBE). On the whole, almost all the participants in the study affirmed that doing CS was something worth doing as it made them feel great as they noticed their development of confidence, knowledge, and practical skills. It allowed the application of information learned from books.

### 5.4.2 THEME 2: Category 2.2: CS perceived as beneficial

The following data display segments list experiences the participants in the current study, regarded as the benefits of doing CS:

- *Provides an opportunity for refining the practical skills*
- *Provides an environment to reflect and assess the extent of one's knowledge and gaps*
- *It allowed the application of information learned from books*
- *Enhances gaining a lot of practical skills.*
- *Gained a lot of knowledge and practical skills*
- *Able to apply knowledge attained at previous education and training institution*
- *Learned a lot and gained a lot of knowledge and practical skills*
- *Were able to focus and concentrate on the work*

Regarding the aspects listed in the current thesis as benefits of doing CS, the participants thought that CS assisted them in refining their skills since they did not have adequate opportunities to be in the clinical areas for extended periods during their training. One participant reminded the researcher:

*Remember we came from the university having been taught so many things and when we go out there we did not have enough time, so Com-Serve has shown us the practicality of it, …it makes us to learn more.*

Evolving from the findings, the current study's participants highlighted that CS afforded them a chance to apply their minds extensively to doing things practically. Constant encouragement from senior personnel strengthened this in their placement areas. Also, from time to time, they were allowed to work independently under the guidance of the senior professional nurses who continuously reminded them that they were professional nurses and thus should perform as such. The following excerpt confirms this.

*The sister will say that remember that you are now a professional nurse… so whatever you learn, you must keep your eyes open, you must combine all you learned from school to make your own decisions.*

Furthermore, a few participants voiced that doing CS was an excellent prospect that presented them with an environment in which to reflect and assess the degree to which one had attained knowledge for application in clinical patient care. At the same time, it afforded a chance to examine the kind of existing gaps in one's competencies. Where there are gaps, it would be essential to increase one's effort by working harder than before. Additionally, they voiced that their exposure to CS allowed them to gain a lot of knowledge and practical skills due to a wide range of experiences available at different sites. Hence one participant pronounced that

*"it made me to learn a lot."*

The findings of the studies Wranz et al (2011:32) and Andren and Hammami (2013:17) conducted, corroborate the notion that CS is indispensable to provide NQPNs with working and learning opportunities that facilitate quality care of patients. Exposure to an extensive range of experiences enables those doing CS to focus on their work and to contribute positively to circumstances where there is a shortage of nurses or an unwillingness of senior professional nurses to assist them. Hence one participant articulated that:

*We learned to be experienced midwives on our own …. As there were no staff members, and other staff members who were willing to come and work in labour ward … from that experience, I can say that I learned a lot from complications I met from the difficult areas.*

Having a focus and concentration on clinical professional work was indicated by one participant as an added benefit of doing CS, which they cherished. They were no longer attending classes, as was the case when they were still on training. Beyers and Jooste (2013:34) argue that concentrating on doing CS accelerated the NQPNs' confidence and creativity as they were on their learning path in the clinical areas.

## 5.5 THEME 3: NEGATIVE EXPERIENCES OF CS

### 5.5.1 THEME 3: Category 3.1: Administrative and management factors

#### 5.5.1.1 THEME 3: Subcategory 3.1.1: Lack of proper planning

Despite the positive CS experiences of some participants in the current study, they also had qualms about the implementation and process of CS. The following are some of the evidence regarding this point:

- *Its implementation not as expected.*
- *Not allocated at chosen clinical sites as promised/indicated*
- *Lack of information about for instance forms to fill in by the Human Resource Department (HRD)*
- *Their CS forms not completed as a result were not registered promptly by SANC*
- *No visits by government officials to monitor and evaluate the implementation of CS.*

#### 5.5.1.2 THEME 3: Subcategory 3.1.2: Community service is good on paper, but implementation is not as expected

It emanated from the current study's interview data that some participants experienced the implementation of CS not to be according to the guidelines provided. Hence one of the participants indicated that:

*CS is just good on paper, but the implementation is not as expected.*

The improper planning for the placement of a newly qualified CS nurse in settings led to some of these participants' encountering problems in the clinical area. Some were not

adequately provided with information about what to expect and do before commencing and after completion of their CS year. Hence, one participant said*:*

> *There was a lack of information from the people that were supposed to give us that form I am talking about. They did not know we had to sign anything. This means that there was a lack of information on the side of the people who were supposed to tell us about Com Serve. Then it means that now we were not able to register with Council (Meaning SANC).*

#### 5.5.1.3 THEME 3: Subcategory 3.1.3: The farce of placement choice

Participants in the current study were initially informed to choose sites where they wished to work. Usually, the allocation would include one of five institutions they had listed. However, they were often allocated to institutions they had not chosen. It seems that government officials decided to send NQPNs to wherever they might feel there are shortages of nurses. The placement experience was very disappointing to the participants as no one negotiated these surprises with them. One participant related having been allocated initially for six months to a clinical site of her preference where she was warmly welcomed, orientated to the new environment and responsibilities and was firmly supported. However, later, the authorities transferred this participant to another clinic because that clinic experienced a shortage of staff and had large numbers of patients. The whole situation changed for this participant.

#### 5.5.1.4 THEME 3: Subcategory 3.1.4: Documentation

Some of the current study's participants complained about not having been informed about the kind of forms they needed to complete, during and after placement - such the conditions of employment of the CS practitioners and the benefits entrenched in such conditions. Good examples of these are monetary incentives as it is the policy in the ECP that when one does CS in the rural communities, there are rural benefits such as extra salary benefits. Gadieja et al. (2014:68) suggest that orientation about what to expect, for instance, from HRD before commencing CS is essential.

Even on completion of their CS term, there were delays in filling out their completion forms. Participants resented this because it led to late SANC registration. Such delayed registration culminated in late employment as registered nurses, resulting in a financial loss as they were paid lower salaries as CSNPs and not the higher salaries of registered nurses. The participants interviewed by Govender et al (2017:20) voiced that it was unfair to delay SANC registration, especially for university graduates because they earned lower salaries for a long time as they received a salary equivalent to that of a student nurse, while they could have earned higher salaries as registered nurses if their SANC registration had been effected.

#### 5.5.1.5 THEME 3: Subcategory 3.1.5: Lack of orientation

During the interviews, participants indicated that:

> *… the finalist students are supposed to be orientated about doing CS.*

The current study's participants reported that when they started doing CS, there was no orientation by HRD personnel contrary as to what they expected. Claxton (2016:3) declares that the process of quality orientation for NQPNs in their profession is the best thing to do as the commencement of newly qualified graduates in a career can be a daunting experience. Park and Jones (2010 cited in Zaayman & Daniels 2016:43) assert that orientating prospective CS candidates appropriately leads to more pleasant experiences, reduced culture shock, and facilitates a smooth transition into their new professional roles. Many interviewees in the current study stated that there was an absence of any orientation on their commencement of CS or a delay in orientation in some units. The participants regarded this as an unpleasant experience. It put them at a disadvantage as learning was affected by the lack of orientation since they performed activities while not being sure whether they were doing such activities correctly. Some participants even complained that the lack of orientation did not only affect them but their patients as well. Indicators such as those following reflect the experiences of CS nurses' lack of orientation:

- *Nobody provided us with orientation.*
- *Never orientated: were made to work through trial and error*
- *Had to find out on our own what was going on in those wards*
- *We had a bad experience because we were not orientated,*
- *Being not orientated is an unpleasant situation*

- *Orientation was delayed*
- *Sad experience: no orientation, had to figure out ourselves where equipment was stored*
- *Felt neglected by HRD as not being orientated on relevant issues*

Lack of orientation exerts disadvantageous effects on the employees who are new to the workplace. It causes frustration, especially as the environment, and facilities are new and strange. Furthermore, it hinders the proper functioning of those who have to render care because it leaves people unable to know what to do and how to do things. Lack of orientation for the participants was declared as a sad experience because the environment and the facilities were strange for them, but they had to figure their way out. One participant confirmed this, declaring that they did not know where the unit kept the equipment and other things as their orientation only transpired two months after the commencement of their CS. Zaayman and Daniels (2016:42) confirm the lack of orientation reporting that although NQPNs lacked orientation, it was still expected of them to carry out their responsibilities in the clinical area. The NQPNs in the current study found the new environment where they worked challenging because the environment to them was new and strange. As stated by Beyers and Jooste (2013:36), any new environment is challenging for a person who is starting work at a new place. One participant in that study found it difficult to cope in the new environment due to some aspects having to work without seeking advice from the professional nurses.

The lack of orientation also led to unmet expectations of CS participants in the current study. One participant assumed that the government officials, who are the custodians of the CS policy, would visit the sites to which they had been allocated to ascertain whether they had settled or encountered any problems. NQPNs in CS interpret this shortcoming as a lack of interest in and care about them.

In another instances, other participants doing CS (in current study) expressed that they anticipated accommodation to be arranged for them at the practice sites, only to find that they had to arrange their accommodation. It is in line with such a premise that the participants in Andren and Hammami's (2011:10) study, articulated how it is essential to have workshops about doing CS so that when they commence CS, they would know what to expect during their placements.

### 5.5.2 THEME 3: Category 3.2: Reactions of NQPNs doing CS to the attitudes of peers and senior professional nurses

The current study's findings revealed some negative experiences of NQPNs while doing CS. These negative experiences stem from the actions and attitudes of peers and the multidisciplinary team members.

#### 5.5.2.1 THEME 3: Subcategory 3.2.1 Negative emotional reactions of NQPNs

##### 5.5.2.1.1 THEME 3: Sub-subcategory 3.2.1.1 Stressful, strenuous, and difficult or tough experiences

From the findings of the current study, it appears that some participants encountered stressful, strenuous, and challenging experiences due to some deficits in knowledge regarding specific nursing care regimens. Having had no one to ask for advice further aggravated their stress. These findings concur with those of Hussein et al (2017:2; Whitehead and Holmes (2011:21), where NQPNs indicated that during the first six months following their qualification, they had a very stressful and emotionally exhausting experience, as they often felt that they had been inadequately prepared to handle the clinical demands and strive to deliver nursing care effectively.

Shortages of staff also contributed to the stressful experiences of NQPNs. Where there was a staff shortage, it meant that NQPNs were overwhelmed by their responsibilities while they had not reached a stage of knowing everything they had to do in the clinical situation. It was also stressful to them to shoulder such a lot of responsibilities and carry out some of the procedures they were not competent performing, and yet, they did not have senior professional nurses to work with or to check their practices. It was an equally common practice to find them working alone, confronted with having to nurse large numbers of patients. In some instances, non-cooperative peers and senior nurses who would not work hand in hand with the CS practitioners made their situation even worse. To these NQPNs doing CS, who participated in the current study, meant working the hard way and working through trial and error hence the following excerpt:

> *At the beginning, things were tough because when we were students, we were helped by experienced midwives … but now we are forced to work independently … because of the big numbers in labour ward… we are to learn the hard way … we are working in terms of trial and error.*

Chandler (2012:103) attests that new graduates experience difficulties working in an environment associated with workload issues. Furthermore, this author indicates that nurses entering into a new position and environment anticipates that it may be challenging. In the same vein, O'Shea and Kelly (2012:1535) argue that the new nurse graduates may have stressful experience due to multi-dimensional responsibilities, new role, and skills deficits. Additionally, Zaayman and Daniels (2016:43) corroborate the findings of the present study by reporting that participants in their research, experienced difficulties during the transition to the point that some of them felt like abandoning up the nursing profession.

#### 5.5.2.1.2 THEME 3: Sub-subcategory 3.2.1.2: Feeling distraught, angry, depressed and sad and acting outside their scope of practice

The current study's participants expressed undesirable feelings due to a range of experiences. One participant had been initially for six months at the selected clinical site where the staff were welcoming and provided orientation to the new environment and responsibilities and offered support. However, later, the authorities ordered a transfer to another clinic experiencing a shortage of staff and had a large number of patients. This transfer experience evoked anger and depression as voiced:

> *After six months, I was asked to come here because they were short-staffed and the person who was here had trained in the 1970s.*

Subsequently, such a transfer caused a struggle to get reasonable accommodation. Further, conditions at this clinic were not conducive for the appropriate development of this CS nurse's knowledge and skills. There were inadequate resources and equipment to support patient care, as revealed in the following statement:

> *I was frustrated to come here, because, this place is out in the lonely place, the clinic itself is not well equipped with material to nurse patients.*

Furthermore, this CS nurse did not get an adequate opportunity for learning, because of staff shortages, implying working unsupervised most of the time while being overwhelmed by the large number of patients that attended the clinic and how the staff rendered patient care was unsatisfactory. This CS nurse expressed that the clinic's nurses to spend quality

time with patients because they had to do everything in a rush to go through the queues of patients:

> *You know Ma'am what we are doing here is not quality care, but we have to be content with going through a queue of patients.*

According to another participant of the current study, observing how senior nurses neglected patients, at times, caused anger and sadness. These nurses relinquished almost all their responsibilities to the newly graduated CS nurse. As a result, that participant expressed that they had to carry out a workload alone in the wards by stating:

> *The old professional nurses want you to do everything. It was something you had to get used to … Yes, it was a challenge, but I never complained.*

The participants felt that they were given responsibility too soon, leaving them feeling overwhelmed. According to the study findings of Govender et al (2017:18, 19), the NQPNs indicated that, since they had completed their education and training and were professional nurses, they had to do all the work. However, they couldn't know everything promptly after qualifying, so they needed a chance to learn and accomplish the required competencies. One participant in the current study felt pressured to assume massive responsibilities with compelled overstretching while still in the process of comprehending a lot of what they had been taught during their education and training. This was perceived to be somewhat unfair. Although that particular participant had such feelings, she rationalised that she needed to accept the stress positively, realising that even though they were overwhelmed with the responsibilities of their professional roles, doing CS was an intriguing experience. This participant further indicated that they had to taste being professionals, and so they had to be encouraged and strive to work harder. Furthermore, another participant commented that they decided to refrain from complaining to avoid adverse reactions from the senior professional nurses.

Some of the current study's participants had to carry out non-nursing responsibilities that included doctor's responsibilities such as prescribing medication not listed as medication that the nurses could prescribe. Further, some had to do non-nursing duties such as acting as mortuary attendants, who had to wheel corpses to the mortuary and subsequently hand them over to the relatives. All of this caused anger.

It was common to expect the NQPNs to decide on their own about when to report the seriously ill patients to the doctors and to manage patients in crises like head injuries. One participant expressed such an act as infuriating and uncomfortable by stating.

> *I felt the pressure because we had to do all the work … afraid to manage certain procedures … while senior sisters did nothing or minimal and I was angry and uncomfortable being required to do non-nursing responsibilities… and report about patients' conditions to the doctors.*

Having to carry out responsibilities that fell outside of professional nurses' scope of practice was not received well by newly qualified CS nurses.

> *… perform pointless and menial tasks unrelated to their scope of practice*.

Regarding taking on responsibilities outside the scope of practice of a professional nurse, Gadieja et al (2014:45, 49) state that participants in their study mentioned that they had to make beds, do observations,baths,escort patients to other hospitals. The participants' concernsin the current study, were that these tasks out of the scope of their practice made them miss out on executing responsibilities within the scope of practice of a professional nurse.

#### 5.5.2.2 THEME 3: Subcategory 3.2.2: Sources of adverse emotional reactions

##### 5.5.2.2.1 THEME 3: Sub-subcategory 3.2.2.1 Anxiety provoking experiences

The following indicators in the data display are in support of the anxiety-provoking experiences of the participants of the current study.

- *Fear of the unknown regarding:-*
- *How they were going to be treated,*
- *Kind of people they were going to encounter*
- *Commencement of new roles*
- *Working in units, they have not been exposed to as students*
- *Bullying*

All participants reported being satisfied with completing their education. However, on the commencement of CS, they realised that they still had to face some challenging experiences. Some reported their commencement of CS to have been anxiety-provoking

as they could not anticipate how the unfamiliar people they were going to work with for the first time, would treat them. Their thoughts about assuming new responsibilities aggravated their anxiety. Mounting the anxiety was the requirement to work in units where some participants had never worked in, or had done so for limited periods, as students, for instance, intensive care unit and operating theatres. However, Sparacino (2015:43) declares that if the NQPNs receive proper preparation during their learning, while they are in the pre-registration period, they will experience less anxiety when they take up their new roles and responsibilities as professional nurses.

#### 5.5.2.2.2 THEME 3: Sub-subcategory. 3.2.2.2 Hurtful experiences and bullying

According to the Concise Oxford Dictionary (2010:570), the word 'hurtful' refers to something distressing, saddening, or causing mental pain. These synonyms explain the experiences of some of the current study's participants during their CS. It became evident that the handling of some of the newly qualified CS nurses by senior professionals was harsh to the extent of resorting to crying and even thinking of abandoning the nursing profession. Some of the senior personnel showed feelings of doubt and a tendency to undermine the ability of newly qualified CS nurses, hence the following utterances:

> I felt *bad, I felt like crying I feel I must take this thing out. There were times when I felt like crying, but hid, because I did not want to be seen as somebody who needs attention, and people feel pity for. I felt at that time hurt and discouraged: When we were treated badly, we did not tell anyone …. even if we were hurting and depressed. There are those times that these (sisters) made you feeling that you are useless*.

In support of these findings, the results of a study that Gadieja et al (2014:47, 48) indicate that those participants felt hurtful about remarks concerning their performance. They also felt humiliated, intimidated, undermined and useless when regarded as incapable of performing some skills competently Furthermore these authors reported that one participant in their study voiced that her experience was so bad that when she thought of going on duty, she would feel like crying or avoid going to work.

#### 5.5.2.2.3 THEME 3: Sub-subcategory 3.2.2.3 Scary and discouraging experiences

According to the participants of the current study, their experiences during their first year in the CS clinical practice field were threating as evidenced by the data displayed below.

- *New environment*
- *Demands for responsibility and accountability*

According to Oxford Advanced Learners Dictionary English (2015:1303), the word scare means a situation where one becomes frightened by something, especially to the point that the frightened person becomes uncertain about what to do. According to the findings of this study, the NQPNs doing CS were inundated, by scary experiences. These emanated from the fact that they had to work in unfamiliar environments and had to join a team of strangers. They were scared, not knowing how these strangers would treat them. They also did not know how they would fare with executing their responsibilities. Moreover, on commencement of compulsory CS, although, the expectation was that the CS practitioners needed to function under supervision, the senior professional nurses anticipated that it was time for them to take up the responsibility and accountability as professional nurses when they carried out their professional roles. Some of the newly qualified CS nurses regarded that as a scaring experience as they realised that they had to assume their responsibilities without the clinical facilitators who were continually supporting them throughout their training as students.

The conditions of patients even terrified some participants, such as intensive care units for premature babies. Hence one participant indicated that:

> *The first month I was scared to work with those tiny very ill babies.*

Additionally, they indicated that it was a worse experience having to tell the mothers when their babies had died, and the situation was even worse if such babies were precious babies. About this experience, one participant voiced the following:

> *Every time I had to deal with them, I felt touched because some of them were precious babies. It happened that some of the mothers never really had babies before. Each time we got in that ward, I felt anxious and stressed, especially if the condition of the baby changes…*

Ndaba (2013:64) confirms the findings of this study by stating that the NQPNs become overwhelmed by the new environment and worse when they face the demands of their

responsibility and accountability. Mqokozo (2013:4) corroborates that the demand for high levels of efficiency, responsibility, and accountability expected from NQPNs can petrify them. In the same vein, Roziers et al (2014:96) assert that having to provide nursing care can be quite frightening for NQPNs.

#### 5.5.2.2.4 THEME 3: Sub-subcategory 3.2.2.4 Negative attitudes of colleagues

It appears from the findings of the current study that some participants had to endure negative attitudes not only from the senior professional nurses but also from their colleagues. One participant expressed this, stating that such an attitude posed some challenges at times that led to the eruption of arguments and misunderstandings about the sharing of responsibilities in the units amongst CS practitioners and senior professional nurses. The results show that CS practitioners got into heated arguments among themselves regarding the allocation of the number of patients to each of them. In some instances, if one transferred patients to other wards, those in the ward would not attend to the incoming patients. The nurses' misunderstandings even affected the patients as they had to wait for the nurse that has gone out to come back to be attended by her/him. This practice was not appropriate because it meant patients had to suffer due to the differences that occurred among nurses. As one participant indicated:

> *The working relationship with my colleagues … well, I am not going to say it is 100 %. I had differences with my colleagues in terms of the number of patients to nurse, I was transferring the patient, and the other one came, and that patient was sitting, and then when I came back, I thought that the patient should not have had to wait for me.*

In some cases, the newly qualified CS nurses used certain mechanisms to adapt to new situations and endure the improper treatment of some peers and senior professional nurses. For instance, one participant indicated that she had to play humble, keep quiet, and withdraw from the argument when she got into an argument with the senior professional nurses. She withdrew and started to concentrate on doing her work. She expressed herself thus:

> *We exchanged words, and I felt that 'No, I should hold back because I am still a junior, and she is a senior and older person. I actually felt that she was wrong, but from her perspective, she felt she was right because she is old in the profession…. but I know that we have that level of understanding, and we have to show professionalism, and so I had to bury myself in doing my work'.*

Seyedfatem (2017:[Sa]) corroborates the unpleasant and scary attitudes NQPNs experienced in the current study. In their study, participants also voiced their experiences as being terrifying because they had not bee granted enough opportunity and time to perform procedures to acquire competence. They further indicated that although they felt they still had deficits in some procedures, they were made to implement them, they were required to perform those; for instance, putting up intravenous infusions and resuscitating patients. They were concerned about such practices as they believed that the senior professional nurses' attitudes towards them were exposing patients to some hazards. Nkoane and Mavhandu-Mudzusi (2015:51,55) also reverberate the negative attitudes of nursing colleagues towards the NQPNs, who reported during their study, that the attitudes towards the newly graduated CS nurses were so bad that those senior nurses did not even tell the new nurses anything they needed to know. Furthermore, those newly qualified CS nurses felt not being recognised as professional nurses or appreciated in their efforts to carry out their professional roles. Consequently, the newly qualified CS nurses endured much insubordination from the enrolled categories of nurses.

