

**LIVED EXPERIENCES OF NEWLY QUALIFIED PROFESSIONAL NURSES DOING
COMMUNITY SERVICE IN MIDWIFERY SECTION IN ONE GAUTENG HOSPITAL**

by

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SUPERVISOR: PROFESSOR ZZ NKOSI

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DECLARATION

I declare that **LIVED EXPERIENCES OF NEWLY QUALIFIED PROFESSIONAL NURSES DOING COMMUNITY SERVICE IN MIDWIFERY SECTION IN ONE GAUTENG HOSPITAL** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.


.....

SIGNATURE

(Boniswa Jeslina Ndaba)

10 December 2013

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ABSTRACT

The purpose of this study was to explore the lived experiences of the newly qualified professional nurses in midwifery section doing community service. A qualitative descriptive, interpretative phenomenological research was conducted to determine the experiences. The sample included newly qualified professional nurses doing community service. Data collection was conducted by means of unstructured interviews from ten (n=10) informants. Each interview was approximately 45 minutes. Ethical issues were considered. Hessel and Heidergadian's data analysis steps were followed. Four (4) themes and eleven (11) sub-themes emerged from the data collected. The findings revealed that the newly qualified professional nurses were in a state of reality shock, demonstrated by challenges such as shortage of human and material resources; overcrowding; lack of support; and the placement of Midwifery Nursing Science in the curriculum has impacted negatively on midwives' registration as professional nurses.

Based on the current practical nursing education environment and further research, this study concludes by presenting its recommendations and limitations.

Key concepts

Community service, experiences, midwifery. newly qualified; professional nurse

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Dedication

I express first and foremost, my most sincere gratitude to my Creator, whose omnipotence, omniscience, and omnipresence sustained me throughout this study.

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List of abbreviations

ESMOE	Essential Management of Obstetric Emergencies
GDH	Gauteng Department of Health
MDGs	Millennium Development Goals
MEC	Member of the Executive Council
SANC	South African Nursing Council

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

It is a mandatory requirement and stipulation of the South African Nursing Council (SANC) Regulation 425 that newly qualified professional nurses who have successfully completed the Diploma in nursing (General, Psychiatric and Community) and Midwifery and registered for the first time as professional nurses, should perform community service as part of their induction into the nursing profession. This requirement has been published in the Government Gazette Notice No. 765 of 24 August 2005, and further details remunerated community service for this category of nurses for a period of one year at a public health facility in order to improve quality health care to all South Africans (SANC 2008).

Consequent to the promulgation of the requirement for community service for newly qualified professional nurses and midwives (who have successfully completed the Diploma in nursing (General, Psychiatric & Community) and Midwifery in the Government Gazette Notice No. 765 of 24 August 2005; Community Service was implemented for operation as a practice-oriented field of study from the 1st of January 2008. In terms of the above-cited Government Gazette Notice No. 765 of 24 August 2005, the main objective of community service is to ensure improved provision of health services to all citizens of South Africa by empowering young professionals and developing their skills base, enhancement of their knowledge acquire acquisition; while inculcating professional behavioural patterns and critical thinking consistent with professional development (SANC 2008).

In terms of the process of implementing Community Service, these newly qualified professional nurses sign a contract for a period of twelve months with the relevant Provincial Health Authority, according to which they are then placed in respective provincial health facilities according to the services needs criteria prevalent in those health facilities. In accordance with the afore-cited Notice, the Minister may, after consultation with a Member of the Executive Council (MEC) responsible for health in a

particular province, make a final decision with regard to the actual place where the community service must be performed (Nursing Act, 2005, Act No. 33 of 2005). Nurses who have completed their training in Gauteng for instance, have to adhere to a requirement by the Gauteng Department of Health in respect of its Community Service and Contractual Obligation (South Africa 2005:76) which implies that an agreement is signed that these professional nurses must serve a second year of community service to work back some of the time during which their training was sponsored.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

During clinical accompaniment of students – occasioned by the researcher's full-time employment as a Midwifery lecturer in a Gauteng provincial hospital – the researcher met and interacted with some of the newly qualified professional nurses doing community service in the maternity section. These newly qualified nurses expressed high levels of frustration, especially in the labour wards and the neonatal intensive care units. The nurses indicated that they were subjected to a number of stressors that adversely impacted on their capacity to dispense or discharge the knowledge gained from their training. In the event of such stress-induced environments, nurses then feel unprepared for their new roles (Higgins, Spencer & Kane 2009:506). They also expressed a dire lack of mentoring, especially during the early period of their involvement as professional nursing practitioners. As a result of the plethora of stressors, they become uncertain of their relevance and impact; which leads to poor performance. Some have even considered abandoning the profession.

The aura of ennui seemingly encompassing the performance of these nurses exacerbates further in view of the critical importance of meeting the Millennium Development Goals (MDGs), especially goal number four (4) related to the reduction of the child mortality rates; and goal number five (5) related to improvement of maternal health by two thirds between 1990 and 2015 (National Department of Health 2007:8). These MDGs can only be achieved with universal access to reproductive health, a factor whose optimum achievement resides in the sustainable availability of competent and skilled professional nurses in the service.

The SANC Regulation 425 of 22 February 1985 states that the duration of a course or field of study leading to registration as a professional nurse is four academic years;

whereas a basic qualification in Midwifery Nursing Science should at least be of two years' duration. The Gauteng Department of Health's curriculum requirement for the Diploma in nursing (General, Psychiatric and Community) and Midwifery is derived from the South African Nursing Council's Regulation 425 (SANC 1988).

In their second level of training, student nurses are exposed to a realistic midwifery situation in which they will be able to administer holistic midwifery care to a low risk (no complications) woman and child during ante-natal care, normal labour and post natal period. During the third level of training, learners are required to render midwifery care to a high risk woman and child during the actual ante-natal period, labour process and post-natal period. At this level, the learners are able to attend to patients who present with complications. It is at this stage and level that both the theoretical and practical aspects of the Midwifery Nursing Science course are incorporated for the full completion of the selfsame Midwifery Nursing Science course (SANC 1988).

In the fourth of study, the curriculum prescribes that only Psychiatric Nursing Science and Community Nursing Science are to be completed. This structure of the curriculum poses a challenge to the newly qualified professional nurses, as their last contact with Midwifery as a field of study was during the second and third year of study (SANC 1988).

Working in a clinical area as a newly qualified professional nurse can be very stressful, especially in instances characterised by the unavailability of mentoring by more experienced nurses. A further contributory factor relating to stressful occurrences is the multi dimensional nature of their responsibilities in the form of, *inter alia*, the patient care they are expected to perform, administrative tasks, and human resource issues (O'Shea & Kelly 2007:1535). The recurrent themes of infant and maternal deaths; patient suffering and humiliation; inhumane and poor treatment of patients; and lack of infection control on the one hand; as well as nurse's misconduct, incompetence, and exceptionally negative attitudes on the other, illustrate a state of affairs that is inimical to satisfactory patient care and effective health services delivery and projects a dim view of the nursing profession in some instances (Oosthuizen & Phil 2012:57).

The Health Systems Trust ([s.a.]) indicates that there were 28 186 registered professional nurses in Gauteng in 2008 There is also a reflection of more litigation on

the midwifery section. According to the South African Nursing Council's health statistics, the period between July 2003 and July 2008 reflects the highest number of cases of misconduct lodged against registered midwives. The number of offences committed during that period is 629, of which 128 are maternity related offences; followed by 286 offences for poor basic nursing care. This was also highlighted in the statistical report of misconduct cases in June 2012 that there were five (5) maternity related cases of misconduct in Gauteng province out of eleven (11) cases from all the provinces.

Kruse (2011) cites that the number of nurses registered with the South African Nursing Council is disproportionate to the actual number of nurses required to execute primary health care functions. There is a definite decline in the number of newly qualified nurses, with 28% of those who are in the service having previously considered abandoning the profession; and about 20% intending to do the same after completing their part of the community service. The performance of newly qualified professional nurses was also put under scrutiny in the psychiatric wards, where an increased rate of re-admissions of patients in institutions manned by these newly qualified professional nurses was observed (Zonke 2012:20). This researcher also found out that some of the challenges encountered by the newly qualified nurses were due to a lack of the requisite expertise for the execution of tasks delegated to them, resulting in hindrances to their performance (Zonke 2012:52). Problems such as these are not only common in midwifery, but are also experienced in general nursing and psychiatric disciplines.

Based on these observations and experiences during her clinical accompaniment of nursing students, this researcher was challenged to explore the lived experiences of the professional nurses during community service in the Midwifery units.

1.3 STATEMENT OF THE RESEARCH PROBLEM

The Scope of Practice of the Midwife, Regulation 2598 entails Acts and procedures applicable to the administration of midwifery services to both mother and child (SANC 1991), as well as regulations relating to the conditions under which registered midwives and enrolled midwives may execute their professional duties. Regulation 2488 guides midwives' expected conduct and expertise in the execution of their midwifery care during the antepartum, intrapartum, postpartum, and neonatal care periods (SANC 1990).

Studies conducted previously highlighted that being newly qualified professional nurses doing community service are subjected to a variety of stressors; and enter the profession unprepared (O'Shea & Kelly 2007:1535). When unsupported by experienced staff, these nurses become dissatisfied and perform poorly, which leads to an increased attrition rate and absenteeism.

The findings by Kelly and Ahern (2008) indicate that participants had a limited awareness of the vagaries of nursing, and were unprepared for the nursing profession prior to their commencement of employment. Studies on the transition from students to professional nurse practitioner indicated that newly qualified nursing professionals found out that in Lesotho, the transition period was disturbing and stressful in nursing education institutions (Makhakhe 2010:5). This researcher observed that during their community service, nurses experience a high level of physical and emotional stress, which results in cases of a significant number to opt out of the service. Exacerbating the problem of their working environments is the fact that during the period of community service, a significant number of nurses are exposed to litigations prescribed in terms of the Nursing Act, 2005 (Act 33 of 2005).

The state of affairs impacting adversely on the nurses' capacity to perform their functions effectively eventually prompted the researcher to explore further on the subject of the lived experiences of the newly qualified nurses when allocated midwifery community services, especially focusing on the Millennium Development Goals number four and five.

In its entirety, the research problem stated above highlights the plight and challenges of newly qualified nurses and midwives induced by stressors in their work environments. If not properly addressed and resolved, such difficulties and problems have the undesirable likelihood to deplete the nursing profession of its much needed skills. For that reason, the general populace – especially the indigent – is deprived of effective and efficient health care service delivery.

1.4 RESEARCH AIM/PURPOSE

The purpose of this study is to explore the lived experiences of the newly qualified professional nurses doing community nursing service in the midwifery section of one of Gauteng's provincial hospitals.

1.4.1 Research objectives

Whereas the purpose/aim of a study relates to the broader intentions/goals of the particular study, the research objectives particularly relate to the narrower and specifically detailed intentions of the particular study. In this instance, the research objectives have been articulated thus:

- To describe the lived experiences of newly qualified professional nurses during their community service in the midwifery section of a Gauteng hospital.
- To utilise the findings/results of these nurses' lived experiences as the basis for recommendations to support and improve their job performance.

1.4.2 Research question

The following research question was deemed pertinent to the study:

- What is the nature of the lived experiences affecting newly qualified professional nurses in midwifery in one of the Gauteng hospital in the Midwifery section during their compulsory community service?

1.5 SIGNIFICANCE OF THE STUDY

The significance and worthiness of a study is generally determined by its contribution to the body of knowledge in a particular discipline – in this instance – nursing practice (Polit & Beck 2012:173). In respect of its contribution to midwifery, this study's immense contribution resides in the provision of curriculum guidelines intended to elevate nurses' levels of competence, confidence, and assertiveness during implementation of midwifery care. By logical extension, such a curriculum based approach will advance the achievement of goals four and five of the Millennium Development Goals aimed at reducing child mortality and improvement of maternal health.

The findings of the study will be very instrumental in the development of additional or new policies which to guide the implementation of community service as a factor of nurses' contribution to the quality of health care in society as a whole.

1.6 DEFINITION OF KEY CONCEPTS

The following key concepts were selected on the basis of their direct bearing to, and affinity with the research topic and other related research variables – such as the research design and method. The alphabetic sequencing of the key concepts does not necessarily relate to any order of importance in relation to the research topic and other attendant research variables.

1.6.1 Community service

Remunerated health care performed for a period of one year at a public health facility by a newly qualified professional nurse who is a citizen of South Africa intending to register for the first time and practice as a professional nurse in a prescribed category (South Africa 2005:5).

1.6.2 Experience

The ability to generalise and recognise regularities, and make predictions based on observations (Polit & Beck 2008:12). In this study, experiences are associated with events encountered by the newly qualified professional nurses and have the effect to influence their actions in practice positively or negatively during the acquisition and application of knowledge and skills in training.

1.6.3 Midwifery

The caring profession practised by persons registered under the Nursing Act (Act No. 33 of 2005), which support and assist the health care user and in particular the mother and the baby, to achieve and maintain optimum health during pregnancy, all stages of labour and the puerperium (South Africa 2005:61) guided by South African Nursing Council Regulation 2488 of 26 October 1990, The South African Nursing Council Regulation 2598 of 30 November 1984 and the scope of Practice of a Midwife Regulation 2598 chapter 3.