#### 5.5.2.2.5 THEME 3: Sub-subcategory 3.5.2.2.5 Unsupportive organisational culture and senior professional nurses

The following data highlight some indicators of the unsupportive behaviour of the senior professional nurses (towards newly qualified CS nurses who participated in the current study):

- *Were referred to books*
- *Never got assistance when needed*
- *Let to work on their own*
- *Staff- shortage*
- *No mentoring*
- *Never assisted with whatever they needed to do:- if they enquired to know anything would be asked: What does your Brunner say?*

It evolved from some participants of the current study that they worked in clinical environments that were not supportive. They experienced minimal support from some units of the facilities, which affected the execution of their responsibilities adversely.

Furthermore, it affected the process of knowledge and skills development negatively. Whenever the newly qualified CS nurse requested assistance when they required knowledge and skills to perform procedures, they were ignored or referred to their prescribed books used during their training. As one participant said:

> *They never assisted us with whatever we needed to do. If we enquired to know something, they would refer us to Brunner, a medical and surgical nursing textbook*.

Halfer and Graf (2006:152); Mthembu and Zakwe (2012:13), and Beyers and Jooste (2013:34) support these findings in which the current study's participants felt they did not get the required support from the senior professional nurses and site managers. Thus they reported working in unsupportive organisational cultures. In line with the views of the authors in the previous paragraph, Zaayman and Daniels (2016:61), reporting on the study they conducted, stated that working alone in the clinical area was a big challenge for the newly graduated nurse. Furthermore, these authors felt that the presence of senior qualified nurses is crucial as they are the ones who possess more skills and expertise in nursing practice, so it is essential for them to help transfer knowledge and practical skills through guidance, coaching, giving advice and clarifying issues when NQPNs might have questions.

#### 5.5.2.2.6 THEME 3: Sub-subcategory 3.2.2.6 Limited learning experiences and opportunities

The following data display reflects statements of the current study's participants on aspects that contributed to poor learning experiences in the clinical sites, as some of their negative experiences.

*Limited learning opportunities*:

- *The small size of the institution lacking crucial facilities like X-rays department, theatre*
- *A limited number of prevalent conditions/diseases*
- *No opportunities for in-service education provided*
- *Most of the time, patients are transferred to other institutions:*
    - *Short stay in some of the units*
    - *Limited range of prevalent diseases*

According to one participant in the current study, she did not learn much from the allotted CS institution due to the small size of the institution and patients not suffering from a range of diseases from which they could gain learning experiences. She cited that prevalent diseases like tuberculosis and HIV/Aids-related cases made up most of the

patient population as the institution transferred most patients to larger institutions. Facilities like X-ray machines and operating theatres were absent at this particular institution hence the following excerpt:

> *The size of the facility denies me the opportunity to grow; because of the same conditions of patients in the wards are the challenge is that there are no doctors."*

An area which a participant anticipated would help her to develop her competencies was an area of in-service education and training. To her disappointment, this particular participant articulated that CS nurses were not involved in any in-service training, which she regarded as a valuable formal educational programme that could enhance their empowerment during CS. Regarding the aspect of in-service training, one participant voiced the following:

> "*What I was going to say also there is that thing termed in-service training as there is no one to mentor you."*

Makua and Nkosi (2016:134, 140) emphasise the importance of having a scheduled in-service training programme for NQPNs in various units of the facility. These authors propose sending the newly graduated nurse to such in-service sessions based on the manager's assessment of their needs within specific units. In-service training provides learning platforms where people can update new practices and revive old practices which can benefit the NQPNs in upskilling their competencies and even those of experienced older nurses. Eslamian, Morini and Soleimani (2013:[Sa]) reverberate the importance of updating the knowledge of nurses through continuing education as it does not only enhance the competency of nurses but also facilitates efficient patient care. It was, therefore, essential to provide the NQPNs with the opportunity to have in-service education since that would contribute towards improving their knowledge as well as refining their competencies as this is one of the objectives of the phenomenon of interest of the current study. Such in-service educational experiences also provided a forum for discussion of more current knowledge which the NQPNs might have about specific conditions and problems.

#### 5.5.2.2.7 THEME 3: Sub-subcategory 3.2.2.7 Isolation and feelings of not belonging

The following subcategories indicate isolation and the feeling of not belonging in the Cs area:

- *Isolated from colleagues due to the language barrier*
- *Isolated and feeling of not belonging*
  - *Felt being cut off*
  - *Felt being friendless/peerless*
- *Language as a barrier to reaching out to patients.*

Isolation is lack of contact between persons or groups of people or failure of a person to make contact with others or to maintain sincere communication where interaction with others persists (Collin's English Dictionary 2011:869). Isolation means remoteness, loneliness, seclusion, segregation, separation, and friendlessness. Oxford Advanced Learners Dictionary (2015:791) refers to isolation as a situation where a person is separated from the others and thus feels alone and can neither meet nor speak to the others. Some participants experienced a sense of isolation from their colleagues in their clinical CS areas. Isolation evolved because they did not understand the language their colleagues and senior professional nurses used. More often, these nurses were frustrated because, at times, they encountered negative attitudes from their counterparts when they requested them to assist in interpreting for them when attending to patients. The intensity of isolation made one of the participants to share that she even felt that, concentration in her work was affected as she was preoccupied continuously with strong feelings of missing her family and the community from which she came. She said:

> *The language barrier was something I experienced; I got to be used to those terminologies when the patients first came."*

The results of a study conducted by Mostert-Wentzel and Frantz (2013:[Sa]) confirm that language could present a barrier for physiotherapists in executing their responsibilities, even when provided with a language interpreter. The inability to communicate effectively with colleagues and patients is a concern because it prevents the holistic effort of rendering health care delivery to patients as a team which is a norm in the clinical environment. Furthermore, this prohibits reaching out entirely to the patients, thus

affecting the desire for some of these nurses to attain self-satisfaction in addressing the needs of the patients as individuals.

On the other hand, the other participant (in the current study) who had been affected by such a language barrier indicated that she had to find coping mechanisms to deal with such isolation. She would, for instance, stay away from colleagues, look for some work to do or sometimes would bring along her laptop and work on it so that she would not feel the seclusion to which she had been exposed. Hence she said:

> *I tended to bury myself by doing more work … we sat together as professional nurses they conversed in IsiXhosa, … I decided to go away and keep myself busy in the ward…. Sometimes I would bring my laptop and keep myself busy with the laptop. They made me to feel a sense of not belonging together with them. It was an unfortunate situation; I would feel lost and isolated.*

The two participants who experienced the language barrier felt cut off and friendless/peerless from the environment in which they worked. Proficient communication forms the base for good interpersonal relationships. It allows for sharing a special bond among co-workers. It also leads to the maintenance of trust, respect, and positive feelings for one another. Keeping good interpersonal relationships and communication at work creates a better understanding among employees. Conroy, Feo, Boucaut and Kitson (2017:[Sa]) affirm that, in the nursing profession, interpersonal relationships play a vital role among nursing colleagues as these enhance the effective delivery of patient care. It is thus possible that poor bonding among the isolated newly qualified CS nurses and their colleagues might have affected their skills development and implementation of professional responsibilities, thus denying CS nurse the ultimate chance of personal and professional development.

The findings emanating in the current study as a feeling of isolation, reverberate the findings of the study conducted by Beyers and Jooste (2013:34) and Ndaba and Nkosi (2013:68) where the NQPNs felt a sense of personal isolation and contention amongst the staff members in the clinical areas. These mentioned authors further indicated that the senior professional nurses isolated those NQPNs by leaving them ‘out there’ and ‘sitting in the staff-rooms’ away from the NQPNs. The senior professional nurses would only have contact with newly qualified CS nurses when they needed or wanted to ask something from them.

#### 5.5.2.2.8 THEME 3: Sub-subcategory 3.2.2.8 Difficult patients

Experiences of newly qualified CS nurses, who participated in the current study, included the segments of data displayed below about their encounters with difficult patients.

- *Encounter with patients pretending to be pregnant*
- *Dealing with patients seeking overnight accommodation*
- *Dealing with vulnerable, hungry community members who disguised as patients*

Dealing with a difficult patient was another challenge some newly qualified CS nurses experienced in maternity units. Such patients approached the wards from local communities pretending to be in labour, but they were merely hungry and needed food, some were destitute and wanted to have a shelter or in some cases, they would have gone to a place of entertainment and would want to have an overnight place to stay. Since in many instances, the NQPNs nurses were left alone, they had to cope dealing with such cases. No literature was found to illuminate this kind of experience of NQPNs with patients.

#### 5.5.2.2.9 THEME 3: Sub-subcategory 3.2.2.9 Hierarchy-related experiences

The following data display reflects the statements on the newly qualified CS nurses' lived experiences of how their colleagues regarded them, the sub-professional categories of nurses as well as the senior professional nurses regarding the hierarchical structure, as reported by participants of the current study:

- *Not recognised as professional nurses*
- *Treated as students*
- *Treated as children*

The CS practitioners experienced a problem regarding their hierarchical position with sub-professional categories of nurses**.** They indicated that because they were young, and even though introduced to staff nurses and nursing assistants, as professional nurses, the former had the habit of treating newly qualified CS nurses like children. They were handled as soft targets, as ward messengers and were sent around at times not even carrying out nursing-related responsibilities. Hence the following excerpt:

*Because we are small nurses, we have a challenge with the staff nurses and assistant nurses. Much as they were told/orientated that we are professional nurses, they would send us to other wards. Where we were working we were treated as children we were regarded as children … However, we had to be smart; we had to have positive attitude.*

Using the newly qualified CS nurses as messengers was also a challenge that was encountered by the participants in a study conducted by Gadieja et al (2014:50) where, for instance, being sent to the blood bank or pharmacy to collect medication were common practices. However, the notion of being treated like children as different participants expressed it, exhibited two connotations. On one side, it seemed as though they were not recognised as professional nurses, especially by sub-professional categories of nurses. On the other hand, being treated as children elicited care, nurturance, love, and appreciation from some of the senior professional nurses. Govender et al (2017:19) affirm that the NQPNs were really treated as students/ children and the title of Community Service Nurse Practitioner made them not recognised as professional nurses, and not allowed to perform specific tasks (Gadieja et al 2014:50).

**5.5.2.2.10 THEME 3: Sub-subcategory 3.2.2.10 Lack of equipment**

The findings of the study revealed another challenge that the current study's participants experienced, namely the lack of equipment which compelled the newly qualified CS nurses to improvise most of the time, on the realisation that they had an obligation to render care to the patients against all the odds. Hence the following pronouncement:

*I was frustrated to come here, because, this place is out in the lonely place, the clinic itself is not well equipped with material to nurse patients. Another challenge is sometimes the working equipment is not always sometimes there so like CTG and blood pressure machine so, we had to improvise."*

To provide adequate and efficient patient care requires the support of working material, like equipment and appropriate facilities. Having the proper material to work with does not only ensure the proper delivery of health care but also expands the knowledge and skills base of the practitioners. If the newly qualified healthcare personnel focus on doing things right from the beginning of their professional careers, such practices will enhance their lifelong apposite practices within their areas of professional practice. A lack of supportive equipment to back up the work of the newly graduated nurses, as reported in Nkoane and Mavhandu- Mudzusi (2015:38, 39), not only disadvantages the newly graduated nurses'

development but also compromises the health care of the patients. This notion is corroborated by the findings of the study conducted by (Moyimane, Matlala and Kekana 2017:2, 5) who indicated that lack of equipment leads to failure of integration of theory with practice by the students in preparation for skills development that might be used by newly graduated nurses in their future practice as professional nurses. Furthermore, these authors claim that effective learning opportunities for rendering quality care are interfered with, production of well- prepared nurse professionals is hampered as inability of use of certain equipment denies the development of expertise for nurses who do not get such opportunity during their practice as nurses.

### 5.6 THEME 4: POSITIVE EXPERIENCE/VIEWS ABOUT CS

The following sub-categories define this theme:

- *Provided a sense of joy*
- *Happiness*
- *Warmly welcomed*
- *Were lucky to be:*
  - *Warmly welcome*
  - *Encountering friendly people:*
- *Were respected*
- *Not undermined*
- *Were Appreciated by staff*
  - *developed self-esteem*
- *Being introduced to members of staff*
- *Developed accelerated responsibility and accountability*
- *Capacitated on conditions not encountered during student life on HIV/Aids*
- *Having had senior members of staff to work with during the first week*

From the content of the data display under 5.4.1, it seems as if doing CS had moments to be appreciated as they were perceived as positive aspects of their experience during the one year of CS. Regarding the positive aspects of doing CS, the participants identified that they experienced a sense of joy, and happiness as they voiced that they were lucky to be warmly welcomed by people who were friendly, and who appreciated and respected them. As a result, they developed a strong sense of self-esteem. The results of this study closely resemble the findings of the research conducted by Ndaba and Nkosi (2013:46), where participants confirmed that they received a warm welcome, very positive attitude and excellent orientation from senior members of staff. Furthermore, the site managers

provided them with a registered nurse to take them through all they needed to know for a whole month.

Similarly, Zaayman and Daniels (2016:47) confirm from their study, that the NQPNs doing CS, voiced some enjoyment they had during their CS year because they had good positive experience as they developed positive relationships with the members of staff who helped them acquire professional development. One participant was cited by these authors as even commented that she enjoyed every moment of placement in doing CS, because of their amazing positive experience. They considered CS as helpful, useful, and valuable as it facilitated their professional development. Judging from the information provided by the participants in the current study, as well as information gathered from literature, if a working environment is made conducive and supportive to practice, it makes those allocated there to execute their practice, to relax, enjoy it and render effective services.

Of added interest to this study is that a few of the current study's participants shared that they were *treasured and respected* by the senior professional nurses, because of the valuable contributions of information that they shared with them on new developments in the nursing profession. This was information the senior professional nurses were ignorant about, especially in the area of the management of HIV and AIDS-related conditions as well as tuberculosis. They also taught their junior nurses as well as the students that came from the local nursing college. The NQPNs were excited and regarded it as a golden opportunity to teach their senior nurses. The praises and the appreciation of the information they imparted to influence the care of the patients, boosted their morale and pride in doing something good for the patients. To them, it was fascinating to realise that they had resumed their teaching role for the junior members in the ward, which is one of the key functions of a registered nurse in enhancing patient care.

The origin of experiences identified in the current research can be classified as either externally or internally generated.

### 5.6.1 THEME 4: Category 4.1: Externally generated factors

#### 5.6.1.1 THEME 4: Subcategory 4.1.1: Supportive environment

Emanating from the findings of the current study, CS practitioners received continuous support from the professional nurses, while working with other members of the multidisciplinary team. For the NQPNs, being taught, guided, corrected, and even given some assignments to present cases was the source of their joy and happiness during their CS placements**.** Furthermore**,** being given tasks, having valuable arguments during discussions, and having to consult books and read as well as getting to the Internet to search for relevant information, were cited as some of the highlights of their experience during their CS placements. Earning praises from their supervisors for the work well done accelerated their motivation and heightened their pride, which stimulated them to desire to work harder in executing their nursing responsibilities.

A significant aspect of the clinical area as a supportive learning environment emerged from the data displayed below.

- *We received continuous support*
- *Exposed to working with members of the multi-disciplinary team*
- *There were people to offer help*
- *Allocated supervisor*
- *Were allocated senior members of staff to work with during the first week*
- *Ensured that they never worked alone (initially)*
- *Later let to work on their own (assured to seek assistance whenever needed)*
- *Received empathy from colleagues*
- *Were taught and supported by NGO members*
- *Doctors capacitated them as they taught them*
- *Were also taught on research skills*
- *We were praised for work done*

Regarding the support that is essential to be offered to the newly qualified CS nurses on their journey of transition from newly qualified graduates to professional nurses, one participant voiced that she was immediately provided with a supervisor to work with to the point that she felt comfortable and content that she was able to work on her own. To some participants, the senior professional nurses offered support initially for the first few weeks, and after that, they were allowed to work on their own and were advised to call for assistance whenever they needed it. To some participants, support was reported to be continuous. All health care professionals joined hands and supported the NQPNs in some units.

In all the units where orientation took place, experienced healthcare workers empathised with the newly qualified CS nurses. They realised that it is not always possible for the NQPNs to know everything on qualifying as a nurse. In connecting the findings of the

current study with reports available on literature, Hussein et al (2017:6) reported that, in their study, the nurses who were exposed to the positive work environment and having the support of preceptors during their transition, felt comfortable and found the transition to professional nurses easy as they even commented that it was "*excellent and exceptional".* Claxton (2016:7, 10) affirms that preceptorship assists to speed up the development of nurses to be ready to take up and master their roles to be competent nurses in the execution of their responsibilities. Consequently, the same author asserts that the NQPNs must be adequately supported during their first year of practice to enhance improvement in their knowledge, skills, and competencies attained during their education and training as nurses. Furthermore, such support enables the refinement and development of their soft skills of self-reflection, critical thinking, and clinical judgement.

About the significance of support during the transition to professional nurse, Beyers and Jooste (2013:34) reported from their study, that NQPNs experienced and enjoyed interpersonal support from nurses and members of the multidisciplinary team. Zaayman and Daniels (2016:60) corroborate this, stating that their participants emphasised the great support they received mainly from managers and staff nurses of units in the absence of senior professional nurses. Also, (Claxton 2016:7) declares that having expert support and learning from best practice at any given time, offers a basis for lifelong learning, encourages relationships among team members enhances personal development and enables the nurses to provide effective patient-centred care with confidence.

### 5.6.1.2 THEME 4: Subcategory 4.1.2: Capacitated by a multi-disciplinary team and NGOs

The following data display portrays the multi-disciplinary team's contribution towards the capacity building of NQPNs on different aspects of competencies required for carrying out their professional roles, (as reported by participants in the current study).

- *Being capacitated on conditions that they did not come across during student life, e.g., HIV and AIDS*
- *Were taught management and administration skills*
- *Were also capacitated on research skills*
- Coordinated health care.

It became evident from the current study's findings that some participants experienced their units as enabling the members of the multidisciplinary team, senior health professionals and enrolled nurses alike, enhancing their capacity by sharing extensive experience and valuable knowledge on PHC issues. Knowledge sharing also involved capacitation in research skills and coordinated health care. Non-government organisations (NGOs), which work in association with some of the units, also assisted in this, especially in the case of newly qualified CS nurses working at clinics. Doctors also were cited as having taken a vital role in teaching CS practitioners.

Clare (2012:41), commenting on capacitation of newly qualified graduates, asserts that these practitioners get an opportunity to learn about contributions made by the multi-professional team towards the alleviation of patient suffering as well as about the coordinated health care responsibility offered by the multi-sectoral team. Newly qualified graduates, in a study conducted by Andren and Hammami (2011:11), affirmed doing CS to be a great experience that made them gain knowledge and skills under constant supervision and mentoring. They found this splendid because they never learned some of the aspects encountered in the practical situation while in class. They also appreciated having doctors and other nurses around acting as sources of support and information (Matlhaba et al 2019:[Sa]. CS is an excellent and vital part of their development and was most rewarding because it happened with continual support for some of the newly qualified professional nurse in the current study.

### 5.6.2 THEME 4: Subcategory 4.2: Internally generated factors

#### 5.6.2.1 THEME 4: Subcategory 4.2.1: Rewarding experience / motivational

The following are some positive internally generated expressions of aspects of lived experiences of NQPNs, which emanated from the analysed descriptions of participants of the current study.

- *Find self in comfort zone*
- *Felt protected*
- *Experienced a sense of belonging*
- *Felt needed to be there*
- *Not being undermined*
- *Felt a sense of growth and maturity*

- *Succeeded in fulfilling the learning requirements (Acquisition of practical skills)*
- *Felt great and successful in fulfilling the learning requirements*
- *Were able to focus and concentrate on their work*
- *Able to apply knowledge attained at previous education and training institution*
- *Gained a lot of knowledge and practical skills*
- *Felt sense of growth and maturity personally and professionally*
- *Had good relationships and interaction with multi-disciplinary team members*
- *Were taught management and administration skills*
- *Had good relationships and interaction with multi-disciplinary team member*

Doing CS, in the current study, was expressed in various ways as being a motivating and rewarding experience. The ability to manage to carry out responsibility independently was very motivating and fulfilling. The ability to be self-driven in executing their responsibilities boosted participants' self-esteem, confidence, and accountability for everything they did. It provided a comfort zone, as expressed by one participant because it provided an opportunity for that CS practitioner to measure her ability to apply what she had learned previously and what she was able to do in practice.

Furthermore, some of the participants felt a sense of belonging when they were in their clinical placement areas. They were able to join the other members of the healthcare team and together were able to carry out their health care duties. Being among senior members in the practical field enabled them to observe and emulate the professional values displayed by these senior colleagues. This made them anticipate that their professional and personal development had a good chance of success. The sense of being there with the others also encouraged the development of interpersonal relationships. CS is an opportunity to encourage learning from one another and sharing of responsibilities as well. The positive dynamics of the workplace can lead to pleasant feelings, experienced as rewarding. Hence the participants even voiced that they felt that they were needed and not undermined where allocated. Ebrahimi, Hassankhani, Negarandeh, Gillespie and Azizi (2016:12) emphasise the significance of providing emotional support for NQPNs because they indicated that it provides a sense of belonging to those who work together in an environment. Participants expressed this notion of a sense of belonging when warmly welcomed in the CS area.

Furthermore, they were respected, and the senior nurses in their environment wished them well in their endeavours as they commenced practice as NQPNs.

It emerged from the findings that some participants felt doing CS was a great experience in the sense that they faced the reality of applying theory to practice and the successful acquisition of practical skills. This was much appreciated. As a participant noted:

> *"When you do it, you know it?"*

Engaging in the application of the previously learned theory culminated in the development of confidence, personal development, and professional development. The participants in the current study expressed that doing CS rounded up their learning requirements making the one year of compulsory implementation of CS a success. According to the results of a study conducted by Hussein, Everette, Ranjan, Hu, and Salamnson (2017:6), these findings are supported by what was expressed by the participants in their study. These participants indicated that through the exceptional support they obtained from nurse educators, site managers, and clinical specialists, they fulfilled their learning needs.