1.6.4 Newly Qualified.

In this study, such persons are those professional nurses in their first and second year of community service and are allocated to midwifery wards at a public hospital in Gauteng (South Africa 2005:61).

1.6.5 Professional nurse

According to the Nursing Act (Act No. 33 of 2005), 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 is capable of assuming responsibility and accountability for such practice.

1.7 RESEARCH DESIGN

The most important aspect of the current chapter was to provide an overview of the study, according to which the entire architecture of the research variables – including the study's intentions – are to be actualised. The general and specific intentions of the study, together with the research questions, were jointly influenced and shaped according to the construction and formulation of the research methods and the data collection techniques.

The concepts “research design” and “research methodology” are construed differently by different social scientists and researchers – depending on the prevailing intellectual influences of a particular community of researchers. Some opt for the usage of “research design” and “research methodology” as two separate, but mutually related research nuances; while others use the terms as synonymous and interrelated. In this study, “research design” and “research methodology” are viewed as two separate but mutually related research variables. Accordingly, they are applied complementarily throughout this study.

Whereas the research design of this study is concerned with the broader course of action or plan of how the study was conducted, the research methodology relates to the specific research instruments or tools that were utilised to advance the research

objectives (Henning 2005:142). To some extent, the research design is also regarded as “the management plan” (Henning 2005:142) of the study since it outlines the course of action for the processes and procedures followed in the realisation of the research objectives and the researcher’s resolution of the research problem.

The qualitative aspects of the study relate to the descriptive (non-statistical) elements which rely on the researcher’s own interpretive and analytic acumen. Methods of data collection such as focus group interviews, questionnaire administration, naturalistic or participant observation, and the review of documents – exemplify qualitative aspects of a study.

The qualitative research paradigm has been opted for in this study, and constitutes a very significant aspect of the data collection approach most suitable and appropriate to a naturalistic environment. The researcher has opted for the qualitative approach as she would be directly involved with the informants in the maternity wards where they would be able to describe and reflect on their lived experiences as newly qualified professional nurses (Polit & Beck 2008:16).

Such an approach enables the researcher to observe and collect relevant data directly from the research subjects in their most familiar habitat. Data and information collected in this systematic and holistic manner focuses on understanding the research subjects’ human experience as it is lived (Polit & Beck 2008:219). The information received from the informants during the qualitative data collection process is reflected on as the basis for determining what has been learned from the informants.

In order to enhance participant observation, the researcher was also able to observe and examine the extent of social interaction of the newly qualified professional nurses doing midwifery community services with other members of the health team allocated to them, as well as their activities (such as their subjective behaviour) in the wards during their accompaniment by the researcher in her capacity as a lecturer at the same academic hospital where the study is being conducted (Burns & Grove 2005:536). Their subjective behaviour itself constitutes an aspect of the truthfulness of their lived experiences, which, according to the philosophical Husserl and Heidegger design, relates to “being in the world” - an understanding of people’s everyday life experiences according to their relationship with that environment, to the extent that the relationship

with the environment also accounts for their job performance. In the event that subjective behaviour was being observed, no formal session was required for observational purposes.

1.8 RESEARCH METHODOLOGY

During the data collection process (based mainly on the unstructured interviews), the researcher adhered to descriptive phenomenology variables such as bracketing; which relates to the identification and withholding of the researcher's preconceived ideas and opinions about the phenomena under investigation, considering also that the researcher is a lecturer in Midwifery at the very same research site. It was therefore a research *sine qua non* that absolute objectivity and neutrality be maintained (Polit & Beck 2008:228). The researcher bracketed the fact that students were not afforded exposure to intensive care unit practice. This was a stark contravention of an agreement reached between lecturers and the clinical unit managers in a meeting held on the 10th December 2012, where a request was made that at least two students be placed in the surgical intensive care unit at a given time during training.

Data collection and analysis occurred concurrently. Intuiting was applied in the manner of the researcher extracting statements, categorising the information from the statements, identifying and exploring gaps, and eventually reviewing the data until there is a consolidated understanding of the phenomenon or phenomena under review (Burns & Grove 2009:55).

1.8.1 Population and sample selection

The empirical aspect of the study was facilitated by means of conducting interviews with the research informants in their most naturalistic environment; that is, first and second year midwifery students in one of Gauteng's academic hospitals where the researcher is also a lecturer in Midwifery Nursing Science. In order to render the study credible, the participants were selected (sampled) insofar as they accurately complied with the purpose and objectives of the study.

1.8.1.1 Research population

The research population refers to a larger representative group from which a pre-selected set of traits or common characteristics is obtainable. The targeted population of the study were newly qualified professional nurses who were in their first and second years of study in a midwifery course, and were doing midwifery community service in different wards in one Gauteng academic hospital.

1.8.1.2 Sample size

A sample as a small set of cases a researcher selects from a large pool and generalises the population. It is also worth noting that the sample should be viewed as an approximation of the whole rather than as a whole in itself. Accordingly, the sample size refers to the actual number of research participants selected according to a pre-determined set of criteria. Social scientist has contested the actual representative size of the larger research population. Some contend that an appropriate sample size should be informed by the research objective, research question, and the research design; in qualitative is to generate enough in depth data that can illuminate the patterns categories, and dimensions of the phenomena under study (Polit & Beck 2012:521). The focus is on the quality of the information, obtained from the persons, situation, event or documents sampled versus the size of the sample (Burns & Grove 2009:361).

In this study, the sample size (n=10) from a population of 16 newly qualified in first year and 31 newly qualified professional nurses in second year of community service was adhered to until the point of data saturation was reached. It normally uses small sample size with each informant providing good quality of information under investigation. Ten newly qualified professional nurses doing community service in 2013 participated in the study until data on the lived experience was saturated.

1.8.1.3 Sampling techniques

Sampling techniques or methods are classified as either probability or non-probability. Probability sampling is based on the notion that the probability of selection of each informant is known, while non-probability sampling is premised on the notion that the

probability of selection is not known. The probability techniques include simple random, systematic sampling, stratified sampling, and cluster sampling; while the non-probability techniques are convenience sampling, quota sampling, snowball sampling and judgment/purposive sampling.

In selecting the research sites and the research participants, judgement/purposive sampling was opted for by the researcher. In terms of this approach, the researcher's own critical judgement becomes the 'arbiter' in determining the suitability and viability of the research participants to enhance the main objectives of the study (Polit & Beck 2004:218). Purposive sampling procedures make demands on the researcher to carefully select participants who reflect the most salient characteristics or variables of the particular group being targeted. In this study, purposive/judgement sampling was opted for, as the researcher is knowledgeable about, and familiar with the research milieu to be studied (Polit & Beck 2008:343).

1.8.1.4 Sampling criteria

The sampling criteria refer to the extent to which the research participants do, or do not meet the pre-selected traits or characteristics intended to advance specifically the research objectives (Polit & Beck 2008:218). The research participants could either be included or excluded from participation in the study according to the pre-requisite criteria and involves selecting cases that meet a predetermined criterion of importance (Polit & Beck 2012:519).

Inclusion criteria

For inclusion in the study, the sampled participants had to comply with the following criteria:

- should perform community service as part of their induction into the nursing profession and be allocated in the midwifery section only in the selected academic hospital in Gauteng
- be willing to provide information by describing their lived experiences in the midwifery section of the selected academic hospital in Gauteng

Exclusion criteria

For purposes of this study, the following were excluded from participating in the study:

- non-South African citizens
- nurses of any other category working in a non-midwifery section of the hospital;
- newly qualified professional nurses who have completed community service

1.8.2 Data collection

The process of data collection occurred concurrently with data analysis. This simultaneous process enabled the researcher to perceive and interact with the information to the point of data saturation (Burns & Grove 2005:540). In order to minimise disruptions and enhance rapport between the researcher and the participants, the interviews were conducted in a private room agreed upon with the informant.. In order to maximise spontaneity, the in-depth unstructured interviews transpired within the parameters of a 'grand tour' of questions which were not readily prepared, but were guided by an interview guide (see Annexure H) designed to obtain a detailed description of the experience of these professionals in the performance of their daily professional tasks.

During these unstructured interviews, the informants were left to narrate their experiences with minimal interruption. 'Grand tour' questions were asked with the view to identifying themes and/or sub-themes from the elicited responses. Non-verbal cues – such as nodding by the researcher – were used to propel the informants to elicit more responses.

1.8.2.1 Data collection instrument

The worth and scientific value of data collection is mainly reliant on the selection of an appropriate tool/instrument to broaden understanding of the phenomenon's wider investigation. Invariably, the instrument is mainly the means to an end, not the end itself; that is, the research is therefore not the data itself, but the means by which the sought data was to be collected. The type and quality of the research instrument also determines the extent to which the instrument will either increase or decrease understanding on the investigated phenomenon/phenomena. In this study the 'grand

tour' question and the attendant interview guide were pivotal in the research instrumentation process. The 'grand tour' question was framed thus:

- *Describe your experiences when you are allocated in the Midwifery section.*

The question above is open-ended and allows for the informants to describe and detail a range of experiences. The researcher may also prompt the informant to "say more". The actual words of the informants and notes were recorded and audio-taped in order to maximise the capturing of all the valuable information (Polit & Beck 2008:400).

1.8.3 Data management and analysis

The collection and analysis of data occurred concurrently, which enabled the process of theme and/or sub-theme identification (Polit & Beck 2008:507).

Audio-taped and verbatim data from the informants was accurately transcribed and kept safely. As part of the data analysis process, the researcher read each informant's transcript with the view to a better understanding of meanings and descriptions of the data obtained.

Narrative data was broken down into smaller units and codes attached to each unit. The reductionist process was enhanced by means of clustering all related items for categorisation. Data synthesis occurred with the grouping of information with common themes in order to gain further insight to the experiences of the newly qualified professional nurses.

Descriptive phenomenology became the foundational approach to data analysis, in accordance with Husserl's philosophy of the research validating the result (Polit & Beck 2008:521).

The researcher will read all the data collected from the informants, obtain meaning from each units psychological insight which will thus be synthesised by transforming these units into statements referred to as 'structure of experience' (Burns & Grove 2005:531).

1.8.4 Data and design quality

The design and quality of data are invariably aspects of authenticating the scientific worth and trustworthiness of this predominantly qualitative study. Trustworthiness is the concept used to determine accuracy and quality in qualitative research, and is assessed mainly by these four variables: credibility, transferability, dependability, and confirmability in terms of Lincoln's and Guba's 1985 data and design quality matrix (Polit & Beck 2008:539).

1.8.4.1 Credibility

Credibility refers to the truthfulness of the findings as judged by participants and others within the discipline (Lobiondo-Wood & Harber 2010:119). Credibility of data and its concomitant findings also serves as a quality assurance mechanism of the study. A truthful account of the data is also evaluated in respect of the extent to which the findings accurately represent the social or other phenomenon under investigation.

The researcher conducted unstructured interviews during data collection by writing notes and use audiotapes in order to enhance exactness and originality of information. Engagement and repeated interviewing analysis with the informants was done to the point of data saturation. The researcher further confirmed with the informants to verify and authenticate the veracity of the manner in which their lived experiences have been captured accurately. Assessment of the data was used to allow expert to scrutinise the correctness of the methodology used to obtain and analyse data.

1.8.4.2 Dependability

The dependability/reliability refers to the extent to which the findings are applicable if repeated in a different situation with similar characteristics to those of the original/first research site. This criterion determines whether the finding of the study will be consistent if repeated in the same format (Polit & Beck 2012:175).

In this study, information gathered during data collection and data analysis was kept safe and for availability for an independent audit and perusal with the same themes addressing the research problem of the study.

1.8.4.3 Confirmability

Confirmability refers to the degree to which the study results are derived from characteristic of participants and the study context, and not from the researcher's bias (Polit & Beck 2012:175). In this study, objectivity and neutrality were maintained during the data processing and management process by, amongst others, bracketing preconceived ideas about the phenomena under study, as the researcher is also a professional nurse and lecturer at the very academic hospital where the research was conducted. As independent and detached stakeholders, colleagues, experts and the informants were requested to verify data for accuracy, relevance and objective reporting (Polit & Beck 2008:539).

1.8.4.4 Transferability

Transferability refers to the extent to which the findings are both generalisable and can also be transferred or applicable to other setting (Polit & Beck 2008:539). Once the generalisability of the study is authenticated, the study could lay claim to valid and irrefutable findings. This will allow other researchers to use the findings and the process of research methodology will be made available.