#### 5.6.2.2 THEME 4: Subcategory 4.2.2: Development of a sense of professionalism

According to Bimray, Jooste and Julie (2019:1) professionalism implies an endeavour to behave according to the code of conduct, rules, and principles of behaviour that are set out by the profession. Furthermore, it should consider values, vision, goals, and mission that should be apprehended by the members of the profession. Hadrian, Salsali and Cheraghi (2014:1) state that professionalism is an essential, multifaceted, vibrant and inevitable process of the professional job which is branded by cognitive, attitudinal and psychomotor attributes. Professionalism, reflected within the nursing and medical professions, is a process aimed at providing quality care to consumers of health care, whilst upholding the values, respect, responsibility and accountability by those who provide care (Brennan & Monson 2014:645). It is grounded on trust and aims at holding up the needs of, and concerns of the patient above all considerations.

About professionalism, one of the current study's participants indicated that being exposed in the clinical area, evoked a sense of wishing to be professional in various

ways. For instance, starting from essential aspects as wearing a uniform appropriately, personal behaviour, the manner of communicating with others as well as acting as a role model, thus displaying the kind of behaviour that motivates the others to emulate such examples. The appreciation this particular participant had towards the nursing profession is reflected in the following statement.

*Professionalism … my personality changed; it really changed. I tended to be professional, even the way I wore the uniform. I tended to care about everything I do. Wherever I go and what I do and how I express myself in a professional manner. So, it really changed me … made me to work like a role model a people's role model. So, we felt we had a responsibility to care for the people.*

Dickmen, Karatas, Arslan and Ak (2016:[Sa]) support the view of that specific participant that a professional nurse should portray professionalism by adhering to the profession's stated values and expected behavioural attributes. Adhering to these and displaying them reflect a high degree of dedication and commitment to the nursing profession, patients, clients, and the general public.

### 5.7 THEME 5: ASPIRATIONS AFTER HAVING DONE CS

The findings of the current study showed that the exposure of NQPNs to some other experiences stimulated them to have different aspirations to advance their careers in various nursing areas as indicated in the following data display:

- *To advance studies and do Masters in Midwifery*
- *Paediatrics.*
- *Pursue Masters*
- *Future plans to work at the clinics*
- *Wished to be a lecturer in future.*

Doing CS was comprehended by the CS practitioners as something instrumental in determining what to pursue in their future nursing careers. One participant said:

> *CS for me is OK…it makes you to have many experiences. It makes you decide on what you want to pursue in future, something you want to do."*

The participants, who indicated that they would pursue master's degrees in midwifery and paediatrics, indicated that they enjoyed working in these units reflecting on nursing care

activities on which they received positive feedback from the senior professional nurses. They worked independently and made independent decisions about patient care, which further fostered these aspirations. One other area highlighted as attractive to work at in future is at the clinics. The attraction of working at clinics resides in the possibility of working most of the time independently. Nurses at the clinics have an advantage of prescribing medications and making independent decisions in meeting the patients' and clients' health care needs.

Working towards becoming a lecturer also emerged as the future choice for advancing her career by one participant. She indicated that the presentations they had to do when given assignments influenced her interest in that area. This particular participant stated that she would become a nurse educator once she feels that she has contributed enough in the area where she received grooming as a professional nurse.

> "M*y aspiration is to be a lecturer… I think my dreams are taking me to that direction. I am presently wrapping up my Masters."*

The respondents appreciated the praise they received from the senior professional nurses and other members of the multi-disciplinary team. Abrahimmi et al (2016:14, 15) affirm that the positive attitude and constant support towards the NQPNs create a sence of encouragement, feeling of being valued, respected, loved, relaxation, increased self-esteem and confidence amongst the newly NQPNs. It further gives them hope, commitment to the profession, permanent stay and be successful within the profession.

## 5.8 CONCLUSION

This chapter presented the themes, categories, and sub-categories arrived at following the data analysis at the idiographic and nomothetic levels of analyses. These have been discussed and supported by relevant literature from the findings of previous studies conducted by various authors. Figure 5.1 displays a summary and conclusion of the themes, categories, and subcategories. The next chapter discusses a summary of the findings and focuses on the construct of adapting /adjusting that emanated from the findings of the current study. Subsequently it gives the process of development of guidelines and the rationale suggested for the implementation of developed and

suggested guidelines. It integrates currently available related theories with the themes, categories, and subcategories.

# CHAPTER 6

# SUMMARY OF THE RESEARCH PROCESS, FINDINGS OF THE STUDY AND DEVELOPMENT OF GUIDELINES

## 6.1 INTRODUCTION

This chapter gives a summary of the research process followed during the current study, summarises the interpretation of the findings and provides the guidelines based on the findings of the study. It is just over two decades that mandatory community service was introduced for the health care professionals, for which the doctors were the first ones to commence its implementation. The nurses followed, into being in it after just over one decade of its implementation. Subsequently, there have been a series of studies that have been developed on its implementation and these are in various provinces of the country. These studies were both from medical field and mostly in nursing and their implementation depicts some interest in the phenomenon by nurses who form the backbone of the health care system as indicated by Motsoaledi (2011:[Sa] ).

The researcher, influenced, by the findings of studies conducted, and the fact that, even after two decade that the policy of community service was introduced, there had been up to date, only one study conducted in the Eastern Cape on this phenomenon and its focus was on experiences of midwives. The current study explored the experiences of the newly qualified professional nurses doing community service. The main purpose of such a study was to gain empirically based information on the experiences of NQPNs in the Government's CS program, to ensure adequate coverage of all communities with access to the health care system of the country and ensure refinement of their skills. Subsequently, based on the findings of the study, and influenced by a series of factors that were anticipated to influence the adjustment of the NQPNs the researcher, developed guidelines with an objective that says; "to assist the Newly Qualified Professional Nurses to adjust to community service, understand the structure and meaning of their experiences in their immediate environment", this undertaking was engaged in so as to be able to develop such guidelines which when having been

validated and implemented will strengthen the capacity of NQPNs to adjust in the clinical area and thus be enabled to carry out their professional responsibilities and consequently, provide effective and efficient patient care.

### 6.2 THE OBJECTIVES OF THE STUDY WERE TO:

- Explore and describe the experiences of the newly qualified professional nurses in compulsory community service
- Identify and describe the gaps of the community service in the Eastern Cape
- Assess the knowledge gained from the community service from the newly qualified professional
- Develop the guidelines to assist the NQPNs to adjust to the community service to understand the structure and meaning of the immediately lived experiences.

### 6.3 THE QUESTIONS OF THE STUDY WERE:

- What are the experiences of newly qualified professional nurses in compulsory community service?
- What are the gaps of the community service in the Eastern Cape?
- What is the knowledge gained from the community service from the newly qualified professional?
- What is the potential application of the developed construct (adaptation/ adjustment) into nursing practice as experienced by NQPNs in doing CS?
- What measures can be used to assist the NQPNs to adjust to the community service to understand the structure and meaning of the immediately lived experiences?

### 6.4 THE RESEARCH DESIGN

The study falls within phenomenology with the research process structured according to Wertz (1983:204-210), 1985:168-173, and Wertz et al 2011:124-156) and Grbich (2013:93-101). Empirical psychological reflection, an approach within existential phenomenology, was essential in conducting the study. Furthermore, informed by the findings of the study, the process of development of guidelines has been employed in the study.

### 6.4.1 Methodology

The focus of the study was on the experiences of NQPNs doing a compulsory one-year CS after completion of their qualifications. Thus, phenomenology seemed suitable to the study, both as an underlying philosophy and a research method.

### 6.4.2 Sampling

The newly qualified professional nurses who met the inclusion criteria and who were willing to take part in this study were purposively selected. The participants in the current study had exposure to CS for at least three months after obtaining their nursing degrees or diplomas according to Regulation R425 of 28 February 1985 as amended: Regulations Leading to Registration as a Nurse (General, Community, and Psychiatric) and Midwife. Furthermore, the nurse educators and the site managers where the participants obtained their education and training and as well as site managers where the NQPNs were allocated, were respectively random sampled. Their views regarding factors that would enhance adjustment of NQPNs in the clinical field were sought.

### 6.4.3 Data Collection

Twelve participants agreed to take part in the study. Nonetheless, only six participants were interviewed as data got saturated. The researcher conducted formal qualitative in-depth and unstructured interviews to obtain rich information about the phenomenon of interest. When conducting the interviews the researcher started off by a single grand- tour question to the participants and further negotiated it with the participants to uncover their experiences. The researcher explored the research topic in-depth, using probing questions derived from interviewees' statements to ensure that she exhausted their experiences of the phenomenon under study when data got saturated. She audio-taped the interviews and transcribed these recordings verbatim in preparation for data analysis.

### 6.4.4 Data analysis

The researcher analysed the data at the idiographic/ideographic and nomothetic levels according to Wertz's (2011:124-150) empirical psychological reflection (EPR) and Grbich (2013:96) interpretation thereof. During the idiographic/ ideographic phase the researcher

went through the individual participant's contributions. "Eidetic seeing" guided the scrutiny of the analysed data of individual cases (Wertz et al 2011:150) and led to the prediction of specific characteristics of the phenomenon under investigation; the "experiences of NQPNs doing community service in the ECP." Subsequently, the researcher compared all attributes of all the cases that participated in the study to uncover the General Structural Phenomenal Description (GSPD) obtained through continuous free imaginative variation. The researcher then scrutinised the data looking for statements or "meaning units" which were grouped into categories which later became subcategories as more extensive categories emerged from the data, forming categories in even more general themes. Furthermore, the data was thoroughly examined to compile individual summative outcomes of individual psychological descriptions. Following this, the researcher moved on to the nomothetic level of analysis, where the different individuals' summative outcomes were combined. The details of these analyses appear in section 3.12 of this thesis.

The transcripts were analysed verbatim and structured as themes with supporting categories and sub-categories supported by data. According to Wertz's (2011:150) suggestion, on completion of data analysis and logic consideration of themes, categories, and sub-categories, the researcher related them to one another. During this phase of data analysis, the following numbers of themes and categories emerged:

- 5 Main themes
- 8 Categories
- 16 Sub-categories
- 12 Sub-subcategories and these were obtained when data from the NQPNs was analysed.
  Subsequently, when data was obtained from the educators and the site managers there were 2 categories and six sub-categories that evolved from such data.

The researcher then identified the central concepts of transition and adaptation and accommodating all the themes and categories of the phenomenon under investigation. Of these two concepts, "being in transition" is the more inclusive one and accommodates "adaptation /adjusting" to the situation and, as such, adaptation/adjustment becomes the process of maintaining an equilibrium; a dynamic equilibrium. Where the situation was conducive, adaptation/adjusting appeared to accelerate and slow down the participants' coping with challenges. The process of transition, discussed in chapter 4 within the "Transition Framework", rests on aspects of Duchscher's (2008: 441-447) Theory of

Transition, developed from the experiences of NQPNs within 12 months after obtaining their professional qualifications.

This showed that the NQPNs traverse a journey/ transtion during their one year period of doing CS from “being a novice to being experts” - to borrow from Benner (2001).
The overall findings of the study show that when the newly qualified nurses were allotted to clinical areas for implementation of mandatory one year community service, they were subjected to positive and negative lived experiences**.** Nonetheless, no matter how their experiences were, it was observed on data collection and analysis that a few readily adjusted to their environmental situations and some had to draw on psychological defence mechanisms to withstand the situations that made them uncomfortable in the practice environment. Participants, too viewed “adapting”/adjusment to the environment as instrumental in enabling them to focus on the rendering of effective and efficient patient care. Such adaptation /adjustment needs to occur when the newly qualified professaional nurses are allocated in the clinical arrears, because, they need to be psychologically settled to be able to concentrate to all that happens in the clinical field in order for them to learn more and be able to refine their competencies and thus in turn be able to render efficient patient care.

The adaptation/adjustment which occurred during their transition, developed through various processes and phases throughout the one year of implementation of mandatory community service. The researcher, therefore, chose Duchscher’s (2008) Theory of Transition as the main framework to guide the development of guideline within which to discuss the emergent constructs adjusting/ adaptation of the current study. This theory was found best fiting the findings of the study. The experiences of the NQPNs, who did CS and participated in the present study, have much in common with Duchscher’s (2008) theory. The discussions that subsequently follow in this chapter evolved from the study and have been used to support the course of development of guidelines regarding the process of adjustment of the NQPNs doing CS in the practice enviroment.Such findings have been integrated with literature review that support the concept of adjustment to a strange new enviroment, which is the clinical field in the case of this study. Herewith, this chapter presents the summary of the findings of the study and the process of developing the guidelines on “assisting the Newly Qualified Professional Nurses to adjust to

community service, understand the structure and meaning of their experiences in their immediate environment".

### 6.4. 6 Definition of terms relevant to the study

- **Transition**

According to online dictionary (2021: [Sa]) transition can be defined as the process of adapting to a new role and is experienced by newly graduated nurses. This happens when one makes a move from situation to another to take up new responsibilities. Duchscher (2009:1103); Meiles ([2010 [Sa]) indicate that transition is the process of moving from a state to another and is usually associated with significant changes in goals, roles and responsibilities. In the context of this study, transition means change from one professional position to another and this is characterised by change in environment and the manner of carrying out role responsibilities within the nursing profession.

- **Reality shock**

Reality shock is a term for describing the reaction of an individual who has received education in the field and has just started working. (Caliskan & Ergun 2012:1395). Reality shock can also be described as a condition in which a person enters a profession, but finds him or herself unprepared and yet faced with expectations and responsibility that has never experienced before and thus feels helpless (Sparcino 2015:[Sa]). It is not unique to nursing, though it can certainly happen in the nursing field. It is also declared reality shock is a reaction to adopted where the newly qualified nurses discover that the work situation for which they were educated operates differently to the ideals and the values they had imagined (Online English dictionary (2017:[Sa]; Online dictionary (2020:[Sa]). In this study reality shock is understood as a situation where the newly qualified professional nurses find themselves having to work in a strange environment with strange people (health professionals and others). It is a situation where they begin to realise that they need to take a responsibility and accountability for patient care and yet discover that not all that they learnt at the nursing education institution merges up with what they need to do in to do in the real situation.

- **Definition of adjustment**

Adjustment entails mental processes used to adapt, cope, and manage the issues encountered in normal life (Ababu, Yigzaw,Besene & Wondela (2018:[Sa]).It is an

educational process referring to the changes in behaviour towards better life, better relationships and better contribution to the society (Online medical dictionary 2011:[Sa]) and it enhances coping to everyday life which is influenced by constant relationships encountered in ever changing environment (Weiten, Dunn & Hammer 2015:[Sa].

- **Professional adjustment**

Online medical dictionary (2011:[Sa]) refers to professional adjustment as development and growth of an entire individual regarding all his/her capacity, physical, mental and spiritual towards efficient and effective performance of his/ profession. Furthermore, professional adjustment signifies behavioural changes towards better life and relationships that occur, influenced by education where an individual makes contributions to life as well as attaining awareness and in-depth understanding of the pros and cons of the profession (Online Spider-Web blog Sports 2011:Sa]). In the context of this study professional adjustment pertains to ability of the newly qualified professional nurses getting acquainted with the new practice environment wherein they cope to render their professional responsibilities effectively and proficiently.

## 6.5 GUIDELINES TO ASSIST THE NEWLY QUALIFIED PROFESSIONAL NURSES TO ADJUST IN THE CLINICAL AREAS DURING DOING COMMUNITY SERVICE

### 6.5.1 INTRODUCTION

Literature shows that there are some studies that have been conducted internationally and a few, nationally, on adjustment of the newly qualified nurses to the culture of nursing practice and to the demands of health care. Those studies evidence that the newly qualified nurses encounter challenges in adapting /adjusting to new clinical areas. This hampers the development of their skills and consequently effective patient care (Kinghorn, Halcomb, Froggatt &Thomas, 2017:[Sa]). The writings, too, extracted from United Kingdom Essays (2020) cite Mooney 2007; Nash, Lemcke & Sacre 2009; Husein,Everett and Salamonson 2017:[Sa]) arguing that in all certainty, the newly qualified professional nurses are still experiencing massive challenges and difficulties in adjusting to the newly qualified nurses' role. Sparcino 2021:38;) also claim that the newly qualified nurses indeed face many challenges when they commence their professional role as a results she advocates that there is a need to re-look at the curriculum and the teaching strategies that are employed by the faculties and re-design them to those that might assist the NQPNs to adjust when they get to the clinical areas. Likewise, van

Rooyen, Jordan and Caka, ten Ham-Baloyi (2019:308) recommend that the faculty members and managers should join hands and develop situations that might ensure that the NQPNs are assisted to have smooth transition that will enhance easy adjustment for the NQPNs in the clinical areas. It is therefore, crucial to critically consider the challenges they encountered in the clinical practice environment and thus devise strategies / guidelines to enhance effective adjustment to their new role, hence, the researcher, influenced by some findings of this study decided to develop the guidelines on assisting the newly qualified Pprofessional nurses to adjust to the clinical areas especially during their experience of doing CS.

Through elaborate search of national literature on the concept of adjustment, the researcher, observed that there is scanty literature on that area. Nevertheless, there is reasonable literature obtained which relates very closely with factors that influence adjustment of the newly qualified nurses in the clinical environment. This information is obtainable from findings of studies conducted on experiences of NQPNs and transition of them thereof from students to fully-fledged professional nurses. The findings of those studies and from the current study were therefore, considered in building up the guidelines in this particular study.

Since the intention of the national government of introducing community service is to refine the competencies of the newly qualified nurses and to ensure access of communities to effective patient care, by equitable distribution of health care professionals, it is envisaged that it is crucial to ensure that such health professional adjust easily to the clinical areas. This would make them to focus and be able to address the health needs of the individuals found in the practice environment.

The guidelines proposed to be developed in this study are envisioned to meet the national government's main aim of introducing and implementing the policy of community service. They might serve as essential guidance to ensure that attempts are made to facilitate adjustment of the newly qualified professional nurses to the clinical areas, for their benefit and subsequently benefits of the patients.

Duchsher's (2008:441-447) theory of transition was used as a theoretical framework to scrutinise how certain factors in the clinical field pose as constraints to the development of the newly qualified nurses in the areas where they performed their one year mandatory community service. Some other factors which happen as challenges have been observed

from literature and further integrated with those evolving from the findings of this study to fulfil the objective of developing the guidelines. Health workers, especially, those who have the experience of receiving the newly qualified nurses in their clinical sites were interviewed pertaining to their views regarding the factors they esteem as facilitating or impinging the adjustment of newly qualified nurses in the clinical area during performing community service.

These health care workers cited the following as the key factors that prevent adjustment of newly qualified nurses in the clinical areas; lack of equipment, shortage of staff which deny the newly qualified nurses opportunity to be exposed to sessions of in-service training and also being provided with staff to teach them. Lack of support by those who are in the clinical areas, lack of knowledge envisaged as might be due to poor grounding on clinical skills during their training, since seemingly they lack mentoring as they do not have clinical supervisors that do follow up from the nursing education institutions when they were students. Lack of zeal to take up responsibility on their side was also highlighted as might prevent them from adjusting.

Basically, according to the findings of the study, the factors that facilitated the adjustment of the newly qualified nurses were outnumbered by those which prevented easy adjustment of the NQPNs. The newly qualified nurses in some instances even went to an extent of engaging in some psychological defence mechanisms to enhance their adjustment for instance coping strategies like, rationalisation, avoidance, accommodation, submissiveness and staying positive against odd situations. These factors were influenced by a range of situations, for instance, size of the institution, availability of equipment, nature of the facilities, staff-related factors, workload, interpersonal relationships, profession/ professionalism.

### 6.5.2 Introduction to guidelines development

The transition to registered nurse can prove to be a tempestuous experience to individuals and as well as professionally. This was expressed by the participants in the present study and consequently, indicated in various studies in literature. Literature reveals that transition to registered nurse is a ‘reality shock” (Caliskan & Ergun 2012:1393; Graf, Jacob, Twigg & Natabi 2020:[Sa]) which is incited by organisational arrangements of institutions and education. Yinju 2012:[Sa] assert that negative experiences encountered in the clinical areas by NQPNs can make it difficult for them to adjust emotionally and socially, to the practice environment especially during their first

year after qualification. It is under such circumstances that some studies advocate for provision of positive practice environment to improve perception of newly qualified professional nurses regarding practice environment and consequently improve nurse and patient outcomes. Recommendations too from studies were considered, for instance Andren and Hammami (2011:19) suggest that studies could be undertaken to explore and develop guidelines for support of newly qualified nurses executing the mandatory community service. Chang and Daly (2012:[Sa]) also advocate that, it is crucial even when the nurses are still students, that there be a plan devised to enable them be aware and understand the possibilities that lie ahead of them, which they would encounter and thus pose as problematic during their transition to being professional nurses. Therefore, it is essential that strategies are sought to assist them to make necessary adjustment to more positive experiences in their post-registration period.

### 6.5.3 Purpose of development of guidelines

The purpose of the developing guidelines is to offer a document which contains empirically - based information designed to guide those in nursing care / health professions' education on how to use in their education, strategies of learning and doing practical that can assist their products to readily adjust when they get to the clinical areas.

### 6.5.4 Objectives of the guidelines

The objectives that are designed to develop the guidelines in this study are indicated below.

**The objectives are to:**

• Explain the process of adjustment to the new situation (clinical practice environment) with specific emphasis on factors that can promote such adjustment regarding the experiences for newly qualified nurses doing mandatory community service.

• Describe recommended practices pertaining to how the adjustment of newly NQPPNs can be facilitated so as to advance their skills for carrying out their nursing responsibilities and thus provide effective health care to their patients

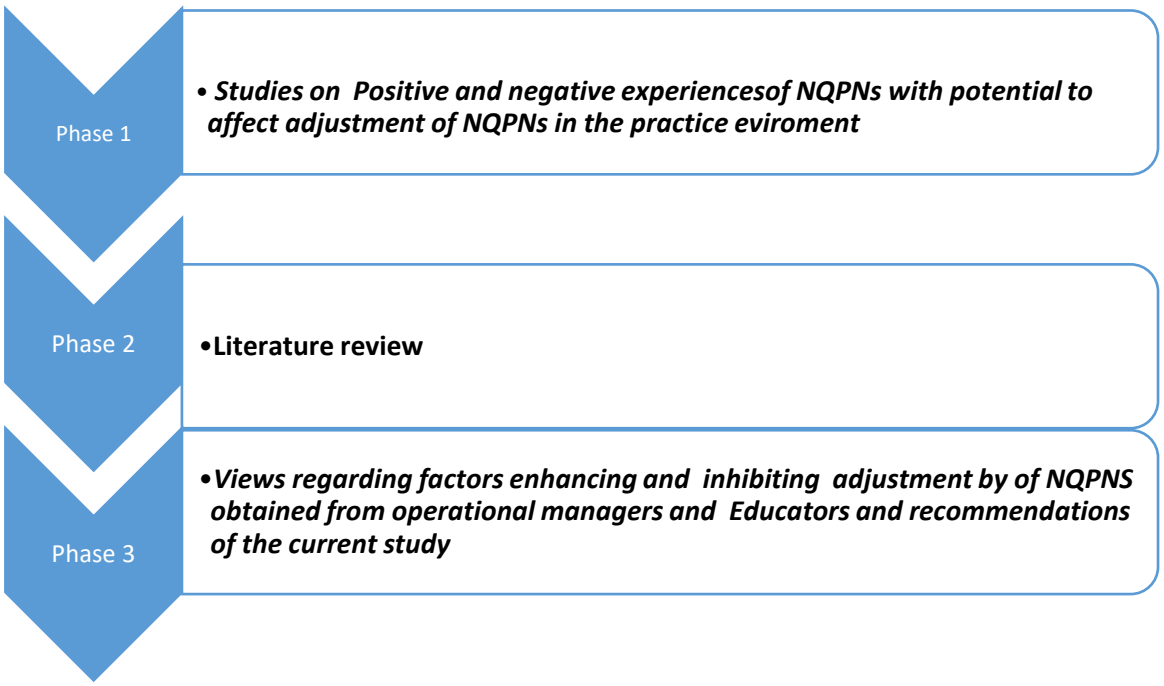
### 6.5.5 Scope of application of guidelines

The guidelines will be applied in teaching of the students for the courses leading to professional qualification at universities and nursing college of the Eastern Cape as well

as nationally in areas where they are deemed to fit situations. The main target groups are nurse educators, who provide direct nurse education, health facility managers in clinical sites where the NQPNs are allocated for one year mandatory community service and health policy makers who are the custodians of the policy of community service. The guidelines can also be shared with the other health care professionals who also experience almost similar problems of adjusting to various challenging situations in the practice environment.

### 6.5.6 Direction for guideline development

The findings from the studies in chapters 5, views sought from the site managers, and educators, recommendations in chapter 7 as well literature review were used to draft the guidelines.




The conceptual framework for developing guidelines is presented in Figure 6.1

**Figure 6.1: Development of guidelines regarding the adjustment of newly qualified nurses in the clinical enviroment**

The findings that are summerised in this chapter, evolved from data analysis derived from application of ideas of a range of authors who published on phenomenology, both as a philosophy and as theory-guided research. These authors refer to writings; mainly about experiences concerning the theory of research and research conducted on experiences of an array of phenomena. The readings the researcher mainly concentrated on are those of Wertz (1983:204-210 and 1985:168-176), Wertz et al (2011:134-156) and Duchscher ( 2008:442-448, 2009:1103-1113) and 2012:20-120). She equally perused several articles on the transition of newly graduated nurses to professional nurses as well as their adjustment in the clinical practice enviroment. Also, she considered looking at the available theories in the discipline of nursing that relate to the concept of adaptation / adjusting emanating from the findings of the current study. These theories are highlighted as closely relating to the concept of adapting/ adjusting and can therefore, be applied in explaining how the NQPNs go through the process of adjusting to the clinical areas. Specifically, these theories direct the development of guidelines in relation to the factors or situations that facilitate or prohibit such adjustment/ adaptation.

Inclusive to the findings of the experiences of newly qualified nurses doing CS, are findings that were obtained from the site managers and educators regarding their views about factors that enhance or might prohibit the adjutment of the NQPNs to their new practice enviroment.

Although there does not seem to be much literature on adjustment of NQPNs to the clinical areas, the researcher was able to obtain some articles which yielded information that could assist the newly qualified nurses to adjust to their practice inviroment. Most of these were articles obtained from international research studies. They put a lot of emphasis on significance of curriculum design to influence the process of adjustment for the NQPNs. In cases where studies highlight factors that prohibit adjustment of NQPNs, such information assited the researchers to develop the guidelines which could be instrumental to making adjustment if they can be considered for implementation.

The guidelines developed is an answer for effective implementation of the CS programme. The guidelines will guide the coming NQPNs to gain autonomy as quickly as possible as they are deployed to the community as nursing profession is dynamic and require the graduates to have survival strategies that will make them grow in the profession.

The following figure and the table depicts the summary of the findings from the various participant categories interviewed in the current study. Consiquently it potrays the the integration of this information in preparation for guideline development.

**SUMMARY OF THE FINDINGS OF THE STUDY AND DEVELOPMENT OF GUIDELINES**

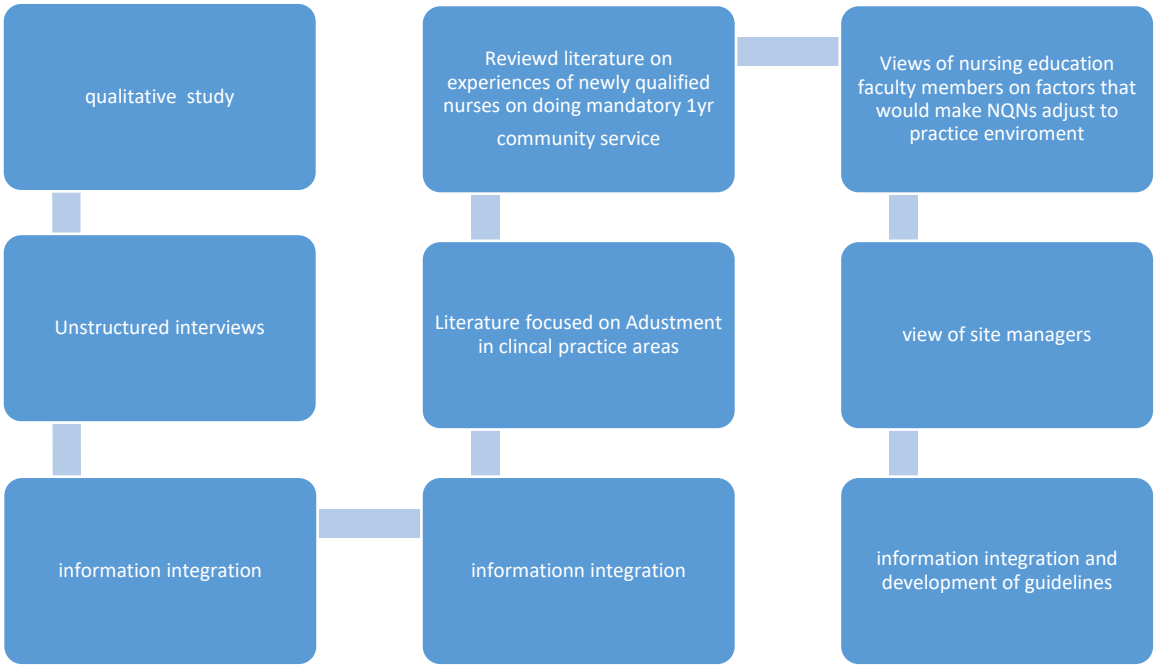



**Figure 6.2 sumarry of findings on which guidelines on adjustment of newly qualified nurses have been developed**

**Table: 3: Showing the findings from the various participants and literature reviewed.**

| Research findings from NQPNs | Findings from Educators views from educators | findings from site managers | Literature review |
|---|---|---|---|
| • Considering the existential baseline of participants | • The content laden curriculum | Staff-shortage<br>Lack of equipment<br>Lack of | • A well-planned clinical observation programme of NQPNs along the |

| | | | |
|---|---|---|---|
| • Conceptualisation of the concept Community service<br>• Carrying out professional responsibilities without supervision and support<br>• The constructive and conducive working environment<br>• Role modelling of professional behaviour to emulate from<br>• Established sense of belonging and interpersonal relationships<br>• Positive reinforcement of excellent work through praises and prompt feedback in areas of gaps-identification<br>• Exposure to a range of wide range of clinical areas | • Minimum number of clinical hours for university graduates<br>• Large number of students per intake<br>• Clinical teaching done by faculty members<br>• Lack of knowledge and skills | opportunities for in-service training<br>Inadequate supervision<br>Lack of interest to learn on the part of NQPNS<br>Knowledge and skills deficiency<br>Observed unwillingness to take up responsibility<br>Unavailability of clinical department<br>Overburdened by overload of work | transition and development guidelines lines identified by Duchscher (2008), should be developed and made available to supervisors in the clinical field.<br>• Collaboration between education and health industry partners for better preparation and support of the newly qualified nurses<br>• Caring attitude by faculty (Sparcino 2015:42; Misen et.al 2016)<br>• Nurses entering practical field with knowledge and skills deficiency<br>• Use of high fidelity simulation laboratories as students (Sparcino 2015:43)<br>• Promotion of positive working environment by unit managers<br>• Good clinical coaching by expectant professional nurses<br>• Giving positive and constructive feedback on performances by NQPNs<br>• Strong mentoring programmes Roziers 2014:98)<br>• Inadequate “text book- |

| | | | |
|---|---|---|---|
| Collaborative interaction and support with senior and professional nurse<br>• Provision of positive practice environment to improve patients' care and its outcomes and impact<br>• Need for mentoring and support<br>• Support and guidance by the senior professional nurses<br>• Unrealistic expectation from senior professional nurses<br>Well planned orientation programme<br>• Exposure to a range of wide range of clinical areas<br>• Constructive corrections to preserve self-image and dignity | | | bound' education which does not prepare nurses well for reality.<br>• Collaboration between education and health industry partners for better preparation and support of the newly qualified nurses<br>• A well-planned clinical observation programme of NQPNs along the transition and development guidelines lines identified by Duchscher (2008), should be developed and made available to supervisors in the clinical field.<br>• Promotion of professional guidance<br>• Adequate support (Dyess and Parker 2012)<br>Offering a good comprehensive support programme can enhance adjustment (Bjerknes and Bjork ([2010:Sa]).<br>- Providing unit |

| | | | |
|---|---|---|---|
| • Unrealistic expectation from senior professional nurses<br>• Eradication of unprofessional conduct/ behaviour of professional nurses | | | specific mentoring programmes (Sparcino 2015:42) |

- The guidelines developed provide some direction to the following findings of the study:

## 6.6 CONSIDERING THE EXISTENTIAL BASELINE OF PARTICIPANTS

In existential phenomenology, the concept of "existential baseline" refers to the wholeness of being at any point in time, the tapestry against which any moment in time reflects and occurs existentially and experientially (The researcher's understanding).

### 6.6.1 Earlier experience as student nurses

Some participants of this study voiced that their experiences as student nurses assisted them in adjusting / adapting to the conditions they experienced as challenging when they commenced doing CS. Their earlier experience of working on their own as student nurses reduced their anxiety and stress during their exposure to the CS practice environment, which often demanded that they executed their professional responsibility without supervision or direct support.

Although working without support frustrated some NQPNs, their earlier experiences of working on their own prepared some of them for these untoward and unexpected experiences when they commenced CS. Their student experiences helped them to endure the circumstances to which they were exposed and thus focused on their further development and conducting their professional roles to the benefit of their patients.

Notwithstanding the experiences that participants had of working independently, they still emphasised a need for mentoring and support. Collaborating with senior professional nurses opens opportunities for learning, thus expanding one's knowledge and skills base. It also provides role models whose professional behaviour can be aspired to and emulated.

**Guideline 1**

- It is essential that during basic nursing course, educators should use teaching strategies that give the learners opportunity to learn to do things independently, however under the guidance of the teachers so that by the time they qualify they do not need constant supervision to carry out their roles in order to adjust to the new environment.
- The teaching strategies also, should be supported by high tech-simulation laboratories which are well equipped to provide moments during which learners can go and practice to strengthen their skills.
- The issues of importance of spending time on their own to use opportunities provided for practical should be emphasised in the curriculum
- Reduce stress and anxiety and thus make NQPNs adjust in the situation where they might encounter being without direct supervision and support when they are in the practice areas doing community service
- Enable the NQPNs to focus and withstand the challenging situations they encounter in the practice situations, so as enhance adjusting to the practice areas
- There should be adequate staff employed to support the learners in the simulation laboratories and the clinical practice areas to ensure effective development of competencies of learners.
- The staff (preceptors or mentors) should be identified to be responsible for clinical learning of students should precisely collaborate with the learners as they execute their responsibilities in the clinical areas

- **Rationale for the guidelines**

  Having the preceptors who are ever with the students especially during their training will make them when they are exposed to CS to adjust to the new environment and thus feel that their personal and professional growth are protected, mishaps that could lead to litigation are prevented and effective and efficient patient care promote and their development of their positive professional self-image is preserved

### 6.6.2 Conceptualisation of the concept of CS

The participants of this study perceived doing CS as something good, worth doing, gratifying, and worthwhile as it ensured the refinement of their skills. Some participants even implied that, despite some difficulties they faced, they had to cope for the sake of their growth and the benefit of their patients.

The findings of this study provide a list of aspects the participants viewed as beneficial in doing CS, including opportunities to refine their knowledge and practical skills. Clinical experience and their existing knowledge and skills, in interaction, assisted them in them to identify any knowledge gaps they had and to focus on working diligently and securely. They thus viewed CS as an extension of their education and training.

According to the current study's participants, recognising the benefits of doing CS made them strive to focus on these benefits all the time and to work hard. Refining their skills was motivating and increased their efforts and commitment towards meeting their learning needs and the needs of their patients. Although challenging at times, they endured, cultivating resilience in realising their contribution and worth.

The NQPNs still perceive doing community service as continuation of their education and training, as such they regarded it as something, good, gratifying, satisfying and worthwhile to refine their competencies. Rigorous interaction with the NQPNs is crucial to assist them to identify any knowledge gaps they had and to focus on working diligently and securely. Once they attain the much needed skills they might begin to adjust to the

practice areas and thus be able to cope to encounter and attain their professional responsibilities.

**Guidelines:**

- Re-inforce the learning and practices of NQPNs positively therefore; praises on the excellent work they performed can help to accomplish this.
- It is equally important to assess and identify any gaps in students' knowledge and practical skills and provide prompt feedback on these.
- Where they do not attain the set standards of work, guidance should be offered
- Provide any possible corrections in a positive, constructive, and professional manner that retain and promote their self- and professional image and dignity.
- Ensure that there are structured opportunities for them to be exposed to formal organised learning where their needs are assessed in each unit and are then taken through what they regard as their gaps in knowledge and skills which need to be filled in.
- It might be a worthwhile exercise to assist professional nurses in the clinical field via in-service education programmes on guiding NQPNs.

**Rationale for the guidelines**

These guidelines will reinforce learning for the purpose of making the professional nurses to perform the work well to ensure effective and proficient patient care after having attained opportunity for adjusting.

### 6.6.3 Expectations of NQPNs

The NQPNs regarded themselves as individuals who still needed to continue learning. They envisaged that they could attain this if properly introduced to staff members and adequately orientated to the CS environment. Orientating NQPNs alert them to the expectations about their placements. It offers an opportunity to be acquainted with the environment and what is available in the units to assist in rendering patient care. They expected exposure to a range of clinical facilities in their institutions as this would enhance their exposure to a broader variety of experiences that would aid in the further

refinement of their competencies. Furthermore, exposing NQPNs to a range of working experiences provides them with skills which they might not have been able to engage in during their term as students as they often spent limited time in some regions of the clinical field. It is thus necessary for the unit managers who receive the NQPNs into their institutions to adhere to the proper exposure to the clinical field during CS.

Once their skills are better improved they can be in a position to adjust in the practice environment because they would have developed ability to execute their responsibilities with confidence. Furthermore, the NQPNs expected that senior nurses would accompany them and assume full responsibility to ensure an environment conducive to their further learning through enforcing a culture of introducing and orientating NQPNs to every aspect of the ward routine as well as rotating them to different clinical areas. However, this did not go according to their expectations in some units. Literature too, in the studies conducted by Govender et al (2015:[Sa] evinces that the newly qualified nurses had similar and different expectation to the ones in the current study for instance they cited that , they expected to be recognised as registered professional nurses, would not be left alone to carry responsibilities unsupervised. They expected to be introduced to responsibilities in a gradual manner. Likewise, they expected to be treated like professionals who would not be excluded from attending in-service education sessions, workshops and seminars. Horsburgh and Ross' (2013:1127) study participants indicated that they expected to be continuously mentored through a well- structured mentoring programme and anticipated to receive prompt and helpful answers whenever they ask about anything they did not know. However, things did not go according to their expectations.

**Guidelines**

Nurses , on their last year of basic traning need to get proper orientation about what they need to do before commencing and completion of community service like:-

- Intended plan for their placement,
- Appropriate forms to sign on completion
- Information about allowances due and the payments to expect.
- Develop a well -planned orientation programme that will expose the NQPNs to all areas of the units in which they are allocated and this will give them information

about the policies, protocols and culture of work performance within the units to ensure that they know well what is expected from them when they have to perform their professional role.

- Developing a well - planned mentoring programme is required to give a directive about how they should perform their responsibilities, how to take up accountability which is crucial for patient care.
- Develop a well-planned clinical observation programme of NQPNs and made available to supervisors in the clinical field (Duchscher 2008:444). Such a plan is essential to be used in order to assess the progress of professional growth of the NQPNs in terms knowledge and skills acquisition, roles performance as well as carrying out of responsibilities and taking up accountability for activities performed in the units.
- The professional nurses should ensure that they enhance continued learning in various units and thus expand their knowledge and skills base to effectively render patient care
- Make NQPNs aware of what is expected from them in a range of units with diverse experiences, thus, they would be aware of how to handle the demanding patient's issues of patient care
- Assess their level of adjustment by providing a well - structured observation programme to determine the progress of adjustment of the NQPNs,
- Each unit will need to observe and document the performances of these newly qualified nurses
- Where are gaps that have been identified in the practice of NQPNs corrective measures should be employed to facilitate chances of improvement

**Rationale of the guidelines**

The guidelines will make NQPNs to be well vexed with the entire culture of professional work performance. This will be ensured by the well- planned orientation and structured observation plans. Through these proposed guidelines the necessary feedback will be provided and the progress in their development will be assessed to facilitate bridging of gaps identified if there are any.

### 6.6.4 Provision of the effectiveness of CS orientation programmes

Orientation and guidance are important because they play key role in developing the competencies of the NQPNS. Consequently, those enable them to give quality care to their patients and further ensure that they are incorporated into the health care team within the organisation.

Providing an orientation programmes for the NQPNs when entering the CS is very crucial. Such orientation programmes need to focus on the physical layout of the facility, the daily working operations of the facility, all categories of staff, possible moral and ethical dilemmas that could arise, the administrative arrangement of CS, and documentation. Orientation should aim at making newcomers welcome and support their participation and function in the clinical field, thus maximising their clinical and administrative experiences. Spacino (2015:44) argues that successful orientation depends on new graduates possessing the knowledge and tools of an advanced beginner, possibly even nearing a competent practitioner. It was reported that orientation and consistent guidance for newly qualified nurses in the practice environment was lacking, off course this depended on various institutional settings in which they were allocated.

**Guidelines**

- Orientate the newly qualified nurses on commencement of CS so that they can begin to realise and understand their role as professional nurses. In turn, this might curb the "reality shock" they often experience when they come to the clinical areas after qualification, so therefore:-
  - Provide positive climate for learning
  - Give individualised attention and opportunities to teach and interact with each of the NQPNs and involve them to a greater extent in the activities that are available in the clinical units
  - Pay particular attention to each one of them so that they mostly feel that they are valued and supported and generally concerned about their being there and their welfare
  - Give them a sense that they are welcomed already included in the 'community of practice' within the clinical learning environment

- Task orientation (the extent to which ward activities are clear and well organised), teacher innovation (the extent to which clinical teachers/clinicians plan new, interesting and productive ward experiences, teaching techniques, learning activities and patient allocations) and individualisation (the extent to which students are allowed to make decisions and are treated differentially according to ability or interest) responses score

- Identify well trained people that can provide a well- designed and comprehensive orientation programme. These people should be chosen on the basis of their expertise, interest and dedication to the profession and who have best interest of patients at heart and thus will be able to provide expectant effective and efficient patient care.
- Professionals elected should have sound knowledge of teaching adults and have fundamental knowledge of evaluation of performances of NQPNs who will be able to provide valuable feedback to the NQPNs.
- The orientation programme should give provision for offering some extension of time for those who might need that.
- Plan for future support as those orientated might not capture and master all that are orientated on.

**Rationale for the guidelines**

These guidelines will decrease anxiety levels. They will develop sense of belonging and thus strengthen the confidence of NQPNs in executing their responsibilities.

### 6.6.5 To provide positive practice environment to improve its perception by the NQPNs as a means to improve patient health care and its outcomes.

One purpose for of the community service program is to ensure that the newly qualified professional nurses get an opportunity to refine their professional competencies. Additionally to that, the CS programme is defined to ensure equitable distribution of health care professional to all communities to ensure that communities have access to health care services available in the country. There is therefore, a need for the facilities to offer a positive practice environment to improve the manner the NQPNs nurses perceive it and thus improve the patient health care and its outcomes. It should also be realised that NQPNs are still learning, so their personal and professional development is still on- going

even after qualification. It is therefore, essential for them to be in a constructive and conducive environment. They basically, still need regular feedback about their performances and further aspire that such a feedback should be constructive and motivational.

The findings of the study, showed that in some instances the practice environment was positive. It offered them opportunities wherein they learned being welcome, orientated and provided with supervision. In such cases their stress and anxiety levels were reduced, they were comfortable and had good chances of acquiring knowledge and practical skills they required. On the contrary, depending on situations within the units, the others encountered difficulties, such as shortage of staff, lack of equipment, minimal orientation and even untoward attitude from either peers or/ and senior professional nurses. Such difficulties denied them golden opportunity of improvement of their competencies and rendering what they perceived as satisfactory care to their patients. Holtzhousen, Cotzee and Ellis (2020:[Sa]) echo the notion of provision of conducive conditions and positive perception of practice environment for NQPNs in order to survive in that space so that they develop positive outlook of environment in order to adjust and comfortably execute their professional roles.