1.9 ETHICAL CONSIDERATIONS

Adherence to research ethics is considered relevant and significant in the study, as it has a direct bearing on the planning and data collection stages of the study. In addition, adherence to research ethics reconciled the conduct of the researcher with the informants' expectations. Adherence to 'behavioural protocol' or 'research etiquette' was pivotal in constructing the 'human' aspect of research, as opposed to the treatment of the research participants as non-living subjects which could be manipulated at any time with the use of a range of research tools. For the entire duration research process, the researcher was committed to the 'behavioural protocol' which served a two-fold purpose of adhering to professional and legal limits and requirements. While the behavioural protocol guided the researcher's expected conduct according to the

acceptable norms within the professional research community of practice, it also guided the researcher's dignified treatment of research participants, which had to be observed, respected and protected at all times during the investigation. Commitment to high standards of research and rejection of the manipulation of research gives research its noble scientific character.

1.9.1 Ethical considerations to participants

Ethical considerations to participants/human data sources specifically relate to the research participants with due respect of their rights, as they do not cease being humans simply on the basis of their research participation.

1.9.1.1 *Respect for human dignity*

As opposed to researcher-focused 'behavioural protocol' (which regulates the researcher's own conduct), participant-focused ethical considerations relate primarily to the researcher's treatment of, or attitude and behaviour towards the research participants. Such treatment of participants ensured that they were treated fairly and with human dignity.

The right to be respected – irrespective of gender, race, creed, or material considerations – is a fundamental human right. The principle of respect for human dignity encompasses people's right to make informed voluntary decisions about their participation in a study. Respect for human dignity implies that human subjects especially, are not to be 'objectified' or used as research experiments in a manner that violates their right to be informed about any aspect of the research. The inviolable principle of respect for human dignity entails the following:

The right to self-determination: Research subjects should be treated as autonomous agents capable of controlling their own activities and destinies.

The right to full disclosure: A full disclosure of the nature and purpose of the study was made to all participants.

Informed consent; The right to be fully informed: The research participants' informed consent is largely the product of the research being fully explained to them. If participants hold the view that the purpose of the research is suspicious, they are likely to withdraw their voluntary participation. In this study, the newly qualified professional nurses participated in the study voluntarily and un-coerced (Burns & Grove 2005:204). Informants were made aware that they may withdraw from the study at anytime they wish during the process of the study. The consent form was explained in details and given to the informant to read and understand.

The right to privacy, confidentiality, and anonymity: Privacy, confidentiality, and anonymity are ethical considerations that are mainly applicable to safeguarding the informants' human dignity from external abuse.

The right to justice: The culture of human rights is legally enforceable, and thus resides in the principle of justice. This principle includes participant's right to fair treatment and the right to privacy. Informants who participated in the study were the newly qualified professional nurses doing their community service, because they are directly involved with the research topic. The interviews were conducted in a private, comfortable and relaxed environment. In order to maintain informants' anonymity, their identities were not revealed. Those who wished to withdraw from the study were not treated unfairly or prejudiced against, neither were they compelled to take part in the study involuntarily. All the information gathered during the study was kept safe, and would not be revealed by all the authorities of the study such as independent auditors; thus in the data analysis, coding and categorising will be applied (Polit & Beck 2008:173).

The right to beneficence: This ethical consideration involves the principle of not subjecting the research clients/subjects to any form of danger or harm during the research process (De Vos, Strydom, Fouche & Delpont 2011:117). Since the study focuses on the lived experiences of the sampled professional nurses, and also touches on the emotional aspect, the researcher temporarily halted questioning during the interview when undue stress was noticed. Non-maleficence was applied in that informants were assured that none of their responses would be used against them or made privy to un-authorized persons, as the study may reveal issues related to

interaction with supervisors or implementation of institutional policies (Polit & Beck 2008:170). The right to beneficence entails the following critical aspect:

- **Freedom from exploitation:** All research entails some element of risk. However, minimal risk should be the desired goal of any research.

1.9.2 Ethical considerations to the institution/research site

In compliance with legal and ethical requirements, the regulations governing both the academic hospital and the higher education institution where the researcher is registered for postgraduate study were observed fully (Lobiondo-Wood & Harber 2010:247).

1.9.2.1 Institutional approval

- Permission to conduct the study was first requested from the Higher Degrees Committee of the University of South Africa.
- Upon the granting of approval to conduct the study by the Higher Degrees Committee of UNISA, a letter was written, and a comprehensive research proposal submitted to the Gauteng Department of Health to formally request for permission to conduct the study in one of the academic hospitals in Gauteng under their jurisdiction (Polit & Beck 2008:184).

1.10 SCOPE AND LIMITATIONS OF THE STUDY

The main limitation to the study resides in its scope. The research project was specifically addressed to nurses of a particular category at a specific site. The study could have benefited from authenticated generalisability/transferability if the inclusion criteria had been broadened.

The research design and method could have been broadened to include structured interviews, as well as other quantitatively-focused aspects such as the usage of the questionnaire. This would have greatly enhanced a triangulated approach to the study and its data collection, analysis, results/findings and recommendations.

1.11 STRUCTURE OF THE DISSERTATION

Chapter	Title	Overview
1	Orientation to the study	Introduction to the study, background to the research problem, purpose and significance of the study, research design, methodology, ethical considerations, and scope and limitations of the study
2	Literature review	Focus on previous studies on the research topic
3	Research design and method	Detailed description of the research methodology
4	Analysis, presentation and description of the research findings	Data analysis and interpretation of the themes and subthemes
5	Conclusions and recommendations	Findings, conclusion and recommendations to the practicals, nursing education and further research

1.12 CONCLUSION

The researcher felt that there is a need to conduct the study on the lived experiences of newly qualified professional nurses, as this would contribute significantly to both nursing education/curriculum and policy formulation.

The adherence to a single qualitative mode of research design served as a foundational phase for the continuation of the same topic in a more comprehensive approach.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is defined as a critical summary of research on the topic of interest, often prepared to put a research problem in context. It is the presentation of what has been researched previously by other researchers and experts concerning the phenomenon or phenomena under study in order to convey to the reader what has been researched about the particular phenomenon or phenomena. In this study, literature review was conducted and incorporated into the findings in order to support the phenomena under investigation, which is entailed in the research topic.

The literature review further provides a foundation on which to base new evidence (Polit & Beck 2012:58). In this study, the main focus of the literature review was to analyse the literature and findings of previous studies that were conducted in relation to the experiences of the newly qualified nurses. Since the focus of the study was to explore the experiences of the newly qualified professional nurses during their community service, the researcher was prompted by the fact that many studies on this aspect were under Psychiatric, General Nursing Science. However, limited studies were conducted in midwifery section. During the literature review process, the researcher looked for the experiential description of the phenomenon being investigated (that is, lived experiences of professional nurses) in order to generate in-depth understanding (Polit & Beck 2012:58).

An exhaustive international and national database search of English-medium articles related to experiences of the newly qualified professional nurses who were placed in the midwifery sections of a hospital. Access to databases was mainly through EBSCO and Sabinet, which allowed searching of other electronic databases. These databases were useful for finding articles in academic journals and other accredited repositories on the research topic. Journals that were considered irrelevant to the topic were discarded. Key words such as “newly qualified”; “experiences”; “professional nurses”; “midwifery”;

and “community service” constituted the core of the guide to critical aspects of the literature review.

Professional nurses accounted for most of the human resources (personnel) that staff the health system. They play a major role in the delivery of care in the health continuum, providing patient care around twenty four hours, necessitating that more newly qualified professional nurses being required each year. A professional nurse would be a person who is qualified and competent to independently practice comprehensive nursing to the level prescribed, and who is capable of assuming responsibility and accountability for such practice .In this study, it will be those professional nurses in their first and second year of compulsory community service allocated in a midwifery ward at a public hospital in Gauteng (South Africa 2005:61).

According to the South African Nursing Council and the Health Systems Trust (2010), the number of professional nurses registered in Gauteng province in 2010 was 30,063, of which 9,393 was employed in the public sector. These figures are acutely minimal, considering that more nurses are needed to be the pillars of the health system (HST 2010:7). The Millennium Development Goals related to improving maternal health care and reducing the child mortality rate by two thirds between 1990 and 2015, can only be achieved with universal access to reproductive health. For these goals to be achieved unequivocally, competent and skilled professional midwives are needed in the service.

According to Motlolometsi and Schoon (2012:784), staff attitudes and an inadequate skills base constitute some of the factors impacting on South Africa struggling to improve maternal and perinatal outcomes and failure to achieve the Millennium Development Goal for maternal health. On E TV’s news broadcast of the 30th October 2013, Dr Aaron Motswaledi (the Minister of Health) announced that 36% of maternal deaths were mostly among teenagers. He further urged that there was a need to improve maternal health by 70% to reach goals four and five of the MDGs. This statement in itself demonstrates irrefutably that there is a dire need to improve the state of reproductive health in the country.

2.2 PROGRAMMES FOR NURSE PREPARATION

In South Africa, the training of professional nurses is guided by the South Africa Nursing Council's Regulation 425, promulgated on 22 February 1985. The latter Regulation stipulates that at the end of training, the Diploma in nursing (General, Psychiatric & Community) and Midwifery is expected to produce mature confident, competent, and skilled practitioners who are able to accept and execute their designated responsibilities. In training, competency and skills acquisition are enhanced by the correlation of theory and clinical practice in the maternity wards. This integrated approach to the training of nurse professionals (which includes Midwifery as a field of study) has an unintended effect on the quality of midwifery, as those who are not interested in Midwifery are compelled to do it because of its incorporation into the curriculum (Motlolometsi & Schoon 2012:784). Consequently, poor outcomes of midwifery care could result.

The National Committee for Confidential Enquires into Maternal Deaths for 2008-2010 has shown no improvement in the health outcome for the past twelve years. The enquiry also determined that there some concerns were raised regarding the quality of training health professionals, doctors and nurses at the academic facilities, posing challenges for them to work in the South African health care environment (Department of Health 2008:1).

The researcher found that the structure of the curriculum is such that when the nurse professionals commence community service, some would have forgotten about midwifery and lack confidence in their practice (Clark & Holmes 2006:1217). The structuring of the curriculum in this manner poses a challenge to the newly qualified professional nurses because of high expectations from the clinical staff (Ferguson & Day 2007:108; Whitehead & Holmes 2011:20). Maitland (2012:42) indicated that the nursing and midwifery students could not link learning in education and practice unless it occurs in a short space of time.

According to the afore-cited National Committee for Confidential Enquiries into Maternal Deaths (2008-2010), as at 15th April 2011, there were 4,807 maternal deaths entered on the database. More maternal deaths were reported during this period than any of the previous years, and the maternal mortality ratio was still increasing. It is against this

background that it is considered here that the structure of the programme should be in such a way that the midwives would be able to contribute towards the improvement of reproductive health in the country.

2.3 COMMUNITY SERVICE

Professional nurses who are registering for the first time are required by the SANC Regulation No 765 of 24 August 2005, relating to performance of Community Service published in the Government Notice to perform a community service for a period of one year in a public hospital (South Africa 2005:76). In terms of the Community Service and Contractual Obligation document (South Africa 2005:76), professional nurses who have completed their training in Gauteng have to adhere to the requirement by the Department of Health, which implies that these professional nurses are required to sign a second year of community service to work back some of the time during which their training has been sponsored. This system could be construed as a strategy of compulsory community service designed to address the problems of human resources shortages in the public health sector.

During this stage (of compulsory community service), these professional nurses are expected to be competent and be able to practice independently without direct supervision, though their training has not adequately equipped them with the knowledge, skills or confidence necessary for independent practice (Clark & Holmes 2007:1211).

2.4 CLINICAL COMPETENCY

The Gauteng nursing colleges' curriculum stipulates that clinical exposure during training should be one thousand hours' duration, during which the nurse professionals would be assisted to integrate theory to practice. The newly qualified professional nurses are faced with challenges in the practice of midwifery during community service, as they would have completed Midwifery Nursing Science when they were in their third year of study. The prevalence of large numbers of students in the nursing colleges may have an impact in the clinical areas, and inadvertently contribute to clinical incompetency and poor patient care.

At the time of registration, newly qualified nurses are expected to be competent enough to practice independently and without direct supervision. However, their training seems not to have equipped them with the prerequisite knowledge, skills and confidence necessary for independent practice (Clark & Holmes 2006:1211). Most of the public wards are staffed by the newly qualified professional nurses. Ten percent of the nursing population within the clinical settings leave the profession within three years of their practice, which then affects the outcome of practice (Teoh, Pua & Chan 2012:146). For effective health care service delivery, the health care system itself demands competent nurse practitioners to ensure quality in health care (Chabeli 2005:1).

The clinical programme aims at preparing them for the challenges that they will face as newly qualified nurses by providing the requisite knowledge and skills necessary for an effective, confident, and accountable practitioner who is able to accept responsibility, think analytically and flexibly, and be able to recognise a need for further preparation; while also willing to engage in self development (Higgins, Spencer & Kane 2009:499).

Several researchers have found that the transition from being student to newly qualified nurse was very challenging. For instance, the qualitative exploratory study by Clark and Holmes (cited in Higgins et al 2009:506) found out that the majority of professional nurses were not ready for independent professional practice, and the increase in responsibility during this time engendered stress and anxiety.