As Whitehead (2011:[Sa]) emphasises, the significance of support, it could even be offered by peers and if it is done through that approach it would provide peer interaction and be of help to lessen and address fears and stress and also provide guidance at all times to / about anything they want to do in the clinical Naughton, Collins and Ryan (2015:8) believe that peer support diminishes frustration and the feeling of isolation and rejection. Bjerknes and Bjorknes (2012: [Sa]) are equally of the opinion that, support offered in good comprehensive programmes could assist the NQPNs in adjusting in the new practice environment). Furthermore, these authors indicate that if the NQPNs can form up mutual and empathetic relationships with their counterparts they can feel at ease and thus adapt /adjust easily to the professional practice culture.

**Guidelines:**

- Facilities should provide positive practice environment to improve the manner the NQPNs nurses perceive it and thus improve the patient health care and its outcomes.

- Support of NQPNs should be ensured by providing an environment wherein they feel welcomed, and are well oriented to ensure that they are acquainted with all that is happening in the practice environment.
- Ensuring that mentoring and support is emphasised and provided throughout their education and training and continued to the period at least to the period of their execution of community service, since this period is earmarked for refinement of their competencies after their qualification
- Mentoring and supervision too, should be entrenched in the curriculum as important requirements during basic learning
- The students whilst still on training should be well prepared for the reality of patient cared by:-

- Affording them adequate exposure time to clinical areas and be groomed for taking up more responsibility of nursing the patients in the real situation
- It is essential that the staff complements are beefed up in the clinical units so that there be adequate staff to provide constant support and mentoring of NQPNs
- Support mechanisms to engage in:-
- Support given should focus on meeting individual newly qualified CS nurses' needs.
- Site managers should attend to any identified insecurities and address these as as a matter of priority during this final phase of "educational" practice before NQPNs register as a professional nurses.
- Site managers and senior staff should assist the newly qualified CS nurses in gaining confidence and competence in applying theory to practice and further expand their clinical nursing skills.
- If support programmes are in place, these should ensure continuous supervision not allowing NQPNs to work alone immediately after their allocation to CS.

**Rationale for guidelines**

- To emphsise consistent support of NQPNs is an invaluable aspect in enhancing adjustment of NQPNs in the clinical field. On- going learning , development of confidence and competence should be established so that these can culminate in producing professionals that are ready to take up their professional responsibilities and implement them effectively.

### 6.6.6 Collaborative interaction with and support by senior professional nurses

Notwithstanding the experiences that participants had of working independently, they still emphasised a need for mentoring and support. Collaborating with senior professional nurses opens opportunities for learning, thus expanding one's knowledge and skills base. It also provides role models whose professional behaviour can be aspired to and emulated. It is therefore, recommended that nurses, doing CS should receive adequate supervision from senior professional nurses who collaborate with them. This will protect their personal and professional growth, prevent mishaps that could lead to litigation and promote effective and efficient patient care and the development of a positive professional self-image.

**Guidelines**

- Provide constant structured professional support to ensure improved competencies and adaptation/adjustment to new working environments with new responsibilities expected to lead to increased work outputs and improved
- This will culminate to improved learning opportunities which lead to attainment of competences enhancing adjustment and consequently providing efficient patient care
- It will also lead to personal a professional growth required, promotion of efficient care and prevention of possible litigations which prevent job satisfaction
- Indeed professional growth, which can be gained through in-service, education would empower the NQPNs to provide care competently.

**Rationale**

Guidelines are very useful to guide training institutions, health facilities and the NQPNs that the end results would be the improvement in making professional nursing services available to the inaccessible areas.

### 6.6.7 Established sense of belonging and interpersonal relationships

The issue of belongingness and how it is promoted is very important. So, the senior professional nurses in the clinical areas, together with all those who work under them should endeavour to perform their roles in a proper manner which offers support and

promote positive interpersonal relationships and facilitate professional development contexts wherein the newly qualified nurses feel loved, respected, accepted and valued.

**Guideline**

- Good interpersonal relationships should be promoted by the senior professional nurses, between themselves and NQPNs and with all members of staff in the units as well
- Instil a sense of belonging to all units in the NQPNs so that they begin to feel loved, accepted, valued and respected
- It is essential to promote a sense of belonging as this creates openness of those in the clinical areas to one another. This might create opportunities to engage in debates about issues which might culminate to information that can turn to be valuable for patient care.

**Rationale for the guideline**

- Adhering to the above guideline will provide a homelike environment to the NQPNs and such will make them to be more relaxed, feel as part of all what is going on in the practice environment and that will make them comfortable and thus adjust well to the clinical environment and thus be able to perform their responsibilities as expected for the benefit of the patients.

### 6.6.8 Need for in- service education

The findings of the study revealed that there were opportunities for some nurses to be exposed to in-services education sessions during their CS. However, it was not all the units which exposed the NQPNs to such opportunities of acquisition of information, knowledge and skills. Amongst the factors provided for denying the NQPNs the chances to further learn at in- service learning services were staff shortages.

The researcher reiterates the importance of a concerted attempt at in-service training on accepting and guiding NQPNs doing CS. This must involve a culture and milieu of nursing, nurturing, and caring among all members of staff. It is the researcher's conviction that continuing in-service education and training will assist in leaving seasoned nurses

self-assured and up to meet the socialisation and practice needs of NQPNs. Also, so doing, NQPNs can potentially adjust in a relaxed manner and render effective patient care.

**Guideline**

- It is essential to expose the NQPNs to available in-service training sessions in the practice units as this might guide them on how to do some of the things to strengthen their knowledge and skills base.

**Rationale for this guideline**

- This is essential as it would expose the NQPNs to the environments where nursing practices for diverse patient conditions are carried out and thus their knowledge and skills base will be expanded
- The NQPNs would begin to know more about the culture of the nursing profession, nurturing and caring of patients
- It would also ensure that in-service education and training assist in leaving seasoned nurses self-assured and up to meet the socialisation and practice needs of NQPNs
- Also, so doing, NQPNs can potentially adjust in a relaxed manner and render effective patient care.

### 6.6.8 Positive reinforcement of excellent work through praises and prompt feedback in areas of gaps- identification

The findings of the study, revealed that the NQPNs yearned for the positive re-enforcement of their learning and work performance from the senior professional nurses. Where they performed well, they welcomed the good praises for their achievements. Prompt feedback for the work performed was equally appreciated, especially where they showed some knowledge and skills gaps. They aspired to quickly know about the feed- back on their work and thus effect corrections which reinforced their continued learning.

**Guideline**

- It is crucial to reinforce the learning and practices of NQPNs positively
- Praises on the excellent work they performed can help to accomplish re-enforced learning
- It is equally important to assess and identify any gaps in students' knowledge and practical skills and provide prompt feedback on these
- In cases of non-attainment of set standards of work, they should be guided and corrected in a positive, constructive, and professional manner that will retain and promote their self- and professional image and dignity

**Rationale for the guideline**

Is ensuring strong practical basis and production of invaluable practice outcomes ideal for the benefit of the patients. This has a potential towards making the NQPNs to be skilful and render effective patient care.

### 6.6.9 Role modelling of professional behaviour to emulate from

Johnson (2015:[Sa]) defines a role model as "a person looked up to" by others as an example to be imitated". Professional nurses in the practice environment have a responsibility of developing the NQPNs personally and professionally. They have to teach them by the way they do things and the manner in which they say things which is acceptable within the norms of the profession. It is important to inspire the NQPNs to work hard, motivate them to see potential each one of them has. They have to instil in them that, to be successful a person has to go through issues. On the other hand, the NQPNs have a responsibility to copy the good behaviour of the senior professional nurses. Being a role model is an important job, and everyone has the capability to be a positive role model.

**Guideline**

- NQPNs need to experience being developed personally and professionally in the units
- They should be motivated to work hard and endeavour to tap out their potential of doing and saying things in accepted manner

- Professional nurses should try to exhibit to the NQPNS professional behaviour which they always uphold and stick to professional norms as they work in the practice environment.

**Rationale for the guideline**

This will help NQPNs to begin to emulate good personal and professional behaviour and be inspired to relax and adjust as they realise that they are being developed to grow professionally and as persons

## 6.7 NEGATIVE EXPERIENCES OF PARTICIPANTS

As it reflects from the findings of this thesis in chapter five, the newly qualified nurses encountered quite a range of negative experiences which have also been considered in developing guidelines for enhancing the NQPNs to adjust to the practice environment. These entail improper planning for their placements as NQPNs and inadequate information regarding how they needed to prepare for CS, such as completing forms to receive remuneration, informing them about their conditions of employment, including their monthly payments.

**Guideline**

Proper planning and orientation of NQPNs before commencing compulry one year community service, is essential to avoid inconviniences like missing up on their payment of salaries, because of lack of information they needed to be provided with before they began implementing CS.

**Rationale for the guideline**

This would prevent unnecessary worries suffered by the NQPNs and would thus enhance their prompt focus on their professional roles after they commenced practising as they needed to adjust in order to render effective patient care.

### 6.7.1 Unrealistic expectations from senior professional nurses

The experiences of the NQPNs were challenging as they were expected to carry out all the professional roles with a marked level of competence. The NQPNs were

overwhelmed by being expected to perform such huge tasks and to shoulder the responsibility of doing everything and be accountable.

It is unrealistic to expect recently qualified nurses to know everything taught to them while in training as it is not possible to expose them to every possible event, condition or context they might encounter in the clinical field. It is impossible or unattainable to appropriately implement all one has learned during training immediately after qualifying as a professional nurses.

**Guideline**

- During nursing education and training the student nurses should be exposed to realistic, practical CS experiences during their last year of official training. Such exposure is crucial to provide them with the maximum experience to gain knowledge of a range of procedures, conditions, and contexts in the clinical field.
- When nurses enter the practice environment immediately after qualifying as professional nurses, they require mentoring and nurturing through structured orientation and mentoring programmes. This demands proper rotation among a range of clinical areas to ensure the expansion of their fields of learning.
- Innovative teaching experiences on their clinical placement should be introduced and implemented. This suggests that more time needs to be spent providing teachers, facilitators and preceptors with a variety of teaching strategies to motivate and encourage student learning in the clinical areas.

### 6.7.2 Improper conduct of professional nurses

Nursing is a noble profession; as such, all individuals who have undertaken this profession are expected to display positive and professional behaviour. They always must uphold the ethics and norms valued by the profession when dealing with colleagues and patients. This culminates in a conducive environment where patients receive their nursing care. It is thus indispensable that the ethic of nursing, nurturing, and caring permeates all spheres of nursing and that a code of ethics permeates in the clinical area through precept and example. This will protect their personal and professional growth, prevent

mishaps that could lead to litigation and promote effective and efficient patient care and the development of a positive professional self-image.

The findings also indicate that the participants suffered exposure to unprofessional behaviour from some senior professional nurses at the CS placement sites.
The other findings of the current study, concerning untoward attitudes of senior professional nurses, evoked feelings like stress, anger, anxiety, frustration, discouragement, discomfort, and fear. Harshness, unwillingness to assist the NQPNs when they needed help and a feeling of isolation and not belonging at the CS sites, were some of the negative experiences of newly qualified CS nurses.

**Guidelines**

- Senior professional nurses should display proper professional attitude towards nurses placed in their units for exposure for mandatory community service
- Adopt and display positive and welcoming professional attitude towards the NQPNs doing CS.
- Always adhere to ethics, values and norms of the profession and dealing with the colleagues and patients

**Rationale for implementation of the guidelines**

- If senior nurses portray a positive and welcoming attitude towards the newly qualified nurses, that would reduce the amount of stress, anxiety, frustration, fear and discomfort. It would make the NQPN to relax, be encouraged to do their work with some commitment and enthusiasm and to the best of their ability. Furthermore, the newly qualified nurses would feel welcome in the clinical sites and thus the feeling of isolation and not belonging will be eliminated and will chances of easily adjusting in these strange work environment will be enhanced. This will make them manage to execute their professional responsibilities for the benefit of the patients.

- **Eradication of unprofessional towards NQPNs**

There is a need for managers to develop strategies for eliminating unprofessional and hostile attitudes towards NQPNs by senior professional nurses. Such a problem may

deter active learning in the clinical area. It may also lead to individuals leaving the nursing profession.

**Guidelines**

- Managers should play a vital role in condemning this kind of untoward attitude towards CS nurses as it impacts negatively on the CS nurses in the clinical area by considering the following
- Avoiding any negative attitude displayed towards the newly qualified nurses as this may prevent any active learning in the clinical areas
- Avoiding any hostile attitude towards the newly qualified nurses that may lead to nurses wanting to leave the profession.

### 6.7.3 Shortage of staff and inadequate equipment in the clinical units

From the findings of the study, the NQPNs cited shortage of staff as one of the struggles they had experienced. This was reverberated by site managers who highlighted it as one of the aspects that affect adjustment of newly qualified nurses. They indicated that this leads to lack of support as are no individuals that can be allocated to fully take up the responsinsibility of constantly supervising the NQPNs. Also such shortage denies the newly qualified nurses the opportunity to be allowed to attend the inservice sessions offered in some parts of the province, because to the managers, if they go there, the additional pairs of hand offered by the newly qualified nurses to render nursing care would be forfitted. Staff shortage in the clinical areas was cited in a number of studies conducted in South Africa, Tsotetsi (2012:46; Thopola, Khole Mamogobo 2013:175; Govender et al 2015:[Sa]; Makau 2016:219). The concern regarding the staff shortage was that the NQPNs, whilst they would lack support, they would also be overburdened with responsibility, and thus have compromised chances to learn. The development of their knowledge and skills will consequently be affected and their chanced to adjust censured, thus be unable to render effective professional care to patients., hence the following guidelines are suggested:-

**Guideline**

There is a need of ensuring adequate complement of staff and sufficient equipment in the practice areas that will boost holistic learning and refining all dimensions of nursing

practice, including seeing self as belonging and being a professional nurse who has adjusted to carryout professional responsibilities

**Rationale for implementation of the guideline**

The unit managers will realise that in order for the units to provide efficient care there is a need to motivate for more staff members to be employed in each unit so that patients receive appropriate nursing care. This could benefit the NQPNs, because where the professional nurses are in accepted numbers in the units, they manage to give attention to their needs by having opportunities to supervise, guide and teach NQPNs. The end result of this is adjustment to the clinical areas and enjoyment of their professional roles because execution of their responsibilities is rendered less stressful.

### 6.7.4 Inadequate equipment

Inadequate equipment to support nursing care activities, surfaced as some of the struggles the NQPNs experienced. Seemingly, in most of the clinical areas where they practiced they found out that there are inadequate equipment. This was considered a barrier in making them cope with their responsibilities and could have culminated in their failure to adjust to the practice enviroment.Furthermore it hampers the development of their knowledge and skills they acquired during their training Moyimane, Matlala and Kekana (2017:[Sa]). Rivaz, Momennasab,Yektatalab and Ebadi (2017:[Sa]) assert that having adequate and proper equipment in the clinical units is crucial, because it enables the staff, and including the NQPNs to execute their responsibilities with ease and successfully. Managers, too whose views were sought regarding factors that can enhance or inhibit adjustment of newly qualified professional nurses cited that the inadequate equipment in the clinical areas where the NQPNs did their CS could prevent them from adjusting in carrying out their professional responsibilities, hence the suggested guidelines below:-

**Guidelines**

- It is essential to procure enough equipment in the practice areas to support the professional activities designed to ensure effective delivery of patient care, thus facilitating patient satisfaction

- Maintenance of equipment made available is equally important to ensure that those who deliver health care do so successfully without any stresses and frustration.

**Rationale for the Guidelines**

Since lack of equipment can lead to stress and job dissatisfaction, it has to be avoided at all costs so as to lessen challenges that might make nurses unable to carry out their responsibilities. Inability to have these can fail them to adjust in the clinical areas.

### 6.7.5 Unclear status of the NQPNs

The findings of the study depicts that the status of the NQPNs was unclear to the members of the unit as they were referred to as “CS practitioners”. They also perceived hierarchical placement-related issues as negative experiences and felt that all these negative experiences denied them enough chances to learn in the clinical areas. Since they had a status that was not well understood and confusing to the unit members, NQPNs felt uncomfortable. As a result, in some units, they were allocated non-nursing responsibilities like being sent to the pharmacy to collect stock or being sent from unit to unit as messengers. Sub-professional categories of nurses mostly practised this kind of behaviour which the NQPNs resented. These negative experiences led to unpleasant interpersonal relationships making some NQPNs feel uncomfortable, finding their placement unconducive for personal and professional growth. They regretted not being recognised as professional nurses. The unclear status associated with the NQPNs was also echoed by Govender et al (2015:59) in the study they conducted where the NQPNs felt that were afforded a status that subject them a sense of not belonging to the rest of nursing fraternity. The discomfort and sense of not belonging is envisaged as could be lessened by the implementation of the following guidelines which can enhance development of adjustment into the clinical field.

**Guidelines**

- There should be orientation of all permanent and seasoned members of staff of all categories in order to have insight into the content of current nursing curricula.

- In specialised clinical fields where the sub-professional nursing staff have vast clinical experiences, both NQPNs and seasoned nurses should be made aware of one another's proficiency and expertise.
- No member of the nursing corps should do non-nursing or "skivvy" work. NQPNs should adhere to clear job descriptions and lines of command should support adherence.

**Rationale for the guidelines**

- Adhering to the proposed guidelines might reduce the uncertainty of the NQPNs about their hierarchical position in the unit set up
- Reduction of tensions and undermining the NQPNS could be eliminated and thus might develop a sense of belonging and relaxation in the practice environment and adjust well.

## 6.8 FINDINGS FROM THE UNIT MANAGERS AND EDUCATORS USED FOR GUIDELINE DEVELOPMENT

### 6.8.1 Lack of knowledge and skillls

One other aspect, that evolved from information attained from the site managers which was also reverberated by educators, was lack of knowledge and skills from these nurses. The lack of skills was associated with observed lack of clinical supervision of these NQPNs by the faculty during their years of training. So they felt that they are left out there to fumble alone , instead of having people to guide them in re-inforcing knowledge and skills when allocated in the practice enviroment. (Benner at al 2010:[Sa]; Ebrahimmi et al (2016:1); Monaghan 2015:[Sa]) also agree that NQPNs commence their practice year after qualification with inadequate knowledge and practical skills., yet they are expected to carry out effective and proficient patient care. Woo and Newton (2019:84) declare that lack of knowledge is a stressful experience for the NQPNs it denudes their self-confidence and impacts negatively on their \performance and dignity. Under such conditions it is doubtful if the newly qualified nurses would readily adjust to the clinical areas, hence a need for the following guidelines:-

- Curriculum redesign emphasising learner support require review to ensure strengthening of knowledge and skills base of the NQPNs so that by the time they enter into the clinical areas they readily adjust for taking up their professional roles.

### 6.8.2 Observed lack of interest to take up responsibility by the NQPNs

This emerged as a unique findings that came from the site managers. One of them cited that some of the NQPNs did not show much eagerness to take up responsibilities they were required to handle in the clinical areas. This hampered their opportunity to learn. In some cases even when the senior nurses tried to motivate them to do so, there was less appreciation and keeness observed in doing so. It is therefore predicted that it might happen that the NQPNs who showed such behaviour had not mastered the skills required in the clinical areas after qualifying. So they probably did not know what to do regarding the required implementation of professional responsibilities.This could not therefore enable them to possibly develop much knowledge and skills to cope with their professional roles and adjust in the clinical area and consequently render effective patient care. The prediction by the interviewed nurse managers was supported by the findings of the study conducted by Penbrant, Nilsson, Ohlen and Rudman's (2012:741) where participants indicated that they did not master the practical skills to a satisfactory extent due to the educators who did not handle the theoretical content in a convincing manner to enable them to associate it with what happens in the clinical areas. In some instances the conntent focused mostly on mastering of theory and very litle on practical skills. In other instances the educators seemed to have inadequate theoretical content to enable them to acquire skills required in the clinical areas.

**Guideline**

- Senior professional nurses in the clinical sites should establish good relationships with the newly qualified nurses so that they become free to express reasons for their observed dampened attitude towards taking up expected responsibilities.

### 6.8.3 Unavaibility of the clinical department

It evolved from the site managers that availability of the clinical department afforeded the nurses whilst they are students an opportunity to have continued support and teaching by the senior nurses. At the nursing education institutions that are in the province there are no such departments anymore. So one of the site managers indicated that unavailability of such a departmenst has posed a barrier for the students to be coached, taught and be

supervised continuously by the experienced clinical teachers so that by the time they qualify they are ready to face the realities of the clinical field. Mwale and Kalawa (2016:6) assert that clinical learning in nursing is very important and as such in the study they conducted they advocate that it is essential for clinical learning to be offered by clinical educators. The participants in this study even claimed that the clinical staff were of vital importance to them, because they demonstrated the requred skills for them, Furthermore, they even covered the content that the faculty staff did not manage to teach.

**Guideline**

- Where possible it is suggested to have clinical departments that support the faculties to strengthen knowledge and skills development of nursing students. This could be done by having well equiped and well staffed simulation laboratories to support the learners. This is envisaged that it could prepare the learners to an extent that when they get to the clinical areas are ready to carry out their professional responsibilities.

### 6.8.3 Inadequate support

The site managers iterated that there was lack of support of the NQPNs as a result of unavailability of preceptors and mentors to guide, teach and support the NQPNs. This, according to the unit managers was observed during the education and training of the NQPNs who were allocated for doing community service post-registration. They alluded that the preceptors and mentors would be of great help to assist the newly qualified nurses to cope with their responsibilities and easily adjust to the practice areas.

**Relationships**

It is instrumental to establish good relationships between the NQPNs with members of the health care team this will facilitate communication amongst them which consequently ensures adjustment to practice environment

**Guidelines**

The major factor affecting nurses' coping with transition is their preparedness.

- Given the paramount importance of transition, nurse managers and policy makers need to develop effective strategies for removing barriers and facilitating nurses' coping with transition. Accordingly,
- Should developing and implementing comprehensive staff development and training programs,
- The mentoring programs should be initiated
- Should strengthen nurses' professional relationships,
- Should supporting nurses during transitions,
- Should promote their professional accountability and commitment, and enhancing the effectiveness of management systems are recommended for facilitating nurses' coping with transitions.

## 6.9 EDUCATORS' VIEWS REGARDING FACTORS THAT INFLUENCE THE ADJUSTMENT OF THE NEWLY QUALIFIED NURSES

### 6.9.1 A heavily parked curriculum with content

It evolved from the information provided by the educators that a heavily packed curriculum prevents the learners from managing to grasp some of the content taught. This happens, because the teachers rush through the content in order to cover it up during the specified time. On the other hand some students might be overwhelmed by receiving too much content at the same time. Such content might be essential in the nursing care of common conditions encountered in the practice areas. Subsequently this might lead to failure of NQPNs to fail during their pre-registration education to acquire competencies hence they experience deficit in their knowledge and skills base which then leads to delayed adjustment in real practice. The challenge of a content laden curriculum was confirmed by Ndawo (2015:106) who indicated that newly qualified complete their training unprepared for practice reality, because they do not grasp the content well as lecturers rush over it and there is also poor theory-practice integration because of massive content that needs to be covered up at any given teaching time.

**Guideline**

- When designing the curriculum, it is crucial to package the content with very common conditions in a particular geographical area so as to avoid loading up the

curriculum with conditions that do not necessarily form the disease profile of a specific geographic region.

- The conditions that are not common could be added in the curriculum to be “nice to know, not must know”. This would ensure that the learners are well grounded on the conditions that are crucial and common in that area.

**Rationale of the guideline**

It is to provide any products of the curriculum with skills that are directly responsive to the needs and problems of the immediate communities where they render their practices. This makes it vital to the learners to focus on aspects that will be of specific value to those that will be consumers of the services. This will also provide focused empowerment of the learners with skills that will be vital for their practice once they qualify. The scope of learning and the content not needed will be narrowed to allow concentration on what will make the newly qualified professional nurses to practice and know well, so that when they get to the clinical areas they are ready to adjust to the demands of the practical environment

### 6.9.2 Minimum number of clinical hours for university graduates

Educators cited that the students who received their education and training at universities are exposed to the real clinical areas for a minimum number of hours than those who are at the nursing colleges. Therefore, it is envisaged that this could affect their adjustment to the clinical areas because they might get to there being short of skills required to carry out effective and efficient nursing care to their patients. Jamshidi, Molezem, Sharif, Torabizedeh and Kalyani (2016:1) have emphasised short fall of the clinical areas which are due to knowledge gap versus development of clinical competencies. These challenges have been highlighted by Heidari and Norouzadeh (2015:[Sa] ) as lack of self-confidence feeling of unpreparedness lack of development of self- efficacy. Such lead to anxiety, insecurity and fear. With such challenges the process of adjustment is delayed and thus performance of professional roles is not done effectively.

**Guideline**

- It is essential that the faculties should have high fidelity simulation laboratories and learners be encouraged to spend time in them as much as they can possibly do so.

This could help them develop their skills in practicing in an environment which provides experiences that are closer to being real.

- Nursing education institutions should ensure that they equip their clinical laboratories with high-tech practice material which heighten the chances of nurses practising like are in the real situation. This boosts the development of their skills and competence in doing practical.

**Rationale for the guideline**

Improvement of skills performance and enhancing competence, proficiencies and readiness to implement effective professional patient care expertise

### 6.9.3 Large number of students per intake

The nurse educators who were interviewed were of the opinion that large groups of learners per intake can later on affect the adjustment of NQPNs when they have to perform their professional roles. Large numbers of students in any intake require added number of staff to teach, guide, coach and mentor in the clinical areas. Since the clinical units are short staffed, these learners do not usually have people to supervise them and expose them to adequate learning experiences, hence they lack knowledge and skills to manage their professional responsibilities. On the other hand, the participants in Motsaanaka, Makhene and Ally's (2020:3) study reported that the senior personnel in the clinical areas encounter problems to cope with large groups of students who even compete for procedures are implemented from which to acquire competencies. The indicated competition impacts negatively on their empowerment with knowledge and practical skills they are required to acquire, in order to perform their daily duties in providing quality nursing care as in the clinical environment.

Killam and Heerchap 2013:[Sa]; Nabolsi, Zumot, Wardam and Abu-Moghli 2012:[Sa] assert that once the facility is overcrowded with large number of students, learning does not take place effectively within such an area. As such attainment of required competencies after qualifying becomes impeded. This leads to newly qualified nurses completing their training without attaining the much required competencies for carrying out their professional responsibilities. In line with this notion Jacobs, Gawe and Vakalisa (2012:23) equally argue that large number of students in a real learning situation could

create difficulty in managing and giving individual attention and opportunities to practice, yet this is essential, because attaining real learning is anchored on translating learning outcomes into practical real-life experiences. Furthermore, O'Mara 2014:[Sa] states that if opportunities to learn have been compromised for nurses whilst on training, this might culminate in the nurse graduates lacking the competency in clinical skills and required nursing standards to carry out their professional responsibilities.

**Guideline**

- Site managers require to make motivations to have their staff complemented so as to balance up with the number of newly qualified nurses who are allotted to the clinical areas. This might afford them some opportunity to focus on assisting the newly qualified nurses to develop, thus making it easy for them to adjust for taking up professional responsibilities

**Rationale for the guideline**

Where there are adequate numbers of staff in the clinical areas, it is possible to have structured sessions for teaching within the units. Such sessions prepare all members of staff, and the NQPNs inclusive to have chances of sharpening their knowledge and skills. For the NQPNs, this might work as opportunity of enhancing adjustment for handling their professional responsibilities

### 6.9.4 Clinical teaching done by faculty members

Clinical teaching done by the members of the faculty was criticised by the educators who gave their views on factors that influence the adjustment of the NQPNs in the clinical areas. They assert that in many instances the faculty members fail to go to clinical areas due to a range of commitments they have to carry out in their respective departments. The students are, most of the time left out without supervision and mentoring. They thus lose out opportunities for re-enforcement of what they had learnt. De Swardt (2019:[Sa]), also affirms that although the nurse educators are knowledgeable and were available to do clinical student supervision, they did not sufficiently applied themselves in carrying that responsibility, because they did not engage themselves much in discussing aspects that pertained to student affairs with the clinical personnel. This practice therefore prevents chances of knowledge attainment and skills development and thus they struggle to adjust to their professional roles once they qualify.

**Guideline**

The following guidelines are thus suggested:

- Preceptors need to be appointed and employed to cater for the clinical teaching of leaners on a continuous basis.

**Rationale for the guideline**

This would act as a precursor for facilitating easy adjustment of the NQPNs to take up their professional role with confidence as might have acquired competence in executing their responsibilities due to expert preparation by their preceptors.

### 6.9.5 Literature on adjustment enhanced by nursing curriculum

Literature attest that in order to attain adjustment, by the NQPNs in the clinical areas there is a need to balance the expectations from the newly qualified nurses with the rigour of the curriculum which prepared them for professional roles when they qualify as they are required to meet workplace expectations (Sparcino 2016:5).

Furthermore the nurses should be put through a curriculum which arms them with vast knowledge and technical skills and the professional educators too, should always portray to the students positive and caring attitude and treat learners equally. It is predicted that, treating the students like this will make them when they learn under such circumstances be able to understand and comprehend the content taught with ease, and this makes them more than ready to get to the clinical area in future being ready to carry out their professional responsibilities effectively. Consequently, this will culminate to easy adjustment soon after qualifying as professional nurses. Furthermore, they should display professional attributes, by acting and behaving in a professional manner at all times and set learners to emulate such behaviour. It is envisaged that where professional behaviour that had been copied by learners during their days of training it could be carried over and be put in practice in future years by NQPNs and thus try to work so hard to heighten their standards of performance to those of the senior professional nurses. Sparcino (2016:5). In order to facilitate the transition process in newly graduated nurses, nursing schools should include intern practice in their curricula Althiga, Mohidin, Park and Tekian

(2017:3). This helps them to promote relationships self- confidence and improved their clinical experiences. Institutions should re-evaluate the content and duration of orientation programs regarding the needs of newly graduated nurses and provide social support in order to help nurses manage stress and anxiety during the transition process. Kinghorn, Holcomb, Fraggatt and Thomas (2017:14) echo the need for support by skilful preceptors, to enhance readiness for adjustment when the newly graduated enter the practice fields. This assists bolstering confidence of NQPNs. Some studies reported that the participants highlighted showing professionalism and positive attitude towards student as essential when dealing with them. This makes them to relax and gain confidence when they get to the clinical field where they have to execute professional responsibilities. Adjustment is envisaged to be enhanced if NQPNS enter the real practice areas with relaxed and confident stance.

**Guideline**

In order to ease adjustment of the newly qualified nurses, it is necessary to strive for the following:

- Admitting the nurses into a curriculum which is reviewed and strengthened so that it prepares them to be able to balance the expectations and the degree of their ability to carry out their professional roles

This can be attained through:

- Empowering learners with vast knowledge and technical skills to ensure that they easily cope with their professional roles when they get to the practice environment

- The curriculum should use teaching strategies that make students to work independently so that they learn quite early be independent critical thinkers capable of taking self- informed decisions in dealing with patient care

- Emphasising positive and caring attitude which encompasses portrayal of professional attributes that make NQPN feel valued and cared for and this will enhance some relaxation amid challenges and hard work they face in the clinical areas when they commence their practice post-registration

## 7 CONCLUSION.

This chapter has presented the development of guidelines which have been formed from the positive and negative experiences of the NQPNs who were exposed to implementation of community service in the Eastern Cape Province. Views of site managers and educators regarding factors they envisaged as might enhance or impinge adjustment of newly qualified nurse to the clinical environment were explored. The guidelines thus produced can be used by nurse educators to strengthen their curricula such that are designed to produce NQPNs who are armed with knowledge and skills that will enhance these nurses to readily adjust to their professional role. Consequently the guidelines will equip the site managers with strategies they need to adopt and implement to make the clinical environment conducive in all ways to the NQPNs so that they can carry out their professional roles without hustles and thus adjust readily to them. The following chapter presents conclusions, and the recommendations from the present study.

# CHAPTER 7

# CONCLUSIONS AND RECOMMENDATIONS

## 7.1 INTRODUCTION

This chapter gives a summary of the research process followed during the current study and summarises the interpretation of the findings and their implications, as well as conclusions and recommendations. The findings are presented in chapter five. These were obtained from conducting qualitative research on the experiences of the newly qualified nurses who had experiences of community service attained from the Eastern Cape Province. In addition to that are findings of the views of Nurse Educators and site Managers where the NQPNs were allocated for CS. These were on the factors anticipated to might influence adjustment of these NQPNs to the clinical areas. The chapter further deliberates the potential contributions of the current study holds for nursing science as well as the limitations of the study.

## 7.2 THE RESEARCH DESIGN AND METHOD

**The research question that guided the current study was**

> "How do newly qualified professional nurses in the Eastern Cape Province experience the one year compulsory community service which is mandatory for all health care professionals?"

Provided below are several questions which arose from the findings of the study and thus were used to guide the proposed development of guidelines

- What are the experiences of newly qualified professional nurses in compulsory community service?
- What are the gaps of the community service in the Eastern Cape?
- What is the knowledge gained from the community service from the newly qualified professional?
- What is the potential application of the developed construct into nursing practice as experienced by NQPNs in doing CS?

- What measures can be used to assist the NQPN to adjust to the community service to understand the structure and meaning of the immediately lived experiences?

- **The aim of the study**

This study aimed to gain empirically based information on the experiences of newly qualified nurses (NQPNs) in the Government's CS program, to ensure adequate coverage of all communities with access to the health care system of the country. It was envisioned that such information might assist in guiding NQPNs in CS and in improving the success of the programme towards improving and refining the competencies of newly qualified professional nurses. Furthermore, the findings of the study, incited a need for development of the guidelines to assist the newly qualified nurses to adjust to the community service, understand the structure and meaning of their experiences in the immediate environment.

## 7.3 THE RESEARCH DESIGN

The study falls within phenomenology with the research process structured according to Wertz (1983, 1985, and 2011) and Grbich (2013). Empirical psychological reflection, an approach within existential phenomenology, was essential in conducting the study.

- **Methodology**

The focus of the study was on the experiences of NQPNs doing a compulsory one-year CS after completion of their qualifications. Thus, phenomenology seemed suitable to the study, both as an underlying philosophy and a research method.

- **Sampling**

The newly qualified professional nurses who met the inclusion criteria and who were willing to take part in this study were purposively selected. The participants in the current study had exposure to CS for at least three months after obtaining their nursing degrees or diplomas according to Regulation R425 of 28 February 1985 as amended: Regulations Leading to Registration as a Nurse (General, Community, Psychiatric) and Midwife.

- **Data Collection**

Eleven NQPNs agreed to take part in the study. However, saturation occurred after six participants were interviewed. The researcher conducted formal qualitative in-depth and unstructured interviews to obtain rich information about the phenomenon of interest. She asked a single grand tour question to the participants and further negotiated it with the participants to uncover their experiences. The researcher explored the research topic in-depth, using probing questions derived from interviewees' statements to ensure that she exhausted their experiences of the phenomenon under study. She audio-taped the interviews and transcribed these recordings verbatim in preparation for data analysis. Subsequent to obtaining the information from the NQPNs, the researcher prompted by the findings of the study, developed guidelines that woulld assist the newly qualified nurses to adjust to the clinical areas in order to execute their responsibilities.

- **Data analysis**

The researcher analysed the data at the idiographic/ideographic and nomothetic levels according to Wertz's (2011) empirical psychological reflection (EPR) and Grbich (2013) interpretation thereof. She analysed the verbatim transcripts and structured it as themes with supporting categories and sub-categories supported by the data.

According to Wertz's (2011) suggestion, on completion of data analysis and logic consideration of themes, categories, and sub-categories, the researcher related them to one another. The researcher then identified the central concepts of transition and adaptation, accommodating all the themes and categories of the phenomenon under investigation. Of these two concepts, "being in transition" is the more inclusive one and accommodates "adaptation/adjusting" to the situation and, as such, adaptation /adjusting becomes the process of maintaining an equilibrium; a dynamic equilibrium. Where the situation was conducive, adaptation appeared to accelerate and heighten the participants' coping with challenges. The process of transition, discussed in chapter 4 within the "Transition Framework", rests on aspects of Duchscher's (2008) Theory of Transition, developed from the experiences of NQPNs within 12 months after obtaining their professional qualifications. The researcher also pointed out instances where the concept of adaptation features in nursing theories.

### 7.3.1 Data analysis at the idiographic/ideographic and nomothetic levels

During this phase of analysis, the researcher went through the individual participant's contributions. The researcher then scrutinised the data looking for statements or "meaning units" which the researcherd grouped into categories which later became subcategories as more extensive categories emerged from the data, forming categories in even more general themes. Furthermore, the researcher thoroughly examined the data to compile individual summative outcomes of individual psychological descriptions. Following this, the researcher moved on to the nomothetic level of analysis, where she combined the different individuals' summative outcomes. The details of these analyses appear in section 3.12 of this thesis.

During this phase, the following numbers of themes and categories emerged:

- 5 Main themes
- 8 Categories
- 16 Sub-categories
- 12 Sub-subcategories

## 7.4 ISSUES ON WHICH THE RESEARCHER MADE RECOMMENDATIONS

### 7.4.1 Existential baseline of NQPNs doing CS

As indicated in Chapter 5, Section 5.3, according to Wertz (1983:207; 1985:175), the norms of psychological existence are typical of everyday life, in which the phenomenon under study is not profoundly present or in which other predominating phenomena are implicit in the researcher's mind. Thus, the phenomenon under study is not an independent entity but a variation of other phenomena and stands out against this background. It is the researcher's understanding that this is also true for the research participants' psychological existence; that expectations, knowledge, skills, and experiences immediately define the familiar and the unfamiliar in the clinical CS field. The existential baseline for the current study is thus the context of being a student nurse merged with the professional sphere of nursing while allocated to the CS environment.

### 7.4.2 Conceptualisation of CS

Strictly speaking, conceptualisation is part of the existential baseline, depending on the perspective one takes on the issue. In gathering data in general on the lived experience of doing CS, participants' conceptualisations of the "phenomenon" of CS serves as part of

the existential background. However, the researcher contends that when asked to reflect on what CS is, the phenomenon stepping forward appeared to be experiential and not conceptual (mere cognitive).

### 7.4.3 Positive experiences

The constructive and conducive working environment involving constant mentorship and preceptorship ensured positive experiences for participants; experiences such as feeling that they belong, feeling competent at their hierarchical level and enjoying professional support.

### 7.4.4 Negative experiences

The expected intensive responsibility and accountability mainly instigated participants' negative experiences in executing their professional responsibilities, including the negative experiences elicited by the unsupportive clinical environment and exposure to the hostile attitudes of the senior professional nurses.

### 7.4.5 Articulated needs of NQPNs to improve their competencies

These include constant structured professional support to ensure improved competencies and adaptation to new working environments with new responsibilities expected to lead to increased work outputs and improved patient care. The findings, discussions, and recommendations are based on the empirical research and on the non-empirical research, namely the literature review on theoretical structures that accommodate the emergent concepts from the empirical data analyses. They are also based on perceptions of the educators and site managers that were interviewed on their views regarding factors that assist the NQPNs to adjust to their professional roles in the clinical areas. It (empirical research) thus includes the background of the participants as student nurses, their conceptualisation of CS, and their expectations around doing CS. In section 7.7 of this thesis, the researcher turns to the nursing theories, reflecting on the concepts of adaptation and traversing for guidance and for the practical advancement of these concepts in implementing and promoting adaptation, adjustment and traversing. Section 7.7 of this thesis discusses the application of these concepts in the CS field in detail as well as transposing these models to the field/area of community service.

## 7.5 TRUSTWORTHINESS

The researcher considered the trustworthiness of the study to reflect her personal and scientific integrity through the augmentation of the criteria of credibility, confirmability, dependability, and transferability. Section 3.14 of this thesis discusses these aspects. Regarding transferability, generalisability was achieved by the all-inclusive concepts of "transition" and "adaptation"/ adjustment which applied to all participants whether their experiences of transition to fully-fledged professional nurses were positive or negative.

## 7.6 FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The researcher identified themes and categories which stood out as key issues to be taken cognisance of when NQPNs are doing CS. These key issues emanated from the findings of the positive and negative experiences of the NQPNs as they were in transition from being newly qualified to fully-fledged professional nurses. They also evolved from the perceptions of the educators and site managers. The researcher then based the conclusions on the findings which translated in recommendations.

### 7.6.1 Considering the existential baseline of participants

In existential phenomenology, the concept of "existential baseline" refers to the wholeness of being at any point in time, the tapestry against which any moment in time reflects and occurs existentially and experientially (The researcher's understanding).

#### 7.6.1.1 Earlier experience as student nurses

**Findings**

The participants of this study voiced that their experiences as student nurses assisted them in adjusting and adapting to the conditions they expressed as being challenging when they commenced doing CS. Their earlier experience of working on their own as student nurses reduced their anxiety and stress during their exposure to the CS practice environment, which often demanded that they executed their professional responsibility without supervision or direct support.

**Conclusions**

Although working without support frustrated some NQPNs, their earlier experiences of working on their own prepared some of them for these untoward and unexpected experiences when they commenced CS. Their student experiences helped them to endure the circumstances to which they were exposed and thus focused on their further development and conducting their professional roles to the benefit of their patients.

**Recommendations**

Notwithstanding the experiences that participants had of working independently, they still emphasised a need for mentoring and support. Collaborating with senior professional nurses opens opportunities for learning, thus expanding one's knowledge and skills base. It also provides role models whose professional behaviour can be aspired to and emulated. It is therefore recommended that nurses, doing CS should receive adequate supervision from senior professional nurses who collaborate with them. This will protect their personal and professional growth, prevent mishaps that could lead to litigation and promote effective and efficient patient care and the development of a positive professional self-image.

#### 7.6.1.2 Expectations of NQPNs

**Findings**

The NQPNs regarded themselves as individuals who still needed to continue learning. They envisaged that they could attain this if properly introduced to staff members and adequately orientated to the CS environment. They expected exposure to a range of clinical facilities in their institutions as this would enhance their exposure to a broader variety of experiences that would aid in the further refinement of their competencies.

**Conclusions**

The NQPNs expected that senior nurses would accompany them and assume full responsibility to ensure an environment conducive to their further learning through enforcing a culture of introducing and orientating NQPNs to every aspect of the ward routine as well as rotating them to different clinical areas. However, this did not go according to their expectations in some units.

**Recommendations**

Orientating NQPNs alert them to the expectations about their placements. It offers an opportunity to be acquainted with the environment and what is available in the units to assist in rendering patient care. A well-planned clinical observation programme of NQPNs along the transition and development lines identified by Duchscher (2008:448), should be developed and made available to supervisors in the clinical field.

Furthermore, exposing NQPNs to a range of working experiences provides them with skills which they might not have been able to engage in during their term as students as they often spent limited time in some regions of the clinical field. It is thus necessary for the unit managers who receive the NQPNs into their institutions to adhere to the proper exposure to the clinical field during CS.

The researcher further recommends that when allocating NQPNs to CS in the clinical field, there must be a well-planned and structured programme which allows for mentoring; directing them to take responsibility and accountability central to nursing care. The researcher again emphasises the potential of Duchscher's (2008:448) work in this regard.

### 7.6.2 Conceptualisation of the concept of CS

The participants of this study perceived doing CS as something good, worth doing, gratifying, and worthwhile as it ensured the refinement of their skills. Some participants even implied that, despite some difficulties they faced, they had to cope for the sake of their growth and the benefit of their patients.

**Findings**

The findings of this study provide a list of aspects the participants viewed as beneficial in doing CS, including opportunities to refine their knowledge and practical skills. Clinical experience and their existing knowledge and skills, in interaction, assisted them in them to identify any knowledge gaps they had and to focus on working diligently and securely. They thus viewed CS as an extension of their education and training.

**Conclusions**

According to the current study's participants, recognising the benefits of doing CS made them strive to focus on these benefits all the time and to work hard. Refining their skills was motivating and increased their efforts and commitment towards meeting their learning needs and the needs of their patients. Although challenging at times, they endured, cultivating resilience in realising their contribution and worth.