Newly qualified professional nurses also lack practical skills to satisfactorily complete their tasks, which is largely attributable to shortcomings in pre-registration education in relation to development of confidence in clinical, managerial and organisational skills (Higgins et al 2009:507). The majority of newly qualified nurses were not ready for independent professional practice at the point of registration, and there was an abundant lacuna of practice opportunities in managerial skills. It was only after six months that most of the nurses felt ready for practice (Clark & Holmes 2006:1214).

2.5 PLACEMENT

The allocation of these nurses in the ward for a shorter duration (four months) is another factor posing a challenge to their satisfactory performance and completion of tasks. As this hinders consolidation of tasks, they are then moved to other wards or

areas, where the experienced staff becomes unclear in defining the criteria to assess the presence of the required skills were present – appearing to rely on their intuition for assessment. This state of affairs reduced autonomy on the part of the newly qualified professional nurses and exacerbated dependency (Clark & Holmes 2006:1214).

It also appeared in the study by Teoh et al (2012) that newly qualified nurses are regularly rotated in several clinical areas in order to expose them to multiple settings. During the transition period, they would be exposed to a variety of clinical disciplines, which is potentially disruptive to their professional nurse-to-nurse relationships (Teoh et al 2012:144). The occurrence of disruptions is stressful because each time they moved, they would have to learn new outcomes. The study by Teoh et al (2012) was contrary to the current study because the researcher found that the informants themselves wished to be rotated in order that they gain more experience from other areas.

Newly qualified professional nurses are also expected to perform tasks that they themselves feel ill-equipped for (Clark & Holmes 2006:1219). Support is therefore needed in mentorship and preceptorship programmes during transition periods. In the wards characterised by very busy environments, there are increased anxiety levels and low confidence due to few learning opportunities. Novice nurses were allocated less opportunity to practice under the supervision in complex and emergency clinical situations. It is for this reason that the researcher also included experiences of the newly qualified nurses working in busy areas such as the labour ward, admission and neonatal intensive care unit to assess the high level of decision making. The performance of newly qualified professional nurses was also questioned in the Psychiatric Department of the hospital, where it was identified that there was increased readmission of patients in wards staffed by newly qualified professional nurses (Zonke 2012:52).

The perceived gap between theory and practice and the ward manager's expectations from the newly qualified professional nurses was found to be unrealistic, as some were able to cope when thrown at the deep end; which is not conducive to efficient and effective transition. The increase in the newly qualified nurse's expected levels of responsibility and accountability was found to be the major stressor during the transition period (Whitehead & Holmes 2011:4; Kelly & Ahern 2008:915). As a result of the studies by Whitehead & Holmes 2011:4; Kelly & Ahern 2008:915), the researcher

deemed it necessary to focus on community service in midwifery, as some of the informants in this study felt that they were insufficiently prepared for the real-life experiences in the wards.

Teoh et al (2012) asserts that nursing education and training institutions have to continually investigate and experiment on new and innovative pedagogies that may alleviate the tension of newly qualified professional nurses during their journey of transition journey. These institutions should, on the basis of their investigations and experimentation, make concomitant recommendations in the curriculum relevant to the training of professional nurses.

2.6 CONCLUSION

The literature from other studies was explored interpreted and compared with the findings of this study. The literature revealed that most of the newly qualified nurses were subjected to stress due to poor or no support , had low confidence in practice and the experienced professional nurses had high expectations on them.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

The research design and methodology described the techniques and strategies that were used in conducting the study, including sampling, data collection, data analysis, trust worthiness and ethical considerations (Pope & Mays 2009:2).

3.2 RESEARCH DESIGN

The research design is referred to as the blue print for conducting a study (Burns & Grove 2009:219). The qualitative research design focused on generating more and better understanding of the professional nurses' human experiences in the context of midwifery practice in the real-life environs of a public health facility in Gauteng (Brink, Van der Walt & Van Rensberg 2012:120).

The philosophical design developed by Husserl and Heidegger was applied in this study as it clearly explicates and offers an understanding of people's everyday life experiences, in tandem with the research's stated objectives to explore first and second year qualified professional nurses' life experiences in respect of application of their knowledge and adaption to the new role of professional nursing in a midwifery section of a public hospital (Polit & Beck 2008:227). The Heidegger design explains "being-in-the world" as the relationship of the informants and the environment to which they are exposed, as well as the influence of that relationship on their performance (Polit & Beck 2012:495).

The researcher conducted unstructured interviews with the newly qualified professional nurses in different areas where they were allocated, such as the ante-natal care ward, post- natal care ward, admission ward, labour ward, high-care area, the theatre, and the neo-natal care unit. The human experience paradigm advanced by Husserl's descriptive phenomenology enabled the researcher to obtain deeper insight and understanding of

the lived experiences in the different midwifery areas during their day-to-day activities by means of the conducted interviews (Polit & Beck 2008:228; Kelly & Ahern 2008:911).

The descriptive phenomenological paradigm is also defined as a strategy in which the researcher identifies the essence of human experience about the phenomena (Botma, Greeff, Mulaudzi & Wright 2010:190). The following descriptive phenomenological steps were considered during the data collection process.

3.2.1 Bracketing

Bracketing identifies and withholds preconceived opinions about the phenomena, especially when considering that the researcher was also involved in the training of these professional nurses in both the theory and practical aspects of Midwifery. The information gathered reflected a true account of the informants' experiences (Polit & Beck 2008:228). The researcher put aside her own experiences in order to desist from influencing the information gathered. The researcher bracketed the fact that students were not sufficiently exposed to the neonatal intensive care unit. The orientation to bracketing by the researcher ensured that the experiences of the informants were described free of personal prejudice and bias, as transcripts were coded independently (Kelly & Ahern 2008:911).

This lack of exposure was deliberated in a meeting with the clinical unit managers held on 10 December 2012, where a request was made that at least two students be placed in the surgical intensive care unit at a given time.

3.2.2 Intuiting

The researcher develops an awareness of lived experience and brings meaning that the informants attach to the phenomena (Brink et al 2012:122). The researcher was committed during data collection which was done concurrently with data analysis in order to obtain rich information and put more effort on the lived experiences of these newly qualified professional nurses in order to identify and explore gap under the study and made sense from what have been obtained (Burns & Grove 2009:55).

3.3 RESEARCH METHOD

Qualitative research explores people's subjective understandings of their everyday lives to make sense in the social world that we live in (Pope & Mays 2009:6). The research approach that was used is the qualitative paradigm, which is a naturalistic method developed by Husserl and Heidegger addressing human issues by exploring them directly, and focuses on understanding the human experience as it is lived. It is systematic and holistic using an emergent design from the information received from the informants during data collection and reflecting from what has been learned from the informants (Polit & Beck 2012:487). The researcher's intention was to obtain detailed information as she was interacting with the informants during the interviews.

The researcher has chosen this method because she was directly involved with the informants in the maternity wards where the newly qualified professional nurses would be able to describe and reflect on their lived experiences when they assumed the new role of a professional nurse. The researcher also observed the social interaction of the informants with their clients as some interviews were conducted in the areas of employment and when she was in the wards attending student nurses.

3.3.1 Sampling

Sampling means taking any portion of the population or universe as representative of that population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink et al 2012:132). In this study, the sampled professional nurses (n=10) became the means by which the phenomenon of interest (their lived experiences) was developed to construct a holistic understanding of the lived experiences of the newly qualified professional nurses (Polit & Beck 2008:337). These nurses were sampled according to the inclusion criteria mentioned in the previous chapter.

3.3.1.1 Population

Population refers to the individuals in the universe who possess specific characteristics that need to be studied (De Vos, Strydom, Fouche & Delport 2005:193). The population is the entire group of persons or objects that is of interest to the

researcher in accordance with the criteria that the researcher is interested in studying (Brink et al 2012:131). The researcher focused on the newly qualified professional nurses who were registered with the South African Nursing Council and worked in one of the academic hospitals in Gauteng. In this study, the research population consisted of 16 first year and 31 second year professional nurses.

3.3.1.2 Sampling

Purposive sampling – an aspect of – non-probability sampling – was utilised in the study in accordance with the researcher’s knowledge of the environment being investigated; namely, the social reality of newly qualified professional nurses serving community service during the year 2013 in one of the Gauteng academic hospitals. The study’s informants participated voluntarily in the study and through snowballing (Polit & Beck 2012:517). These were the individuals with expansive information that would generate more understanding of the lived experiences of the newly qualified professional nurses who qualified during 2011 and 2012 respectively, during their first or second year of community service.

3.3.1.3 Ethical issues related to sampling

The researcher obtained the necessary permission (negotiated entry) to access the research site from the academic hospital’s authorities. Furthermore, the researcher restricted the study to one academic hospital in Gauteng, thus limiting the accessible population by adding appropriate characteristics defined to it (Brink et al 2012:131).

Subsequent to the granting of permission to conduct the study and its purpose explained to them, the informants gave their informed consent. Confidentiality and anonymity were also assured to the informants. Information that could link the identity of the informants to the study was not included.

3.3.1.4 Sample

The sample comprised of elements of the population considered for actual inclusion in the study; that is, the subset of measurements drawn from the population of interest (De

Vos et al 2005:195). It is part or fraction of the whole population selected by the researcher to participate in the research study (Brink et al 2012:131).

- **Inclusion criteria**

The researcher selected those newly qualified professional nurses who successfully completed the Diploma in Nursing (General, Psychiatric & Community) and Midwifery under the South African Nursing Council (SANC) Regulation 425 and worked in the midwifery section during their first and second year of community service. These nurses qualified as professional nurses 2011 and 2012 respectively. These were individuals from whom detailed and enriching information would be obtained for the study.

- **Exclusion criteria**

Newly qualified professional nurses who did not work in the midwifery section were excluded. Also excluded from participation in the study were those professional nurses who had already completed their community service. Newly qualified professional nurses whose training had not been authenticated by the SANC Regulation 425 Gauteng curriculum were also excluded.

- **Sample frame**

The sample frame refers to the comprehensive list of the sampling elements in the target population (Brink et al 2012:132). The names of the informants were obtained from the human resources register of the maternity section as the researcher moved from one ward to the other requesting names of newly qualified professional nurses who were still doing community service in their units.

- **Sample size**

The sample size is based on the informational needs which were guided by the principle of data saturation, according to which sampling was conducted to the point at which no new information was obtained, and redundancy achieved (Polit & Beck 2012:521). In this study, the sample size consisted of ten informants, from a population of 47 newly qualified professional nurses.

A sample size of ten (10) newly qualified professional nurses doing community service in 2013 participated in the study, out of the eleven that was initially chosen. This number was determined by the quality of information needed (Burns & Grove 2009:361), as well as the availability of the respondents on a volunteering basis.

3.3.2 Data collection

Data collection is the process of selecting and gathering data from the subjects, with the active involvement of the researcher (Burns & Grove 2009:441). Data collection occurred concurrently with data analysis, according to which the researcher was intensely involved in interacting with the informants and attached meaning to all the information obtained until data saturated was reached. The researcher conducted data collection in the on-site private rooms in order to obviate disruptions, and enhance both confidentiality and appropriate rapport between the researcher and the informants.

3.3.2.1 Data collection approach and method

Data collection in the phenomenological study relied primarily on the in-depth interviews, including diaries and other written material (Polit & Beck 2012:532). In this study, an in-depth unstructured interview accompanied by an interview guide were used to obtain detailed descriptions of the experiences of these professional nurses when they performed their day-to-day professional services, which would necessarily advance in particular, the public health sector's contribution towards meeting millennium development goal four and five by the year 2015. The duration of the interview was between 30 and 45 minutes.

3.3.2.2 Data collection instrument

The researcher used the "self" data collection instrument to collect data from the informants. All the ten informants were exposed to the following "grand tour" questions:

- Describe your experience as you are allocated in the midwifery section.

This was an open-ended question in which specification to the areas of exposure was considered. Such consideration allowed the informants to talk more. Some responses determined the extent of probing or further leading questions (Polit & Beck 2012:536).

- Is the any question you think I should have asked

The informants' responses were written *verbatim* as notes and recorded on audio tape in order that to maximise the capturing of all the valuable information.

3.3.2.3 Data collection process

Ten (10) newly qualified professional nurses participated in the study as data collection was conducted during the times and the working areas that were agreed to by the informants and the researcher. These included agreed upon variables included their place of work during off duty time; the lunch hour; and some were at home in order to allow sufficient time to discuss the lived experience in the midwifery areas with minimum hindrances. Following the 'grand tour' questions, were probing questions such as: *What do you think? Explain further. or Make an example.* This category of questions illustrates the fact that the researcher was interested in the elicitation, detailed exploration, and maximisation of further information on the topic.

Paraphrasing was done to obtain multi-dimensional understanding and meaning of the informants' responses. Questions were asked in the event that the researcher did not understand responses, and pauses were allowed in the conversation to allow informants the opportunity to think clearly on what they wished to add to the conversation. Some of the informants were allowed time to pause during the conversation, as they expressed their emotional state by weeping. Such an eventuality is illuminated by De Vos et al (2005:288). The duration of the unstructured interviews was between 30 and 45 minutes per session. The researcher displayed minimal nodding and verbal responses such as "mm-mm-mm". In other instances, the researcher would say "Yes", to indicate to the informant that the researcher was paying serious attention to the conversation. Engagement and repeated interviewing analysis with the informants was done to the point of data saturation.

3.3.2.4 Ethical considerations related to data collection

Ethical implications of research are considered sacrosanct, especially when the researcher is considering adopting research findings in practice (Brink et al 2012:45) as indicated in this study of lived experiences in the practice of midwifery. Considerations to ethics are both legal and professional compliance mechanism to ensure that the involvement of human research subjects in research is neither abused nor exploited. Furthermore, ethical considerations also address the behavioural conduct of those who are conducting the research (Lobiondo-Wood & Harber 2010:247). The following ethical principles were maintained in the study.

- **Respect for human dignity**

The newly qualified professional nurses who participated in the study were given a detailed report about the process of the study, including the use of audiovisual tape during data collection (Burns & Grove 2005:204). Informants were also made aware that their involvement was without any coercion, and that they were free to withdraw from the study at anytime they wished during the process of the study if they felt their rights were violated. All these measures of honesty and transparency were adhered to in order to obtain their informed consent and voluntary participation, after which the informed consent was signed prior to the actual interview being conducted. The informed consent is indicated in Annexure D.

- **Institutional approval**

Permission to conduct the study was first granted by the Higher Degrees Committee of the University of South Africa (see Annexure E). A letter was written to the Gauteng Department of Health to ask for permission to conduct the study in one of the academic hospitals in Gauteng (see Annexure B), where a comprehensive research proposal was handed to their Research Ethics Committee for their perusal and approval, after which the study process and data collection was initiated (Polit & Beck 2008:184). Permission to conduct the study was requested from Chris Hani Baragwanath Hospital (see Annexure C). Institutional approval is entailed in Annexures F and G.

- **Beneficence**

This principle entails that the informants' involvement in the study was as innocuous as possible, especially that the study focused on the lived experiences of the professional nurses – which also encompasses the emotional aspect of their being and work. The researcher withheld questioning and paused during the interviews when undue stress was exhibited by especially two of the informants' intermittent weeping.

Whereas the informants in the study may not benefit immediately from the accrued improvement recommendations, future professional nurses doing community service and public health care institutions will also benefit when the recommended strategies and policies are implemented (Botma et al 2010:20).

- **Non-maleficence**

Informants were assured that information gathered will not be used against them at any stage because the study may reveal issues related to their interaction with supervisors or implementation of institutional policies (Polit & Beck 2008:170). The researcher's honesty was exemplified with the usage of the audio tape for accurate data collection, as an aspect of respect for the informants' human dignity.

During the debriefing sessions, informants were afforded the opportunity to ask questions at the end of the interviews, especially to those who seemed stressed when communicating their experiences (Brink et al 2009:36).

- **The principle of justice**

This principle includes participants' right to fair treatment, anonymity, non-coercion, and privacy (Botma et al 2010:20). All relevant details pertaining to respondents' inviolable informed consent were followed unequivocally.

The setting of the interview was conducted in private, comfortable and relaxed environs. Anonymity and confidentiality were maintained by withholding all the information gathered during data collection and the identity of all the informants from any unauthorised persons. Those who wished to withdraw from the study were treated in an

un-prejudicial manner (Annexure D). During the data analysis phase, data coding and categorisation was applied. Agreements with the informants such as the date, the time, and the venue of the interviews were honoured (Polit & Beck 2012:15).

3.3.3 Data analysis

Data analysis refers to the methodological and interpretive presumptions that the researcher brings to bear on the data, how the researcher is going to engage with the data .the researcher reflect on the relationship with the participant and the phenomena under study (Botma et al 2010:292). Data collection and analysis occurred concurrently in this predominantly qualitative study, which involved clustering together related types of narrative information into a coherent scheme, identifying themes and categories to build a detailed and comprehensive description of a phenomenon (Polit & Beck 2012:62).

Phenomenologists use strategies that involve the interpretation of narrative data within the context of “the whole text” (Polit & Beck 2012:565). Husserl’s and Heidegardian’s steps were used in analysing the data.

Audio-taped interviews and *verbatim* data from the informants were accurately transcribed, and the researcher read the transcripts from each informant followed by the extraction of significant information in order to obtain an understanding and meaning of the description of the data obtained (Kelly & Ahern 2008:911).

The researcher read all the data collected from the informants and attached meanings to each unit for articulating psychological insight and synthesis by transforming these units into statements referred to as “structure of experience” (Burns & Grove 2005:531; Polit & Beck 2008:521). Data analysis involved breaking up the data into manageable themes, patterns, trends, and relationships, in order to understand the various constitutive elements of one’s data through inspection of the relationship between concepts to establish themes in the data (Mouton 2013:109).

Narrative data were broken down into smaller units and codes attached to each unit during the reductionist process. All the related items were clustered together and subsequently categorised. Data with common themes was synthesised for purposes of

obtaining better understanding of the experiences of the newly qualified professional nurses.

3.4 TRUSTWORTHINESS

Trustworthiness is the concept used to determine accuracy and quality in qualitative research according to Lincoln's and Guba's model (1985) steeped on four criteria (Polit & Beck 2008:539).

- **Credibility**

Credibility is the truthfulness of findings as judged by participants and others within the discipline (Lobiondo-Wood & Haber 2010:119). The truth value is usually obtained by using strategy of credibility and criteria for prolonged engagement and member checking (Botma et al 2010:233). In this study, prolonged engagement with the informants and repeated interviewing analysis with the informants until data saturation took about 30-45 minutes. Credibility also demonstrates that the enquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos et al 2005:346).

The researcher conducted unstructured interviews during data collection by writing notes and used the audiotape in order to collect precise information from the informants. Paraphrasing was done to ensure clarity of the information. Objectivity was maintained throughout data collection and participants were not coerced .

Good interpersonal relationship with the respondents was maintained throughout in order to develop rapport and build the assurance that the findings obtained were truthful. The researcher confirmed the interpretation with the informant, in order to ascertain whether or not the experiences were captured accurately. At the end of each interview, the summary of the discussion was read to the informant to ensure that information that was captured was reflective of their initial response. Some transcripts were read back to the informants to confirm that the information obtained was their true response.

- **Dependability**

The researcher's refined understanding of the research environment and its characteristics stood in good stead in the event of changing conditions in the phenomenon chosen for the study (De Vos et al 2005:346). This criteria determines whether or not the finding of the study will be consistent if repeated with the different informants (with similar characteristics as the original ones) in a different context. The methods of data collection and analysis for the study were clearly described. Information gathered during data collection, data analysis and management was kept safe and made available to an independent audit for perusal and brings about the same themes addressing the research problem of the study (Botma et al 2010:233).

- **Confirmability**

Confirmability captures the concept of objectivity, and stresses the need for the findings of the study to be confirmed by another study on the same research topic (De Vos et al 2005:347). Freedom from bias during the research process and result description are solely concerned with the informants and the condition of the research (Botma et al 2010:233). The researcher maintained objectivity and remained neutral during the research process by bracketing preconceived ideas about the phenomenon under investigation, as the researcher is also a professional nurse and was a lecturer for these newly qualified nurses. Bracketing assisted in the dissolution of undue prejudicial influences on the study.

The researcher's colleagues were requested as independent people to verify the data for accuracy and relevance (Polit & Beck 2008:539).

- **Transferability**

The notion of transferability refers to generalisability of the data, the extent to which the findings are transferred or applicable to other settings (Polit & Beck 2008:539). The researcher selected newly qualified professional nurses during their community service period. During the interview, data collection was further advanced by probing until data saturation, which allows for other researchers to use the findings.

3.5 CONCLUSION

This chapter focused on the research design and method, data collection, ethical consideration and trustworthiness. This chapter is critical insofar as it outlined the credibility and scientific worthiness of the study as a whole. Data analysis is discussed in the next chapter.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter mainly addresses data analysis and interpretation of the results of this study in order to obtain better understanding of each informant's information from the data that was collected. Data analysis refers to the methodological and interpretive presumptions that the researcher brought to bear on their data. The chapter further reflects on the researcher's relationship with the participants and the phenomena under study (Botma et al 2010:292).

4.2 DATA ANALYSIS AND MANAGEMENT

Data collection and analysis occurred concurrently in this qualitative study, involving the clustering together of related types of narrative information into a coherent scheme, and identifying themes and categories to build a more detailed description of the phenomenon under investigation (Polit & Beck 2008:507); namely, the lived experiences of newly qualified professional nurses in their first and second year of midwifery, and doing compulsory community service at one of Gauteng's public hospitals.

Data analysis involves breaking up the data into manageable themes, patterns, trends and relationships, in order to understand the various constitutive elements of data by inspection of the relationship between concepts to establish themes (Mouton 2013:109). Husserl's philosophy of descriptive phenomenology informed the approach opted for in the analysis of data.

The researcher read and re-read all the scripts of data collected from the informants. Audiotapes and *verbatim* data from the informants were accurately transcribed, and discriminated units from the informants' description on their lived experiences were thoroughly interpreted from their transcripts. The researcher thematically ascribed and

synthesised units of meaning to each unit into consistent statements regarding participants' experiences with the view to articulating some degree of psychological insights (Burns & Grove 2009:531; Polit & Beck 2012:566).

The researcher read each informant's transcript and extracted significant information in order to derive better understanding and meaning of the description of the data obtained (see Annexure I). The information derived in this manner enabled the development of themes and sub-themes. The results/findings of this study were integrated with findings from other studies.

4.3 RESEARCH FINDINGS

This section of the entire chapter is entirely concerned with the presentation of the actual results/findings on the systematically conducted investigation into the lived experiences of newly qualified professional nurses doing their first and second year midwifery respectively, and also doing compulsory community service at one Gauteng academic hospital.

4.3.1 Informants' demographic profile

Semi-structured interviews were used the means by which data was collected from ten informants, all of whom responded to one 'grand tour' question, with secondary/ancillary questions following their responses. Data was collected until no new information could be obtained. At the time of data collection, there were no male nurses who were serving community service in the allocated maternity sections. This state of affairs accounted for all the informants being females. The following tabular presentation depicts the demographic distribution of the informants.

Table 4.1: Total number of participants (N=10)

Number of informants	Ages of informants	Years of experience as newly qualified professional nurse
2	20-29 yrs	1 st year=1 2 nd year=1
3	30-39 yrs	2 nd year=3
3	40-49 yrs	1 st year=1 2 nd year=2
2	50-59 yrs	1 st year=2
N=10		1 st year=4
		2 nd year=6

Table 4.1 above illustrates that the majority of respondents (6 out of 10, or (60%) were collectively in the 30-39 years and 40-49 years age groups respectively; an indication that younger professional nurses' interests are in other areas of the nursing profession. Furthermore, this age category (30-39 years and 40-49 years age groups) some of these nurses have been long in the service, being staff nurses and auxiliary nurses. They have now upgraded themselves to the professional nurse category.

Table 4.2: Areas of ward exposure of the informants

Areas of exposure during the first and second year	Number of informants
Ante-natal clinic	1
Ante-natal ward	1
Admission	6
Labour ward	8
High-care area	5
Post-natal ward	2
Theatre	2
Neo-natal intensive care unit	1
N=8	

There were eight areas of allocation, and one of the informants worked in more than one area. Some of the informants who were allocated to other areas such as the ante-natal ward and post-natal ward were exposed to the labour ward unit on relief basis when there was a staff shortage. Only two of the ten informants (20%) were never exposed to the labour ward. The most common allocations were in the labour ward, admission ward and high care area respectively.

The following identified themes and sub-themes are discussed on the basis of the analysis of the results/findings.

4.4 THEMES

Following the data analysis from the collected data accruing from the ten informants, four themes and eleven sub- themes were identified. Each theme is discussed in detail below, and the relevant *verbatim* quotations from the informants’ transcripts are presented without interference.