**Recommendations**

It is crucial to reinforce the learning and practices of NQPNs positively. Praises on the excellent work they performed can help to accomplish this. It is equally important to assess and identify any gaps in students' knowledge and practical skills and provide prompt feedback on these. Where they do not attain the set standards of work, they should be guided and corrected in a positive, constructive, and professional manner that will retain and promote their self- and professional image and dignity. It might be a worthwhile exercise to assist professional nurses in the clinical field via in-service education programmes on guiding NQPNs.

### 7.6.3 Positive experiences of participants

**Findings**

The participants voiced a range of positive experiences during their CS tenure. These included being warmly welcomed into the clinical field, making them feel appreciated and respected. Friendliness from colleagues and senior staff members led to a sense of joy and happiness where they worked. This made them feel comfortable, needed, and secure, and they developed a sense of belonging and of not being undermined. The sense of responsibility and accountability was enhanced, and this led to accelerated enhanced self-esteem and growth as individuals and as professionals. However, not all participants enjoyed such splendid experiences. Nonetheless, no experiences in the wards were wholly positive nor entirely negative.

**Conclusion**

The transition of the NQPNs from being newly qualified to being fully integrated professional nurses had moments treasured by all NQPNs. This, however, depended on the calibre of colleagues and senior professional nurses they encountered during their transition.

**Recommendations**

Nursing is a noble profession; as such, all individuals who have undertaken this profession are expected to display positive and professional behaviour. They always must uphold the ethics and norms valued by the profession when dealing with colleagues and patients. This culminates in a conducive environment where patients receive their nursing care. It is thus indispensable that the ethic of nursing, nurturing, and caring

permeates all spheres of nursing and that a code of ethics permeates in the clinical area through precept and example.

### 7.6.4 Negative experiences of participants

#### 7.6.4.1 Unrealistic expectations from senior professional nurses

**Findings**

The experiences of the NQPNs were challenging as they were expected to carry out all the professional roles with a marked level of competence. The NQPNs were overwhelmed by being expected to perform such huge tasks and to shoulder the responsibility of doing everything and be accountable.

**Conclusions**

It is unrealistic to expect recently qualified nurses to know everything taught to them while in training as it is not possible to expose them to every possible event, condition or context they might encounter in the clinical field. It is impossible or unattainable to appropriately implement all one has learned during training immediately after qualifying as a professional nurse.

**Recommendations**

The researcher recommends exposing student nurses to realistic, practical CS experiences during their last year of official training. Such exposure is crucial to provide them with the maximum experience to gain knowledge of a range of procedures, conditions, and contexts in the clinical field. When nurses enter the practice environment immediately after qualifying as professional nurses, they require mentoring and nurturing through structured orientation and mentoring programmes. This demands proper rotation among a range of clinical areas to ensure the expansion of their fields of learning.

#### 7.6.4.2 Improper conduct of professional nurses

**Findings**

The NQPNs faced negative experiences in the clinical field, including improper planning for their placements as NQPNs and inadequate information regarding how they needed to prepare for CS, such as completing forms to receive remuneration, informing them about their conditions of employment, including their monthly payments. The findings also

indicate that the participants suffered exposure to unprofessional behaviour from some senior professional nurses at the CS placement sites.

The other findings of the current study, concerning untoward attitudes of senior professional nurses, evoked feelings like stress, anger, anxiety, frustration, discouragement, discomfort, and fear. Harshness, unwillingness to assist the NQPNs when they needed help and a feeling of isolation and not belonging at the CS sites, were some of the negative experiences of newly qualified professional jnurse doing CS. Additionally, the shortage of staff and inadequate equipment, to support nursing care activities, surfaced as some of the struggles the NQPNs experienced. They also perceived hierarchical placement-related issues as negative experiences and felt that all these negative experiences denied them enough opportunities to learn in the clinical areas.

**Conclusion**

The negative experiences the NQPNs had to face somehow hampered their holistic learning of refining all dimensions of nursing practice, including seeing self as belonging and being a professional nurse.

**Recommendation**

The researcher reiterates the importance of a concerted attempt at in-service training on accepting and guiding NQPNs doing CS. This must involve a culture and milieu of nursing, nurturing, and caring among all members of staff. It is the researcher's conviction that continuing in-service education and training will assist in leaving seasoned nurses self-assured and up to meet the socialisation and practice needs of NQPNs. Also, so doing, the NQPNs can do so in a relaxed manner and render effective patient care.

### 7.6.4.3 Unclear status of the NQPNs

**Findings**

In addition to the negative factors identified, the NQPNs' unclear professional status made them feel uncomfortable during CS. Although the staff members were orientated that the newly qualified CS nurses were professionals, they were referred to as "CS practitioners", confusing their status to some unit staff members. As a result, in some units, they were allocated non-nursing responsibilities like being sent to the pharmacy to

collect stock or being sent from unit to unit as messengers. Sub-professional categories of nurses mostly practised this kind of behaviour which the NQPNs resented.

**Conclusion**

These negative experiences led to unpleasant interpersonal relationships making some NQPNs feel uncomfortable, finding their placement unconducive for personal and professional growth. They regretted not being recognised as professional nurses.

**Recommendations**

The researcher recommends that permanent and seasoned members of staff of all categories must have insight into the content of current nursing curricula. Especially in more specialised clinical fields where the sub-professional nursing staff has vast clinical experiences, both NQPNs and seasoned nurses should be made aware of one another's proficiency and expertise. No member of the nursing corps should do non-nursing or "skivvy" work. NQPNs should adhere to clear job descriptions and lines of command should support adherence.

## 7.7 RECOMMENDATIONS REGARDING FUTURE RESEARCH

### 7.7.1 Research regarding monitoring and evaluation of the implementation of the CS policy by nurses

Some research is needed in the areas of monitoring and evaluation of the effectiveness of the implementation of a CS policy. This would highlight whether the policy meets the objectives for which it was intended. It would also inform nurses and other health professionals about the successes and constraints of the implementation of the policy. The recommendations derived from the nursing theories to which the central concepts of adaptation traversing and related terms, discussed in the preceding sections, might assist in this.

### 7.7.2 Research relating to the adequacy of the period of doing CS

Research must be done to establish if the one-year period of doing CS is adequate. Such research should focus on NQPNs' discretion in making decisions about primary clinical nursing care and management. This might call for the establishment of a central (national, provincial, or district) clinical examination committee to examine and standardise the requirements of basic nursing care and management.

### 7.7.3 Research relating to the utilisation and allocation of NQPNs doing SC

From the interviews the researcher conducted, it appears that managers use NQPNs doing CS in health care areas where there seems to be a shortage of staff. This defeats the partial goal of community service to serve as an interim orientation period between being a student nurse and being a professional nurse in different health settings. The researcher suggests that exposing NQPN doing CS to a variety of health care settings to be perused.

## 7.8 RECOMMENDATIONS REGARDING THE IMPLEMENTATION AND MANAGEMENT OF CS

### 7.8.1 The organisation of the implementation process of CS

There is a need amongst stakeholders, responsible for CS implementation, to have clear communication strategies to inform all concerned, about the structure, the processes involved, and expectations from the NQPNs regarding the CS implementation. This might curb the problems encountered by the site managers, the policymakers, and the NQPNs when they commence doing CS. Clarifying the status of the newly qualified CS nurse, designing a clear protocol akin to a scope of practice and spelling out the responsibilities of all stakeholders, are recommended.

### 7.8.2 Support for the NQPNs

The following recommendations aim at supporting NQPNs doing CS.

#### 7.8.2.1 Structured peer support groups

The researcher recommends the development of structured peer support groups for NQPNs, especially during their initial period of allocation in the clinical field. NQPNs experience many insecurities, and CS site managers should attend to these as a matter of priority during this final phase of “educational” practice before registration as a professional nurse. Site managers and senior staff should assist the newly qualified CS nurses in gaining confidence and competence in applying theory to practice and further expand their clinical nursing skills. In this regard also refer to the recommendation based on the nursing theories in section 7.7 of this thesis.

#### 7.8.2.2 Support mechanisms

The support given should focus on meeting individual newly qualified professional CS nurses' needs. Arranging the continuous presence of experienced senior nurses, ensuring continuous assessment of the performance of each NQPNS might achieve this. Regular feedback about each newly qualified CS nurse's performance might assist with their personal and professional development. If support programmes are in place, these should ensure continuous supervision not allowing NQPNs to work alone immediately after their allocation to CS. In this regard also refer to the recommendation based on the nursing theories in section 7.7 of this thesis.

#### 7.8.2.3 Recommendation about the effectiveness of CS orientation programmes

The researcher recommends the orientation of all NQPNs on entering the CS area. Such orientation programmes need to focus on the physical layout of the facility, the daily working operations of the facility, all categories of staff, possible moral and ethical dilemmas that could arise, the administrative arrangement of CS, and documentation. Orientation should aim at making newcomers welcome and support their participation and function in the clinical field, thus maximising their clinical and administrative experiences.

### 7.8.3 Recommendations about nursing education training

It is crucial that, during the education and training period, the students are well prepared for the reality of patient care, by ensuring that they are afforded adequate exposure time to clinical areas so that they can have more responsibility of nursing the patients in the real situation. During such a period, they can begin to realise and understand their role as professional nurses. In turn, this might curb the "reality shock" they often experience when they come to the clinical areas after qualification. Thus, it is recommended that the orientation of students regarding CS should be the starting point of doing CS.

### 7.8.4 Recommendations regarding eradication of unprofessional attitude towards NQPNs

There is a need for managers to develop strategies for eliminating unprofessional and hostile attitudes towards NQPNs by senior professional nurses. Managers should play a vital role in condemning this kind of untoward attitude towards CS nurses as it impacts negatively on the nurses in the clinical area. Such a problem may deter active learning in the clinical area. It may also lead to individuals leaving the nursing profession. Ongoing

in-service education programmes should also serve as a forum for supervisors and other members of staff in the clinical area to air their experiences with NQPNs doing CS

### 7.8.5 Recommendations about the monitoring and evaluation of the CS policy

The researcher recommends that policymakers monitor and evaluate NQPNs continuously along the lines of the set objectives for CS. Furthermore, monitoring and evaluation must determine whether the initiative, in its current form and format, allows for the fair coverage of communities by professional nurses in rural, urban and semi-urban areas and what problems the NQPNs encounter in these areas that could prevent the effective development of these nurses for their professional roles.

### 7.8.6 Recommendations about the workload in the clinical areas

It is necessary to relieve the newly qualified professional nurses in CS from the burden of heavy workloads where they must carry out all the responsibilities in a work situation. It is unrealistic and unfair to expect the newly qualified professional nurses doing CS to have mastered the knowledge of everything taught during their training. It is on such a basis that the researcher recommends that they collaborate with experienced professional nurses who can guide and teach them or at least be there all the time to support and affirm what they do during patient care. The researcher would also like to return to the point of a protocol akin to a scope of practice that clearly indicates what NQPNs are allowed to do on their own and for what they need one-to-one supervision until they have gained expertise in these matters.

## 7.9 CONTRIBUTIONS OF THE STUDY

The following sub-sections briefly discuss the contributions offered by the findings of the present study.

### 7.9.1 Contribution towards the curriculum

Curriculum implementation has a profound impact on developing nurses for their professional roles. Based on the findings of the current study, it became clear that enabling the students to become independent during their training shapes them for their future independent professional nursing roles. Although the newly qualified professional nurses in CS , who participated in the current study, complained about the lack of

continuous monitoring, working independently was not that much of a negative issue to them. It reinforced their independent decision making as they experienced that during their CS tenure. Exposing these CS nurses to the acquisition of soft skills appears to require re-enforcement during their last year of formal education and training.

Exposing the NQPNs to intense experiences of performing practical skills during training adds value to their preparation for their roles as professional nurses. Although this occurs during their education and training, not all such circumstances or hard work affect learning. Preceptors should always be available to mentor them and guide them throughout their development. The researcher also reiterates that in specific clinical fields, an adapted practice protocol or scope of practice needs to be designed (such as neonatal intensive care) to allow for experience and application of theory and skills in more technical and complex nursing areas.

### 7.9.2 Contribution towards CS

The current research indicates a need for the proper and efficient preparation of NQPNs about to begin their CS responsibilities. The current study's findings indicate the need for proper orientation programmes during these nurses' student days. The findings also allude to the importance of area-specific orientation programmes with detailed protocols of what newly qualified professional nurses in CS may do on their own and what definitively needs initial supervision. The recommendations that emanated from the nursing theories, reflecting the central concepts of adaptation, conservation, and traversing, provide succinct, though complicated, suggestions for multifaceted monitoring and evaluation of both individual CS nurses and the CS programme.

These theories also provide for the inclusion of all stakeholders involved in CS to be monitored and evaluated on the roles they play and whether their contributions are sufficient.

### 7.9.3 Contribution relating to managers at CS sites

The CS experience of NQPNs can be enhanced by the availability of adequate facilities and equipment supporting nursing care practices. Although some of the current study's participants echoed that they were appreciated and handled with love and respect by the senior professional nurses, a better and more professional attitude towards the newly qualified CS nurses is required to strengthen their further learning and development as future fully-fledged professional nurses. Being good role models, as well as providing a

friendly and conducive work environment, the nursing profession can impact positively on those who need professional care.

### 7.9.4 Contribution relating to NQPNs community service nurses

The current research alludes to both the knowledge and skill of NQPNs, their application in practice, and the effect the internal and external environments have on the newly qualified CS nurses. It also alludes to the physical, social, psychological, and professional identity aspects of the newly qualified CS nurses. All the recommendations made in this chapter in some way, involve the wellbeing of the newly qualified professional nurses in CS. The contribution is thus a formalised view on the integration of NQPNs into CS and eventually into professional nursing.

### 7.9.5 Contribution relating to the researcher

Despite the limitations of the study and the arduous methodology, the researcher found the research most enlightening. Not only did she gather a better understanding of NQPNs' CS experience, but she also gained invaluable experience in theory application and understanding of the rather implicit method of data analysis in phenomenology as which is offered by Wertz et al 2011 and Grbich 2013.

## 7.10 LIMITATIONS OF THE STUDY

The design chosen for the study required the use of a small number of participants with the necessary experience from whom to obtain in-depth and rich information about the phenomenon under study. The small sample impinges on the generalisability and transferability of the current study's findings.

The researcher also acted as a nurse educator for most of the participants during their basic training, which made it difficult for some interviewees to relax during the individual interviews. The researcher noticed that participants would sometimes tend towards giving answers they anticipated would be more acceptable to the researcher. On becoming suspicious of such tendencies, the researcher reassured the participants that what is in the past stays there and that they had to focus on the purpose and objectives of the current study.

Furthermore, the interviewees saw the interviews as a forum to vent their grievances about the problems they encountered in the practice field, rather than sharing their

experiences in the field. It was quite challenging to balance the interviews and not to polarise them and doing so without offending the interviewees.

The researcher found the methodology intricate and not easy to apply. Even the works of authors such as Wertz (1983, 1985 & 2011) and Grbich (2013), applied during data analysis, were difficult to grasp. She had to read and re-read it several times. The researcher found it indeed to be a case of “reading for a doctoral thesis”.

Analysing the data manually (without a qualitative software program) acquainted her thoroughly with the data, although the process was difficult and time-consuming.

An added limitation to the study is the fact that only one province out of nine South African provinces participated in the current study, and as it is, only a single metropolitan area.

## 7.11 CONCLUSION

In this chapter, the academic presented a summary of the research process and the research findings. The conclusions based on the findings were formulated and made recommendations based on the conclusions were also provided. The chapter also presents the study’s contribution to the field of nursing science as well as the limitations that characterised the study.

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**ANNEXURES**

**ANNEXURE:** A: Approval from the university

UNISA university of south africa

**UNIVERSITY OF SOUTH AFRICA**
**Health Studies Research & Ethics Committee**
**(HSREC)**
**Faculty of Human Sciences**
**CLEARANCE CERTIFICATE**

Date of meeting: 9 November 2010 Project No: 0500-834-4

Project Title: Phenomenological analysis of the experience of newly qualified nurses in Community Science

Researcher: Adelicia Nomawethu Mbatha

Supervisor/Promoter: Dr DM van der Wal

Joint Supervisor/Joint Promoter: Prof VJ Ehlers

Department: Health Studies

Degree: DLITT ET PHIL (Health Studies)

**DECISION OF COMMITTEE**

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

**Prof TR Mavundla**
**RESEARCH COORDINATOR**

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

**PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES**

**Annexure: B:** Letter seeking Consent from the Department of Health: Easter Cape Province

From: To:0866282006 04/07/2011 14:03 #299 P.001/001

**Eastern Cape Department of Health**


| | | | |
|---|---|---|---|
| Enquiries: | Zonwabele Merle | Tel No: | 040 608 0830 |
| Date: | 04th July 2011 | Fax No: | 043 642 1409 |
| e-mail address: | zonwabele.merle@impilo.ecprov.gov.za | | |


Dear Mrs NA Mbatha

**Re: Phenomenological analysis of the experience of newly qualified nurses in Community Science**

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

**DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT**

# ANNEXURE : C: Letter of Approval Departments of Health

P.O. Box 4068
King William's Town
5600
Date: 24-1.0-2012

Telephone (W): 043 -7047582

Cell Number: 0837491478/ 0716736479
Fax No : 0866282006

E-mail address: adeliciambatha@gmail.com

Mr Lusasa
District Manager
9 Vincent Road
East London

Dear Sir,

**Regarding:** Request to conduct interviews with the newly qualified nurses who are doing Community Service at the health care facilities that fall are under Amathole District

I am currently, a student at the University of South Africa (UNISA) engaged in studying towards obtaining a PhD in Nursing and I am employed as a lecturer at in the Nursing Science Department, University of Fort Hare.
The title of my research project i.e:

**PHENOMENOLOGICAL ANALYSIS OF THE EXPERIENCES OF NEWLY QUALIFIED NURSE9 DOING COMMUNITY SERVICE IN THE EASTERN CAPE**

The purpose of this letter is to request to be allowed to conduct interviews with the Community Service Practitioners who are allocated in the facilities indicated above for the purpose of collecting data on the given topic.
On responding to this communication I will ensure that I provide you with my abridged protocol for the study, the ethical clearance certificate from the University's (UNISA) ethics Committee as well as permission to access the health care institutions of the Eastern Cape which I obtained from the Department of Health Research and Epidemiology Directorate.
I would greatly appreciate your favourable consideration of my request.
Yours sincerely
AN Mbatha

## ANNEXURE: D DATA COLLECTION TOOL (Interview Guide)

INTERVIEW GUIDE: (Duration of each interview: 45- 60/90minutes)

An in - depth phenomenological interview guide for conducting interviews on:

PHENOMENOLOGICAL EXPERIENCES OF THE NEWLY QUALIFIED NURSES IN COMMUNITY SERVICE

**Pre- plan for interview according to the guidelines in Speziale and Carpenter (2007:64) as follows:**

Two weeks prior to the Interview:

- The researcher will meet with the participants to prepare them and to answer any preliminary questions.
- An invite will be sent to each participant.

A week prior to interview:

- The participants will sign the informed consent and agreement to audiotape recordings.
- Will be given a letter explaining all details regarding the research and expectations from the participants
- Arrangements for the venue will be made

**Logistics:**

The venue will be prepared a day prior to interview se6siof19.

The researcher will take into consideration the participants' comfort,

- Will availability of table and chairs and,

Make sure that background noise is eliminated.

- Prepare audio tape as well as to ensure extra batteries.

**INTERVIEW GUIDE: USED DURING ACTUAL DATA COLLECTION**
**DATE……**
**Setting:** Rural/ Urban/ Clinic/ Hospital

**Participant No:… ……**

**Gender:** Male/ Female
**Previous institution of learning:** Public College/ University/ Private College

**During Actual interview:**
**s**

- Greet the participant
- Introduce self
- Ask permission to record information
- Spell out the purpose of the study
- Spell out expectation during the interview
- Let the participant to sign the consent

**Interview question:** *What are your experiences of doing community service in the clinical areas where you are allocated? Alternatively:*

*How does it feel like doing community service where you are allocated?*

***FOLLOW UP QUESTIONS***

……
……
……
……..

**Concluding questions**

- *What would you like to see happening in implementing community service? Or what are your suggestions regarding its implementation?*
- *Anything more that you would like to add?*

*Comments on observed behaviour/ emotions:*

……
……..

**Follow up interview:** ***Yes/ No***

- *Thanking the participant*
- *Wish the participant well for the day*

# ANNEXURE E: THE CONSENT FORM:

THE UNIVERSITY OF THE INVESTIGATOR: UNIVERSITY OF SOUTH AFRICA (UNISA)

PROJECT TITTLE: PHENOMENOLOGICAL ANALYSIS OF THE EXPERIENCES OF THE NEWLY QUALIFIED NURSES DOING COMMUNITY SERVICE IN THE EASTERN CAPE

INVESTIGATOR: Adelicia Nomawethu Mbatha: Contact Number: 0837491478/ 0769913637.

E-mail Address: ambatha@ufh.ac.za

FAX NO 0866282008

PROMOTOR: DR DM van der Wal

CO-PROMOTOR: Professor Ehlers

The Purpose of the study: Explore, and obtain research-based empirical information regarding the lived experiences of the newly qualified nurses in Community Service;

- Suggest future improvements to the implementation (execution) of CS
- To understand the professional socialisation potential of CS into the nursing profession.

INFORMATION REGARDING THE INTERVIEW: The interviews will be conducted 2 times. Each interview will last from 60- 90 minutes

The question that will be asked will be “HOW DO YOU EXPERIENCE DOING COMMUNITY SERVICE”?

This will be requiring knowing your feelings about doing community service where you are.

An audio-tape will be used while asking and providing information

The information that will be provided will not be shared with anyone else except those involved in the study.

However, the information from the findings of the study will be shared with the colleagues at conferences or in published papers. This information will not be identified with you.

There will be no direct benefits to you in this study regarding your participation, but there may be a change in client/ patient care and implementation of the policy of community service depending on the findings of the study.

PARTICIPANT'S CONSENT: THIS IS TO CERTIFY THAT

I…..... (Print Name) HERBY agree to participate as a volunteer in the above-named project. I hereby give permission to be interviewed.

I understand that there will be no risk for me resulting from my participation in the research and these interviews will be tape recorded. I understand that at the end of the research the tape will be erased. I understand that the information may be published and my name will not be associated with the research.