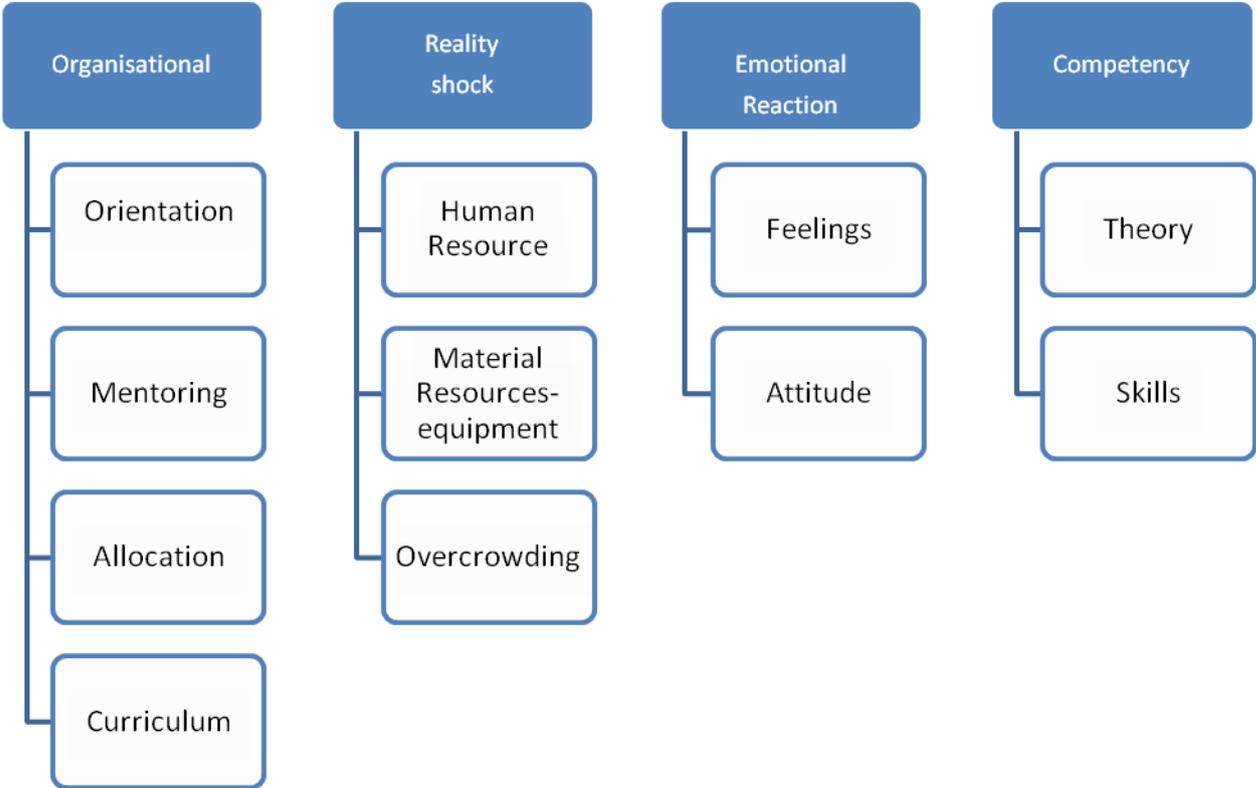


Figure 4.1: Illustration of major themes and sub-themes

4.4.1 Theme 1: Organisational

Institutions and programmes need to have well organised programmes and systems in order to produce and to facilitate smooth transitioning of highly competent professional nurses during community service and throughout the profession as a whole. Human and material resources also form part of the organisational/institutional infrastructure.

4.4.1.1 Sub-theme 1: Orientation

Formal comprehensive and individualised orientation programmes are integral to the transition of newly qualified professional nurses (Teoh et al 2012:144). The orientation of personnel to the work environment facilitates smooth running of the department, promotes time management and efficient use of equipment designed to assess and prevent complications. At the selected Gauteng public hospital, there was only a one-week formal orientation which mainly concentrated on the comprehensive layout of the maternity section. The informants were of the view that the hospital authorities and the unit leaders did not co-ordinate their function in a manner that demonstrated a protracted approach towards their orientation (Du Plessis & Seekoe 2013:135).

Contrastingly, the newly qualified professional nurses expected to receive a formal orientation in their allocated areas in order to perform their duties diligently. Only three of the ten informants indicated that they were adequately orientated in their units, which enhanced smooth running of the units.

In areas such as the labour wards, no orientation was conducted, a factor that was attributable to increased workloads and staff shortages. One had to make amends and find one's way. For the informants to be functional, they had to keep on asking from the veteran nurses, which was time wasting and discouraging. Orientation would at times only be conducted after the occurrence of a problem.

The following scenario outlines the informants' responses based on their ward experiences and observations. The bracketed coding depicts a particular informant, and the italicised information denotes their actual responses.

(I/3): *I was never orientated in the neo-natal theatre, no mentoring. You will be orientated only when there was an adverse situation. I had a child with bad distended abdomen sets ... plus minus 70% ...I did not notice the baby was disorientated ... the baby died.*

(I/7): In the admission ward I was not orientated, and not even introduced to other members of staff [some of whom] will say they [also] experienced the same.

(I/8): I have learned the hard way ... no time for orientation.

The newly qualified professional nurses who were allocated to the ante-natal and post-natal wards indicated that they were warmly welcomed and adequately oriented by their seniors.

(I/9): I got a pleasant welcome and orientation ... placed with the registered nurse for a month who gave me orientation.

4.4.1.2 Sub-theme 2: Mentoring

A mentor is someone who has accumulated sufficient work related experience, and is able to effectively share some of this learning and experience with others (Megginson & Clutterbuck 2009:71). This was a sub-theme of concern; especially that most of the informants expressed the need of mentorship from all the multiple stakeholders who are involved in assisting them to develop during the transitional period. Positive midwife-to-midwife interactions within supportive working environment restores participants' faith in themselves and child birth (Fenwick et al 2012:2059).

Mentorship and support will contribute towards the prevention of neo-natal and maternal mortality and the elimination of most of the challenges that lead to stress, anxiety and other complications. The point of entry to the work environment for newly qualified nurses is crucial to a smooth transition (Whitehead & Holmes 2011:23). The researcher discovered that mentoring was not done in some units, which was inimical to that envisaged transition.

Nursing management skills have been identified as an area of concern for newly qualified nurses (Higgins et al 2009:506). Nurse Managers are in the ideal position to create supportive practice environments that facilitate new nurse integration into the ward setting (Ferguson & Day 2007:107). The culture of support is important to enable successful transition (Jackson 2005:30; Higgins et al 2009:508). It is important for the

informants to be supported in order to promote and facilitate a smooth running of the unit. Unsupported graduates experienced less satisfaction and commitment to remain within an organisation or profession (Kelly & Ahern 2008:911).

Two of the ten informants mentioned that they were no longer interested to work in the maternity section, and that they were only waiting to complete their period of community service.

In areas where support was conducted, especially in the ante-natal and the post-natal wards, there informants experienced decreased stress levels. In other areas, the newly qualified professional nurses were left in a situation where they had to cope rather than being taught (Whitehead & Holmes 2011:23).

Informants indicated that the one-month duration of mentoring was insufficient, as midwifery is very challenging. Due to lack of experiential knowledge, new professional nurses relied on the expertise of others, and frequently sought guidance (Ferguson & Day 2007:108; Higgins et al 2009:507). Various studies by Whitehead & Holmes (2011) and Clark & Holmes (2007) indicated that there is a degree of variability in the extent to which newly qualified nurses experience preceptorship.

(I/6): If you don't understand, you will consult and get support from the team leader. We work together harmoniously, except where there is absenteeism. The team leader is supportive, even if there is a complication and this allays one's anxiety.

(II/10): When you are a comm ... sisters do help you. They even tell you if you are not comfortable, confirm with them until you are sure ... and now I feel confident and very competent to do things on my own.

Informants cited the fact that they were from college did not mean they knew everything, especially that their programme college curriculum was completed at third year. By the time they are registered, they have forgotten about midwifery already. In addition, there was a one year gap between their completion of midwifery and their status as newly qualified registered nurses. They are expected to play their new roles prior to their competency to do so (Jackson 2005:27).

(I/7): *Morale decreased after being left alone in the unit to be taught by the staff nurse.*

The newly qualified professional nurses are of the view that they are let down and just put into the deep by being left alone to do everything, in order to test their coping abilities. The expression, "being thrown in the deep end" was used by two informants in the study who expressed lack of support from their seniors. This usage of the expression was also found in the study of Kelly and Ahern (2008).

(I/9): *I would work with auxiliary nurses who were helpful, but I felt that they were throwing me in the deep end.*

(I/2): *There is lack of support from seniors, and when you have a problem with patient you are on your own ... I think [our] college should do follow up to check how we cope, especially in midwifery [where] I find myself lost.*

(I/3): *I thought as a comm.... I work under the supervision of a qualified sister, and one is on one's own. It is difficult, and nobody is mentoring you. There are some sisters who are strict but not supportive in other units and those who are not. I avoid them.*

(I/4): *Support is non-existent, its either jump or swim; even when there is litigation [against you], you are on your own. The unit manager does not support or accompany you. Other institutions have sisters who are mentoring for the first two months.*

Lack of mentoring and other forms of support affected the newly qualified nurses psychologically and socially.

(I/8): *When you ask questions from the seniors – who call themselves "KKM Kgale kelemona" [loosely translated as: I've long been here]. They ask us what is it that we have learnt at the college is. As a result, only a few of them will be showing you what to do in connection with the patient. No*

support when there is litigation. I was told that my epaulettes will go down the drain.

4.4.1.3 Sub-theme 3: Allocation

Most of the informants were allocated in the busy area for the duration of community service. However, they felt that they were disadvantaged in their professional development. Some indicated that it would be better if allocation was done on three monthly rotations, in acquaint themselves with other areas in the maternity ward. There were only two informants who were allocated in the ante-natal and post-natal wards, as indicated in Table 2. The only time that they were allocated to other areas was on relief basis for a day. In the event of staff shortages in the busy areas such as the labour ward, they were challenged because of poor orientation and support. They also wanted to be allocated with a colleague from the college for moral support. In the study by Jackson (2005), strategies such as rotation programmes are mooted in order to meet the needs of those concerned.

The informants also cited that it would be better to be rotated into other nursing disciplines such as Psychiatric, and not be confined to one area for the duration of their community service. They were of the view that this will afford them the opportunity to nurse patients holistically, as they would have found an area of interest and specialisation in the profession. The impact of being rotated to different areas was also emphasised; that is, being able to experience many nursing aspects while determining the area to work at the completion of the programme (Kelly & Ahern 2008:915).

(I/5): Only allocated in one area for two years, when I have to go to other institutions I will suffer because one was exposed to one area.

4.4.1.4 Sub-theme 4: Curriculum

Curriculum is described as an attempt to communicate the essential principles and features of an educational proposal in such a form that is open to critical scrutiny and capable of effective translation in practice (Quinn & Hughes 2007:108). Nursing curricula should prepare new graduates for foreseeable stressors and oppressive practices so that they can become proactive (Kelly & Ahern 2008:910).

The normal Midwifery Nursing Science 100 course is commenced at the second level of training, and is completed at third year with Midwifery Nursing science 200. In the third year only, they are exposed to the management of high-risk maternal and neo-natal conditions. At fourth year level, Midwifery Nursing Science would have been completed (Gauteng Nursing Colleges Curriculum 2002:48).

The researcher found out that this structure of the programme has a gap of one year. In the fourth year of study, there is no midwifery on completion of the course. The nurses would be allocated in the maternity section, some of whom have totally forgotten about midwifery and its concomitant stress and anxiety. Orientation and mentoring would be very crucial in the stages of transitioning to an experienced professional nurse.

The curriculum is in such a way that in one academic year, the professional nurses are exposed to all four subjects. In their second year, they will do midwifery in their early years of the profession – which is too challenging when they are in clinical areas. There was a strong feeling from the informants that midwifery must continue up to the fourth year, which is their last year of training. At that stage, midwifery would still be vividly embedded in their minds.

(I/3): It would be better if midwifery started from third to fourth year because when we go to clinical, we forget.

The informants also stated that the comprehensive course does not prepare them well enough. They felt that the course was congested, it would be better if midwifery was done in one year without being combined with other courses in one academic year. The informants felt ridiculed by the negative comments from the professional nurses who were not trained under the comprehensive course and thus perceived the newly qualified professional nurses as utterly incompetent.

(I/7): She has done D4 [that is, the Diploma in nursing (General, Psychiatric & Community) and Midwifery], why is she asking many questions, and they don't know anything.

Some of the comments from the informants when they were faced with challenges in practica.

(I/8): *I told them that the last time I was in midwifery was in third year, then I was told “Kanti ufundela ukukhohlwa?, meaning: Did you learn in order to forget?*

They are like empty bottles of Coke [the soft drink].

There were strong suggestions that were made by the informants regarding the course, that midwifery should continue up to the fourth year of study, not to be combined with other courses in one academic year.

4.4.2 Theme 2: Reality shock

The term “reality shock” is used to describe the response from newly qualified when their clinical experience does not always match their values and ideals that they initially perceived (Teoh et al 2012:143).

The informants experienced that transition from being a student nurse to a newly qualified professional nurse exposed them to many expectations and challenges that were never encountered whilst they were still students. The transition entailed huge responsibility and accountability (Whitehead & Holmes 2011:23). The professional nurses were shocked by the levels of accountability and expectations in respect of the conditions under which they worked in the clinical areas. The transition from student to professional nurse has long been recognised as a difficult time, and nursing was the only profession which expected a completely finished product at the end of pre-registration (Jackson 2005:26).

Transition and change is seen as events that are uncontrollable, ambiguous, overwhelming, and causes stress and anxiety (Higgins et al 2009:506). It was also cited in the study by Ferguson and Day (2007:108) that the amount of responsibility, accountability, and stress is overwhelming, and that the programmes had not prepared the informants adequately.

4.4.2.1 Sub-theme 1: Human resources

The informants commented that there were acute staff shortages in the maternity section, which resulted in increased pressure, stress levels, and a decline in expected job performance. Shortage of staff was more pronounced in the labour ward than in other areas such as the ante-natal and post-natal wards. In these wards, it is not uncommon to find an area with 20 cubicles being staffed by three newly qualified professional nurses and one experienced nurse. Such a situation had an overwhelming effect on the informants' stay in these areas, as well as on the care to both the mother and the baby, which increases the potential for litigious action against these nurses. Pressures of time and staffing levels meant these nurses were unable to meet their own expectations (Higgins et al 2009:506).

Eight of the ten informants (80%) raised concerns over staff shortages in the labour ward, and those who were working in other areas other than the labour wards at times had to be moved to the labour ward due to these recurrent shortages of staff. The latter challenge was compounded by the fact that critical areas such as the admissions wards, labour wards, the theatre, and neo-natal intensive care units, needed specialised staff – a factor that was corroborated in other studies (Teoh et al 2012:144). Furthermore, staff shortages also lead to those who were on duty being overwhelmed with work and not breaking for tea and lunch. Such factors augmented to problems of absenteeism in the unit and reduced immune systems on the part of the nurses.

The following are some of the interview responses from the informants.

(I/1): I had a patient with 2nd degree tear. I couldn't suture the patient properly because I had to attend to another patient who was delivering. On my way back [from attending to another patient who was delivering] that patient [who needed suturing] was bleeding.

(I/3): I love midwifery, but I am scared to work in the labour ward ... one sister with 5 cubicles. I don't think I will be able to give care because of overcrowding.

This is also supported in the study of Fenwick et al (2012), as one of the respondents indicated that she loved midwifery, but she was demoralised and stressed because of lack of support.

(I/4): The labour ward needs staff and team work as one cannot work alone ... twenty cubicles should be divided amongst four nurses.

(I/6): One gets tired as the nurse-patient ratio does not tally, leading to absenteeism.

(I/8): In the labour ward, there is a lot of shortage. It was very stressful in the labour ward. I could not cope as I was running seven cubicles by myself. You are expected to do your best; anyway.... Due to the workload, I ended up losing a patient due to bleeding.

4.4.2.2 Sub-theme 2: Material resources

Shortage of material resources was another area of concern that compromised the nurses' performance and led to medico-legal consequences. These shortages and heavy workloads compounded the new graduates' stress levels, which negated the provision of high quality care (Makhakhe 2010:39).

As a result of the shortage of material resources in wards, patients' conditions deteriorated; complicating instead of improving, at times. Nurses could not adequately execute the procedures they were taught, which resulted in stress, confusion, and frustration (Makhakhe 2010:39).

There was insufficient stock of medication such as Celestone and Adalat. The shortage of medication was exacerbated by the dysfunctionality of the available equipment. One informant indicated that such a state of affairs contributed to a decline in staff morale and rendered them ineffective in their work (Zonke 2012:33).

When the above-cited situation was brought to the attention of the public hospital's management, the informants were told to use alternatives, which were themselves also insufficient to address the growing number of patients. Borrowing equipment from other

ward areas not only compounded time wastage, but also exposed both nurse and patient to medico-legal consequences which compromised effective and efficient maternal and neo-natal care. The informants themselves were uncomfortable to use alternative or improvised equipment, due to the possible medico-legal consequences that may occur.

(I1): If the hospital could only attend to human and material resources, we would work harmoniously and be more competent. We raised [equipment related] problems such as the absence of the Non Stress Test (NST) machine. The response has been that we should use the stethoscope, but the number of patients is out-done by the half hourly foetal heart examinations that have to be conducted.

(I3): Packs from the Central Sterilisation Service Department (CSSD) have not been delivered. The absence of adequate and effective equipment meant that one had to use a needle to sever the umbilical cord. In theatre, we use disposable paper from the CSSD pack to catch the baby. The pack may tear and the baby may fall, effectively causing medico-legal implications.

(I4): One has to improvise by using the Jelco needle to inject patients. The shortage of drugs lowers staff morale. You are not sure whether you are doing right or wrong ... you always have to ask in order to use this or that for a particular procedure ... you have to move from one area to another, and then you get an attitude [from the veteran nurses].

(I7): There is no equipment. Just look at the cardiotocograph machine. Its not working. There is [also] no thermometer. You have to buy your own thermometer.

4.4.2.3 Sub-theme 3: Overcrowding

There was a disproportionate nurse-patient ratio in this institution, further causing nurses to work under pressure with the attendant increased stress levels, burn-out, and lot of absenteeism, especially in the labour ward. A cumulative effect of all of these

factors was that attrition to these newly qualified professionals resulted. There were some instances where the nurses would work with neither tea nor lunch break, and the resultant exhaustion would disadvantage their performance.

Overcrowding compromised total patient care – where one would find that some patients were missed during care due to overcrowding – and the ensuing possible medico-legal implications would have a direct bearing on the nurses themselves. Priority patient conditions – such as women with pre-eclampsia who would only be attended to when they fit – were not managed effectively, leading to increased maternal mortality. Such a situation had the undesirable consequence of tarnishing the health institution's image and accounting for possible medico-legal aftermaths.

One informant positively cited that overcrowding exposed the nurses to most of the conditions that affect the mother and child adversely.

(I/9): *Although one is aware of overcrowding, most of the time we end up not doing the correct thing.*

One of the informants highlighted that overcrowding also compromised the student nurses' training as they formed part of the workforce.

(I/3): *I don't think I will be able to give thorough care because of overcrowding. I am not yet experienced. I think I miss something. One is working under pressure, and I have realised that comm serve... they go away because of overcrowding. I used to say I will retire in this hospital, but I think I must go away as well, unless there is a change.*

Care during the puerperium is compromised, especially mothers who delivered by means of caesarean section. They develop infections that may lead to puerperal pyrexia and sepsis which is a priority condition of concern that increases maternal mortality.

(I/4): *There is an increased number of intake ... patients are coming back with septic caesarean section rather than curing we cause more harm.*

The study of Teoh et al (2012) reported that new nurses' workload could be overwhelming at times, there was no predictable or prescribed routine. The work day was described as rhythm amidst chaos, with no time for critical reflection and thinking about their work.

(I/8): There was an incident where the mother delivered a child on the floor. I was called to account by the Gauteng Health Department, and we are still going to account to SANC ... I feel bad and anxious. I cannot cope, at times I could not go for tea and lunch because I was afraid of leaving the cubicles as this would compromise the patient's health.

(I/10): I have noticed that in the maternity ward we admit patients more than ... at ANC. We have 33 beds, and it becomes a challenge because patients sometimes have to sleep on the benches until morning. When you are a student in the maternity ward, you are expected to do everything. There is no time to learn. When I am qualified, I will ask for some things to be clarified before I can be on my own.

(I/9): During practicals, problems such as scarcity of resources and overcrowding compromise the quality of what is taught.

4.4.3 Theme 3: Emotional Reaction

Emotions refer to the feeling that organises and guides a perception, thought and action (Louw & Edwards 2011:746). The informants expressed emotional reaction when they were transitioning from student nurse to qualified professional. They were overwhelmed by the circumstances that they were exposed to during transition. These circumstances induced change; where change is seen as events that are uncontrollable, ambiguous and overwhelming. It was also identified that transition created a period of stress, uncertainty, and fear (Higgins et al 2009:506; Kelly & Ahern 2008:911).

The emotions were more pronounced during the first year of community service and becoming better towards the end of community service when the nurses had gained confidence in the profession.

4.4.3.1 Sub-theme 1: Feelings

The informants experienced mixed feelings while they were providing care. During interviews, two of the informants cried as they expressed their difficult experiences. Some of the respondents viewed these feelings positively as making them strong, feeling good, listened to by other members of the health team such as doctors, experienced professional nurses, and patients. One informant expressed that she felt good about being an advocate for a pregnant woman. The inability to deliver care to the expected standard translated into the emotions of frustration and demoralisation (Higgins et al 2009:506).

Those who have not yet worked in the busy areas such as the labour ward expressed their fears of being allocated to those wards. There was also the feeling of guilt induced by the fear of medico-legal occurrences that may lead to disqualification from the profession.

The responsibility and accountability of being a newly qualified professional nurse brought some fears induced by the uncertainty over their coping capabilities, considering the frequency of litigations that are encountered in the midwifery section. The negative experiences exacerbated their stress levels and affected the worthiness of their qualification (Whitehead & Holmes 2011:23). Increased stress levels affected the health of these nurses.

(I/8): Stress caused me to have diarrhoea and chest pains. I was referred to a psychiatrist because of anxiety.

The leadership style of one manager was questionable as it caused confusion to the informant. This manager controlled the unit by remote while on leave, with scant disregarding to the designated manager who was allocated to that unit at that particular time.

(1/10): Conflict between managers affects us because we are caught up in-between you don't know who to listen to.

The confusion was also confirmed in the study by Hlosana-Lunyawo & Yako (2013), where the respondents raised issues of non-enforcement of policy guidelines. This situation of confusion resulted in confusion as they received different instructions based on different guidelines from different people.

(I/3): I love midwifery but I am scared to work in the labour ward.

(I/4): You have to take the blame even if it is not your fault and if you fail you are being judge.

(I/5): There is no one to help us. At times I feel like crying.

One of the informants was ashamed to even wear her distinguishing devices /epaulettes because of the lack of confidence, a factor that is in concurrence with the findings of the study by Jackson (2005:27). The study indicated that there were fears that wearing of uniform and identifying themselves as staff nurses would have expectations that they may not live up to.

(I/7): I can't wear my epaulettes. I feel embarrassed.

(I/8): I don't have the love of working in the maternity ward. I don't want to see a pregnant woman. I have lost interest [she was crying].

This feeling was expressed because one of the informants' patients experienced maternal death due to primary post-partum haemorrhage. The same informant also indicated that the incident had taught her to be responsibility, but the hard way.

4.4.3.2 Sub-theme 2: Attitude

Attitude is described as irreverent or resistant behaviour (Louw & Edwards 2011:746). Most of the informants explained the positive and negative attitudes they have experienced from senior to lower categories of professional nurses they worked with and patients that have been in the institution for some time during their community service. Negative attitudes were encountered when their performance was below par due to their neophyte status in the nursing profession. The informants stated that they

were expected to know everything because they were fresh from college. They felt undermined at times as their opinions were not taken into consideration until there was a complication to the patient. This experience was indentified in a study by Du Plessis and Seekoe (2013), which also found that many nurses felt supported.

Some of the experienced professional nurses were approachable and very supportive. Good communication also played an important role in imparting information and enhancing acceptable patient care in the maternity ward. Many of the qualified professional nurses explained that they felt supported and cushioned in the traditional hospital system (Du Plessis & Seekoe 2013:133).

Stress levels were also compounded by competition, intimidation, and lack of respect from the lower categories of nurses who have been in the maternity ward for a long time. Nurses in that category didn't want to be delegated by the newly qualified professional nurses.

Poor patient care affects the reputation of the profession and some ill-treated patients will formulate preconceived ideas about the institution and display negative attitudes. Nurses also do not want to appear "stupid" amongst their peers and fellow health colleagues (Teoh et al 2012:145). The study by Kelly and Ahen (2008) indicated that being ridiculed by senior professionals in front of juniors had an effect in the extent of lack of collegial respect and the formation of cliques that excluded new graduates and lack of respect (Kelly & Ahern 2008; Du Plessis & Seekoe 2013).

(I/7): The nursing sister made a laughing stock of me in front of the clerks ... and sisters with many bars. I don't have confidence now. I have to teach myself and wear my distinguishing devices when I'm sure. There are training assistants who turn our profession into a laughing stock [she expressed this while crying].

(I/8): We are not treated accordingly. We are called "empty bottles of Coke", and that we know nothing. We feel bad about that.

(I/6): Patients come to the hospital with their biased information about the hospital and display unbecoming attitudes. That demoralises me as I am here to help. A positive attitude motivates me to do better.

4.4.4 Theme 4: Competence

Competencies are those abilities and qualities that faculty needs for students to be able to perform as they progress through the curriculum. Such qualities and abilities are specific for each outcome identified (Billings 2012:147).

The aim of the Midwifery Nursing Science course is to prepare the student nurses in both theory and practica, at the end of which they should be competent practitioners who are able to prevent mother and child morbidity and mortality. The informants indicated that they need to know the protocols and policies in order to function efficiently, and this could be achieved by mentoring. Some of the informants felt that the 1,000 hours allocated for clinical exposure for both Midwifery Nursing Science 100 and 200 during training was insufficient to prepare them well.

In order to be sufficiently competent, newly qualified professional nurses need support and guidance from all the stakeholders who are involved in their learning. Challenges such as lack of support, insufficient human and material resources retard their progress towards midwives who can function effectively.

(I/4): I am sufficiently competent in some skills, but need to learn in other areas.

(I/9): I think I am competent. I was able to cope because with emerging problems.

4.4.4.1 Sub-theme 1: Theory

Midwifery is a course that involves application of theory and practice in order to enable nurses make informed decisions concerning their patients. Most of the informants felt that they were well prepared at the college as they had higher levels of theoretical

knowledge and were able to impart and share the knowledge to other midwives on training.

Only one informant felt that she was not well prepared well theoretically.

(I/7): Different conditions of mothers were very challenging. I could not apply theory, had to ask other nurses who did not have time to teach me. I don't have confidence.