I understand that I am free to deny answering any specific questions during the interviews. I also understand that I can withdraw my consent and terminate my participation at any time without penalty. I have been given the permission to ask questions I desire and all such questions have been answered to my satisfaction.

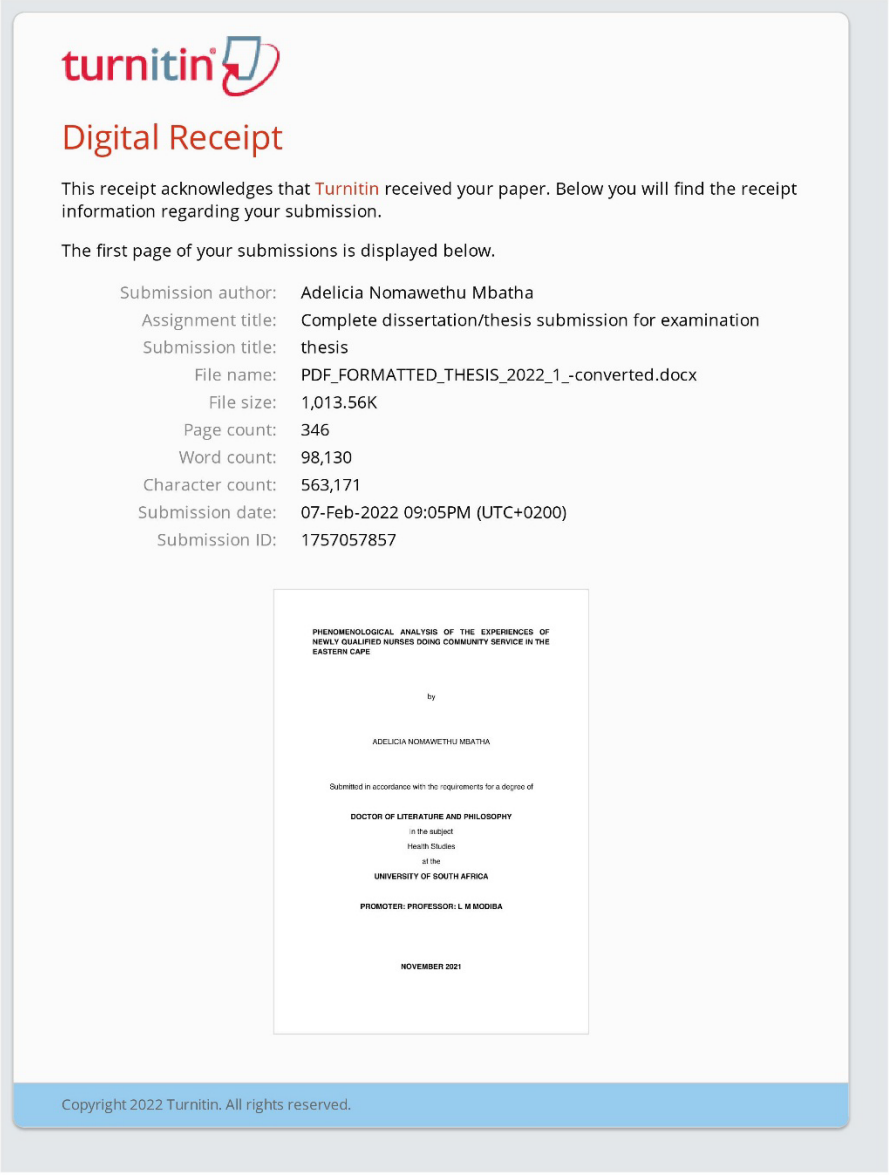
| …… | …… | ……. |
|---|---|---|
| Participant | Witness | Researcher |

# ANNEXURE F: TURNITIN DIGITAL RECEIPT

## Summary of TURNITIN Results:

THESIS TITLE

PROJECT TITTLE: PHENOMENOLOGICAL ANALYSIS OF THE EXPERIENCES OF THE NEWLY QUALIFIED NURSES DOING COMMUNITY SERVICE IN THE EASTERN CAPE



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PHENOMENOLOGICAL ANALYSIS OF THE EXPERIENCES OF NEWLY QUALIFIED NURSES DOING COMMUNITY SERVICE IN THE EASTERN CAPE

by

ADELICIA NOMAWETHU MBATHA

Submitted in accordance with the requirements for a degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

Health Studies

at the

UNIVERSITY OF SOUTH AFRICA

PROMOTER: PROFESSOR: L M MODIBA

NOVEMBER 2021

**ANNEXURE: G INTERVIEW TRANSCRIPT AND ITS ALIGNED ANALYSIS**

**INTERVIEW 1**

**Researcher: What were you experiences in doing Community Service or how was it like doing community service?**

**Participant:** First of all let me thank you for inviting me to share my experiences and from my own perspective I know that community service is something that I believe that every nurse or professional nurse profession should pass through. It is something it know that I had actually experienced from my own perspective I am not going to say that I regret every bit of it though it is challenging in the sense that I do not actually understand the language at list I am following it all. Even if the language for me is not a barrier it is not, because the people I work with they carry me along. Where I did my Com Serve in here in MOU. For the first few months it was OK. So when I was posted there we were practically looking after people that were pregnant going into labour I was happy. The reason why I am saying that is because you do something that you like. No challenges are coming your way that will be so stressful. You are satisfied that it is something I want to do. So basically I love midwifery. When I found myself there I was fortified that this is what I want to do. I started by finding my comfort. The first few months it was OK even though I met a lot of challenges at work like old professional nurses you know they will want you to do everything which at the same time is not bad. It was something you had to get used to. I am not going to say it is abuse, Yes it is challenging, but I never complained. Remember I said this is what I like so I never complained. The issue of language was a little bit challenging initially. But as the time went on I learnt a lot. I am still in the process of learning. With those terminologies when somebody comes. Even with those who do not understand English I got assistance from my colleagues I asked my colleagues in terms of getting information from the patients. You know all those personal information. They are always there, the colleagues. There was some time that we found that there is shortage of staff most of the time where even if you are off you would be called to come back, I never complained because of as the time goes when I came there this is what they do so I had to comply though they told me initially for the first month I worked straight shift Monday to Friday, eight hours before I was put to shifts which I quickly adapted. Another challenge we faced there was the issue of sometimes the working equipment is not always there so like CTG and blood pressure machine. Sometimes we had to improvise. When this person comes do something in order to offer

care and in this case you need to be proper  and all that. Generally, generally the COM Serve was not bad.  After this Com Served I was absorbed into the system and so we continued and I am still there.

**RESEARCHER:** Since you were there for the whole year. Definitely there is a lot more that you can still share that was happening from day to day of your experiences remember definitely you were exposed there to a lot of things

Participant: During that time of com serve one of the things was let me start with the challenges from the side of patients sometimes a lot of people when they come there you find out that they are difficult yes they are. But what I have learnt throughout our stay here about the issue of dealing with patients people are individuals I cannot match person with another person this is what I learnt, secondly, I realised that whilst dealing with patients at times the patients are lying they are not really having problems like now people will come there and when you assess a patient you will find that she is not really in labour, when you prove more you find out that person is there because is hungry. They needed shelter. At times that person is coming from the club she just wants a place to lay the heard. What can you do you cannot chase them away.  All you do you assess the patients and keep them over night. In the morning you give tea and educate the person.

The other aspect the working relationship with my colleagues well I am not going to say it is 100% but I know that we have that level of understanding and we have to show professionalism. Sometimes a person may walk over you and you have to hold yourself back and like in some differences with my colleagues in a case of a patient and we are the only two professional nurses by that time when I was Com serving she had three patients and I had four and the other patient came I decided to take the patient and making mine five. I was transferring the patient and the other one came and that patient was sitting and then when I came back I thought that the patient should not have waited for me.  We exchanged words and I felt that No I should hold back because I am still a junior and she is senior and older person. I actually felt that she was wrong but from her perspective she felt she was right because she is old in the profession.

**RESEARCHER: How did you feel when the other professional you said she walked over you?**

**Participant:** The feeling was not that OK.  Remember that I am in the field to grow, So I am growing. No matter the kind of challenges I am facing I have to grow. I need this

experience and I need to grow. I always take it that I am still growing. If I have that feeling I think that it will hinder me from growing and it makes me to accept it that I am wrong even if I am not.

**RESEARCHER: Accepting that you were wrong you were suppressing some feelings and how did that make you feel?**

**Participant:** Remember that I said individually we are different. When we sit sometimes we sit as two or three sisters and then they will speak Xhosa and I do not understand. I do not want to frustrate myself so I would go to the ward to keep myself busy. I would go away. Normally when I go to work I bring my laptop or maybe try to something in the laptop. What I know sometimes it does not go too far especially when our manager is there. Those are usually the differences I usually have. Sometimes it makes me feel uncomfortable and not belonging. If sometimes there is something I do not understand I will go to someone else and ask her to help me irrespective of what they are saying. It sometimes made me felt that I do not belong there. However even though that was the case, I tried to ask them if there was something that I did not understand.

**RESEARCHER:** Pertaining to refinement of the skills which is CS objectives what would you say?

**Participant**: Yes it helped a lot. Remember we came out from the university having this knowledge and having been taught many things. Then wanting to apply it and when you go out there we did not have enough time. Now it is CS we have to show practicality of it. CS made us to know that we are there to learn more. The observation I made is that when it comes to Midwifery there are no much differences. It is only the practicality of it. The sisters are there as the shelter and they make us independent , the sister will say that remember that you are professional nurse now whatever you do you learn so you must keep your eyes open . They are there for us; they teach us and make us to learn. So I think CS from my perspective is Ok it is fine. By the time you finish CS you will have gained so many experiences and then we will be able to make decisions on our own.by the professional nurses that we were now professional nurses so whatever we were doing we had to keep an eye on it. We were continually being reminded CS is something that makes you to combine everything you learn from school. It also makes you to decide after you have finished it what is it that you want to do. CM Serve for me is OK. It makes you to have many experiences. It makes to decide on what you want to pursue in the future, something you would want to do.

**RESEARCHER: What do you mean by sister being your shelter?**

**Participant:** Remember when you come to the wards we are new there so you follow the footsteps of the sisters and they tell us what to do, we follow systematically what they do. Even if I say we come with this knowledge from school, you know what when you have to present this information the sister or the doctor will want to see if you know what you do. Even if we have this knowledge we still have to explain it to the sister or the doctor step by step. Even when we do that they are still on top of us because we are still COM SERve. Sometimes even when we had some cases, we had cases like emergency cases. So whilst you do these cases the sisters will be there asking you what are doing, why are you doing this thing like this and this?. Like my team leader for instance she always wanted me to do something or say something. We also work with the doctors and make use to do something and in that way they mentor us by telling us and correcting us about the things we do. We also learn to work as the team and they protect us. Even if we go there with the knowledge, when we are doing Com Serve we are still learning. In some cases we would have some emergencies. The sisters would ask us why and how we are doing something and then **they correct** us. When we go for perinatal meetings, the sisters will be there. She will say that we are going to present there, because we are **working as a team.**

So interests as well. The professional nurses are always there to teach and guide. Some of the professional nurses are there to protect your own interests as well.

**Researcher:** When the professional nurses were there to form your “shelter” how did you feel?

**Participant:** You actually feel that at least there is someone there who is protecting you. However some clients can be…, how do I put it? Some of them are rude, and some of them do not understand some of the things. When they are there for instance we come across a patient who has something which is a little bit difficult. The sister will be there. Some of the patients when they come and see the sister they look at her. The sisters are there to say that this is good and this is wrong. Yes when they see that there is this elderly person the sister they tend to show some respect. The sister is always there to see that everything works out fine. So some of the patients come with some understand and knowing certain things. So we have to convince them that yes they know something , but we have to tell them may be they need to do this something like so and so, The sisters are always there to say, this is wrong and this is right.

**Researcher**: I have picked up that you said you come up with this knowledge you have; did you find any clash in that kind of knowledge?

**Participant**: No we did not. She is also studying as well. You know some of them are learning from us they were at school long time ago. They would say you know you are coming up with something new. In that case we are coming up with a change. Remember from time to time we were sent out for training. So in that training there are many things that we learn

**Researcher:** How did you feel when your knowledge was found to be "fresh" and appreciated?

**Participants: I felt** OK in the first place I know that that knowledge I did not find from the air it made me more appreciative of my lecturers, because they actually imparted to me and kind of know that we are doing things that we were taught at the college. These were the fundamental that we were taught at the school.

**Researcher: You said you felt OK, please express what do you mean by this OK?**

**Participant:** What I actually mean is that when they appreciated my knowledge it meant that I contributed the knowledge or the change. You know that I might be arguing, about something. This actually made me to go to my books and read or I google something so that when the sister says OK led us continue with what we were arguing about last time. This kind of behaviour of my sister makes me sometimes to be on my toes getting ready all the time. Sometimes there would be students that would come from the Nursing College and the university and sometimes doing advanced midwifery so they come here to learn so you need to be ready with the information. You have to have the fundamental information, may be CTG . Those things I did to the students are being acknowledge where I am working.

**Researcher: When you realised that the knowledge that you had and contributed how did you feel?**

**Participant:** I felt happy and fulfilled and want to contribute more

**Researcher:** You said Com Seve made you feel you need to go forward with your career. When you had such thoughts how did you feel?

**Participant**: first of all I feel it gives me that feeling. I felt it is motivating thought. It made me to dream and make me feel about where I am coming from. It makes me feel I must

not go back to that place. I always say to my colleagues I do not want to be a bedside nurse no not for a long time. It makes me want to go forward and work harder and harder and more.

**Researcher:** You said when you worked with sisters and doctors you always tried to convince them, when you did so how did you feel?

**Participant:** It made me happy and satisfied and actually and also have a feeling that I can still do more, It gives me a feeling that I this makes me continuously read, because like where I am working we usually have quarterly meetings and I feel that I can learn more from the doctors social workers and the professors at those meetings. I also realised that learning is not meant for certain people. As long as you are here you should go on with learning. Even if you are old you can still learn. Remember that we had these meetings

**Researcher:** You shared with me that you had some challenged and the sources of challenges were from two sources. How did you feel being challenged by customers on one side and the peers on the other side?

**Participant:** I tended to understand from the side of the customer, because they came her and found me being a black person so they would just talk not knowing that I will not understand them.

When the people do not understand my colleagues would help. If it is a customer (patient) I would tell them that I do not understand isiXhosa, but I would say it in such a manner that they do not feel bad. After sometime I realised that some of them are able to speak English. At times I would try to speak a few words in isiXhosa and then the patients would laugh and say no we do not speak like that. Basically, basically. Some would come and tell me they feel a pain because I do understand some of the words. I normally understand some of the words and then we take it from there.

**Researcher:** If a person would not understand what you are saying what would you do?

**Participant:** No I would ask my colleagues. To help me.

**Researcher:** You said at times your colleagues would express themselves in their language and you would go and work on your computer. When you did so what kind of feelings did you have when you did that?

**Participant:** That was not a problem because I would actually become busy when we were doing the night. I would keep myself busy on the computer. After all at night we would be busy getting to patients who needed to be done observations so I would not have time to fall asleep. It did not matter if they speak in that language for instance if I see some people who speak my language I would automatically speak it. When they speak and I feel like I do not understand them I would feel lost and isolated (laughs). At times I would say hey guys I am still here.

**Researcher:** I would like to give you few seconds so that you can think and reflect on what you can still recall about your experiences

**Participant**: I think I can remember something just the kind of like if you can say I must say something about my experiences where I worked, I think I can say generally, generally it is good I can never say that I never thought I did not belong where I did Com Serve. Whenever you do not feel that sense of not belonging you can never hide it. I can say that the people that I work with are the good people to work with and they have been able to carry me along.

**Researcher:** I have not heard you talking about rotation as you were in that facility for Com serve, does it mean you never worked in some other unit?

**Participant:** Actually in MOU you do all the procedures if the woman is in labour before you transfer them.

**Researcher:** How do are your feelings regarding the objectives of CS especially that of being in CS for the purpose of refining your skills?

**Participant:** You know that there are two ways to this what I am going to say. We students we feel bad if you are in a place we do not like. I feel myself that I am where I like. Even if it is challenging it is something I like so. Whether I achieved the objective, yes I did whether I like it. Yes I did. I never regretted any moment. Even if I find myself in another area I do not mind. I would do the same thing.

**Researcher:** What are your comments regarding the other objective that CS was introduced to ensure equitable distribution of health professionals to the health care areas?

**Participant:** I think that objective is OK it is being achieved because once we are sent to other areas whether is the rural areas and when that happens you do not want to go there, but when you get there you feel that it is fine

**Researcher:** Now that you are in the city what kind of problems are you encountering?

**Participants**: It is transport you know you have to get there early even before the time to start the work. So if it is in the morning you are to wake up early and if you are on night duty you have to be there before seven. You have to get to your transport early so that you get there early to be fair to the people who are going to relieve.

**Researcher:** You have said that the CS is paving you way to your future. Where do you hope to be in the near future?

**Participant**: my aspiration is to become a lecturer I think my dream is taking me to that direction. I am rapping up my Masters. But I still want to give back o the faculty because that is where I started. It is through Com Serve that I began to understand. When I started CS I was expected to do presentations I thought this is interesting, perhaps this is what I like.

| Categories | Statements |
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| | • **For** the first few months it was OK. So when I was posted there I was happy. The reason why I am saying that is because you do something you like. No challenges coming your way that will be so stressful. You are satisfied that it is something I want to do. So basically when I found myself there I was fortified that this is what I want to do. I started by finding my comfort. |
| - Sense of growth in the profession against all odds | • The feeling was not that OK. Remember that I am in the field to grow, So I am growing. No matter the kind of challenges I am facing |

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| | I have to grow. I need this experience and I need to grow. I always take it that I am still growing. If I have that feeling I think that it will hinder me from growing and it makes me to accept it that I am wrong even if I am not. |
| - Feeling of discomfort and sense of not belonging | • When we sit sometimes we sit as two or three sisters they will speak Xhosa and I do not understand. I do not want to frustrate myself so I would go away to the ward to keep myself busy. Normally when I go to work I bring my laptop or maybe try to something in the laptop. What I know sometimes it does not go too far especially when our manager is there. Those are usually the differences I usually have.<br><br>• Sometimes it makes me feel uncomfortable and not belonging. If sometimes there is something I do not understand I will go to someone else and ask her to help me irrespective of what they are saying. It sometimes made me felt that I do not belong there. However even though that was the case, I tried to ask them if there was something that I did not |

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| | understand. |
| - Knowledge and skills development enhanced | • CS, Yes it helped a lot. We came out from the university having this knowledge and having been taught many things. Then wanting to apply it and when you go out there we did not have enough time. Now it is CS we have to show practicality of it. CS made us to learn more. So I think CS from my perspective is Ok it is fine. |
| Mentored and taught a lot by senior professional nurses and doctors<br><br>-<br><br>Happy, fulfilled n and satisfied to; learn from multi-disciplinary team | • They (sisters) are there for us; they teach us and make us to learn.<br>• The sisters are always there to say, this is wrong and this is right. The sister is always there to see that everything works out fine.<br>• The professional nurses are always there to teach and guide. Some of the professional nurses are there to protect your own interests as well.<br>• We also work with the doctors and they mentor us by telling us and correcting us about the things we do. Even if we go there with the knowledge, when we are doing Com Serve we are still learning.<br><br>• It made me happy, satisfied and fulfilled and also have a feeling |

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| | that I can still do more, It gives me a feeling to continuously read, because where I am working we usually have quarterly meetings and I feel I can learn more from the doctors social workers and the professors at those meetings |
| - Learnt about teamwork and | • We also learn to work as the team and they protect us |
| - Independence in executing responsibilities developed | • The sisters are there as the shelter and they make us independent , the sister will say that remember that you are professional nurse now whatever you do you learn so you must keep your eyes open . |
| - Decision making skills developed during CS | • By the time you finish CS you will have gained so many experiences and then we will be able to make decisions on our own |
| | |
| **Challenges encountered:-**<br>- Language barrier a challenge<br><br><br><br><br><br>- Work overload and abuse by senior nurses<br>- Staff shortage<br>- Feeling of discontent , but suppressed | • I will not say that I regret every bit of it though it is challenging in the sense that I do not actually understand the language<br>• When they speak and I feel like I do not understand them I would feel lost and isolated (laughs). At times I would say hey guys I am still here.<br>• The first few months it was OK even though I met a lot of challenges at work; like old |

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| - Difficult patients<br>- Inter-collegial relationship ; conflicts over execution of responsibilities | professional nurses; they will want you to do everything which at the same time is not bad. It was something you had to get used to. I am not going to say it is abuse, yes it is challenging, but I never complained. Remember I said this is what I like so I never complained<br><br>• Another challenge was sometimes the working equipment is not always sometimes there so like CTG and blood pressure machine so, we had to improvise.<br>• There was shortage of staff most of the time where even if you are off you would be called come back, I never complained because of as the time goes on when I came there this is what they do so I had to comply.<br><br>• During Com Serve one of the things was a challenge from the side of patients sometimes a lot of people when they come there you discover that they are difficult, yes they are.<br>• A times the patients are lying, they are not having problems like, when you assess a patient she is not in labour, is there because is hungry or needed shelter or just is coming from the club she wants a place to lay the heard. What can you do you cannot chase them away? You assess and keep them over night. In the morning give tea and educate the person.<br>• The other aspect the working relationship with my colleagues well I am not going to say it is 100% but we have level of understanding and have to show professionalism.<br>• We exchanged words and I felt that No I should hold back because I am still a junior and she is senior and older person. I actually felt that she was wrong |

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| | but from her perspective she felt she was right because she is old in the profession |
| - Views about doing CS<br><br>- Future plans | • Generally, generally the COM Serve was not bad. After this Com Serve I was absorbed into the system and so we continued and I am still there.<br><br>• I think that objective of CS is OK it is being achieved because once we are sent to the rural areas and when that happens you do not want to go there, but when you get there you feel that it is fine<br><br>• I think that objective is OK it is being achieved because once we are sent to other areas whether is the rural areas and when that happens you do not want to go there, but when you get there you feel that it is fine<br><br>• My aspiration is to become a lecturer I think my dream is taking me to that direction. I am rapping up my Masters |