(I/8): Theoretically, we are well informed. The only thing is that we need thorough guidance in the third year.

(I/1): All the health conditions were taught at the college, and we are applying them.

(1/6): What we have learnt at the college helped me. I was fast in implementing what was taught. What is good about midwifery is that you can apply what you have learnt, and if there is something that I don't understand, I consult my text book.

4.4.4.2 Sub-theme 2: Practical

For the newly qualified nurses to be competent there should be correlation of theory and practice. The informants felt that during training, their curriculum had not exposed them sufficiently to the requisite skills in clinical areas. They then lacked confidence in their performances, compounded by fear of complications that would lead to litigations. It was therefore imperative that acquired skills be congruent with those needed for professional nursing. Several studies (Ferguson & Day 2007:108; Higgins et al 2009:507) indicated that nurses relied on theoretical knowledge and were concerned with their inadequate technical and appropriate clinical skills, leading to lack of confidence.

The range of skills taught within pre-registration education are less than those required by the newly qualified professional nurses (Jackson 2005:26). In this study, it was found

that the informants had inadequate clinical skills, hence their erosion in confidence, especially in special areas like the neo-natal units.

The structure of the programme disadvantaged the practicals because they would only have the last practice in midwifery in their third year.

(I/2): *We just learn to pass.*

(I/4): *The course as a whole prepared me well, but at college we concentrated on the text book, which is different from the real-life clinical situation.*

During training there was less exposure in specialist areas such as the neo-natal intensive care unit and when exposed they were not allowed to perform some procedures to the neonates like administration of medication, this is challenging when they are now professional nurses because of the expectation to perform. This was also highlighted other studies as novice nurses were given less opportunity to practice under supervision in complex and emergency clinical situations (Teoh et al 2012; Clark & Holmes 2006). New nurses lacked opportunities to learn and practice their development as specialists.

(I/9): *We are not prepared enough from the college. If we only spent more time, especially in the practicals. D4 is very congested to do practica. The real practica we do is during comm. ... serve. That is why we are so challenged.*

4.5 CONCLUSION

This chapter discussed data analysis, interpretation where four themes and eleven sub-themes were identified and findings were incorporated with literature review of other studies.

CHAPTER 5

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Studies on the lived experiences of newly qualified professional nurses have been conducted in other disciplines internationally and nationally, and very few on the lived experiences of midwives.

Chapter 4 discussed data analysis, interpretation and the findings on the lived experiences of the informants. Relevant themes and sub-themes were also identified. Chapter 5 focuses on the findings, conclusions and recommendations.

5.2 RESEARCH DESIGN AND METHOD

This study is guided by the philosophical design developed by Husserl and Heidegger's approach to exploring and better understanding of people's everyday life experiences. The study further focused on how the newly qualified professional nurses adapted to midwifery during their community service. The researcher opted for a phenomenological approach to the investigation, with the belief that the study's truth value is embedded in their experiences (Polit & Beck 2012:494). The Husserl's and Heidegger's model enabled the development of themes and sub-themes from the collected data.

A phenomenological approach aims at advancing an understanding and interpretation of the meaning that the informants attached to their everyday lives (De Vos et al 2005:270).

The Heidegger designs talks of "being in the world", which is the relationship of the informants and the influence of that particular environment on their performance (Welman, Kruger & Mitchell 2012:191). The descriptive phenomenological approach followed the steps developed by Husserl, and it emphasised on the detailed description of human experience, which enabled the researcher to obtain a more comprehensive

understanding of the informants' lived experiences during their day-to-day activities in the different areas of the maternity sections (Polit & Beck 2012:494).

Data was qualitatively gathered by means of in-depth unstructured interviews from the 10 newly qualified professional nurses sampled through purposive sampling, during their community service in the midwifery section. The interview sessions lasted 30-45 minutes, and they were all exposed to one open-ended 'grand tour' question which allowed them to provide more responses than entailed in the original question asked. Data was captured by means of field notes, the use of audio tape and transcriptions, reading and re-reading of data as well as intensive interpretation and analysis. Trustworthiness was maintained by following Lincon and Guba's model (Polit & Beck 2008:539).

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

The researcher was prompted by her own concerns and observations to find out more about the lived experiences of the newly qualified professional nurses during community service in a midwifery section. The research findings revealed that the informants (coded as I/1 to 1/10) shared the same experiences as summarised in the major themes and sub-themes, as well as referenced support from other studies. The themes and subthemes complemented each other; for instance:

- Reality shock
- Emotional reaction
- Organisational
- Competency

5.3.1 Reality shock

The findings revealed that the newly qualified professional nurses were in a state of reality shock, stressed, and overwhelmed by levels of responsibility and accountability when they encountered the conditions they were exposed to in the clinical areas. These conditions had the potential to compromise the delivery of quality care to both mother and child, and also affected their psychological well being. This will hinder the attainment of millennium development goals four and five .These findings were

consistent with the findings of other researchers; for instance, Whitehead and Holmes (2011:3) and Higgins et al (2009:506).

The experiences in the clinical areas did not match the expectations that they initially perceived (Teoh et al 2012:143). The reality shock was also expressed in the study by Makhakhe (2010), according to which professional nurses in Lesotho expressed intense emotional reaction based on their professional expectation (Makhakhe 2010:52). The transition from being a student nurse to a newly qualified professional nurse exposed them to high expectations and challenges which were never encountered as student nurses (Whitehead & Holmes 2011:23; Maitland 2012:228; Clark & Holmes 2006:1210).

- **Human resource experiences**

There was an increase in the shortage of staff in the maternity section. The shortage was even more pronounced in the specialised areas such as the admissions ward, the labour ward, the theatre, and the neo-natal ICU, all of which are coupled with enormous responsibility and accountability levels and that also compromise patient care. Whitehead and Holmes (2011) found that staff shortages were a major contributor to the lack of support given to the newly qualified professional nurses. Time pressures and low staffing levels meant they were unable to meet their targets and expectations in practice. Patient care and safety may be compromised by such a state of affairs (Higgins et al 2009:506; Thopola et al 2013:8).

According to the Scope of Practice of the Midwife Regulation 2598 and Regulation 2488 (regulation relating to the condition under which registered midwives may carry on their profession) prescribed by SANC (1991), newly qualified professional nurses functioned under pressure and do not perform their duties as expected by these regulations. This also increases their stress levels and migration to other sectors of employment after completing community service. This exacerbates the problem of shortage of staff as expressed some informants.

- **Material resources experiences**

There is a shortage of equipment and drugs at times, which has a negative impact on the performance of newly qualified nurses. Instead of promoting good maternal health

and neo-natal care across the spectrum of midwifery, these shortages increased complications leading to medico-legal hazards and accountability to the South African Nursing Council.

Newly qualified professional nurses could not execute the procedures they were taught, resulting in stress, confusion, and frustration (Makhakhe 2010:39). Zonke (2012) found that to be true also in the psychiatric wards. These nurses' experiences were further compounded by shortages of medication for PHC (Primary Health Care) administration, which rendered the nurses ineffective in their work and became a burden to some of the clients (Hlosana-Lunyawo & Yako 2013:9).

The shortage and poor condition of equipment is time-consuming, as nurses have to go around and ask for the equipment in other areas for execution of midwifery interventions. If genuine resources are unavailable – such as stitch packs for suturing of an episiotomy, injecting needle to cut the umbilical cord during delivery – serious danger can be posed to the well being of both mother and child such as maternal and neonatal birth injuries . Frustration and demoralisation contribute to the inability to deliver quality care to the expected standards (Higgins et al 2009:506).

- **Overcrowding experiences**

There is an increased number of patients in relation to the capacity of the units and the staff to provide satisfactory services. Coupled with poor support systems, newly qualified professional nurses seemed not to cope well with these increased numbers. Total patient care is compromised under these conditions, as patients seemed more only in the event of a complication; such as patient with pre eclampsia only being observed when she is presenting with an eclamptic fit. Some patients with post-caesarean section will come from home with septic wounds leading to puerperal sepsis. These are the priority conditions that increase maternal and neo-natal mortality if precautionary measures are not taken. Failure to prevent and manage complications resulting in litigation due to increased overcrowding challenges, could prevent the aim of meeting Millennium Development Goal number 4 and 5 by the year 2015.

The researcher found that there was increased stress levels amongst the staff, working under pressure, burn-out, fatigue, increase absenteeism in the labour ward, lack of

interest in working in the maternity section, all accounted to attrition of the newly qualified midwives to other disciplines on completion of the community service period. If not addressed, a vicious cycle of staff shortages would continue unabated (Kruse 2011:2).

Many participants described the labour ward as a busy, high risk environment where normal birth was a rare event (Fenwick et al 2012:2056). There was an opportunity for learning for the neophyte midwives, because the research site was a level-three hospital where patients presented with different conditions, which in itself is an opportunity to gain experience of managing different conditions. Informant (I/10) expressed that the opportunity to learn was limited. She also felt pity for the current students, because they were treated as part of the workforce. These negative experiences exacerbated their feelings of stress and affected their perception of their qualifications (Whitehead & Holmes 2011:23).

5.3.2 Emotional reaction

Transitioning from being a student nurse to the role of a newly qualified professional nurse brings with it huge responsibility and accountability. One of the informants described the experience as “horrible”, which resonated with the findings of other researchers (Maitland 2012:21). Nurses were overwhelmed by the conditions to which they were exposed. Emotions were brought about by uncertainty, fear and lack of confidence, especially when there was lack of support from the experienced professional nurses and other stakeholders such as doctors.

The researcher found that poor working conditions and negative attitudes received from some of the staff members brought some mixed feelings from the informants who were demoralised about their inability to provide the care that was expected of them.

The labour ward was the most feared area because of the complications and litigations that some have encountered. Two of the informants thought of leaving the maternity section after completion of community service. It is apparent that this will lead to increased attrition rates in the maternity section. However, the spectre of the ever-present medico-legal possibilities engendered fear and loss of interest in midwifery.

Hence such negative experiences affected the health status of the informant, which further contributed to absenteeism and shortage of staff.

- **Attitude**

The researcher found that there were positive and negative behaviours that were portrayed by other members of staff, as attested to by the study of (Maitland 2012:38). Good communication from all members of the health team enhanced smooth running of the public health institution. Some members of staff portrayed a positive attitude towards the newly qualified nurses by being very accommodative when they needed help on issues related to patient care, especially those nurses who worked in other areas such as the ante-natal care and post-natal care wards.

The researcher also found that there was poor communication amongst other members of the staff who displayed negative attitude towards the newly qualified professional nurses. Auxiliary nurses who had been in the institution for a long time, refused delegation of duties from the newly qualified professional nurses. They were ridiculed in front of their juniors when they experienced a knowledge deficit during nursing intervention, being reminded that they were from training, and that they were supposed to be well informed. Findings revealed that participants experienced bullying and conflict with other nurses, while nurse managers isolated them from the experienced nurses (Kelly& Ahern 2008:916). One of the informants indicated that the experienced nurses would isolate themselves, and be at the nurse's station; they would only come to their assistance when there was a complication, which also compromised mother and child quality care. In areas where there was adequate support and positive attitude from other staff members there were no complications.

Some of the experienced professional nurses questioned or doubted the competency of the newly qualified professional nurses who trained under the SANC's Regulation 425. The neophyte nurses were told that they merely obtained many bars, but had very little knowledge to attest to their qualification. These derogatory and degrading remarks impacted negatively on the neophytes' morale and confidence. This indicates that some senior professional nurses undermines the knowledge of professional nurses that trained under the South African nursing Council Regulation 425.

5.3.3 Organisational

The researcher's findings in this aspect related to poor structures in the clinical areas and the educational institution, which were not properly in place to enhance the smooth transitioning of the newly qualified professional nurses.

- **Orientation**

Orientation of the newly qualified professional nurses to the areas of employment was minimally conducted. In other areas such as the labour ward and the neo-natal ICU and theatre, it was not thoroughly conducted. It was very challenging for the newly qualified professional nurses, as at they had to be asking whenever they had to perform their duties, such as the use of equipment. This situation was attributed to shortage of staff and overcrowding. Poor orientation was also cited in the study by Thopola, Kgole and Mamogobo (2013).

Orientation was conducted when there was a problem, which at this stage may not only affect an individual but other members in the unit and the institution. It was for this reason that the newly qualified professional nurses felt that they were put "in the deep end" of learning the hard way. They had expected formal orientations in each ward they were allocated. Induction of personnel was also stated in the condition of service. A welcoming and pleasant orientation was noted in areas where there was less pressure of work, such as the ante-natal and post-natal wards.

- **Mentoring**

A smooth transition from newly qualified to experienced professional nurse is facilitated by an environment where newly qualified nurses' first place of entry to work is concomitantly conducive to such a transition (Whitehead & Holmes 2011:23; Higgins et al 2009:508).

The study by Maben and Clark (2005) demonstrated that it was important to work as part of the team and having one's values and judgement recognised. The culture of support is important to enable successful transition (Jackson 2005:30; Higgins et al 2009:508; Clark & Holmes 2006:1217; Clements, Fenwick & Davis 2012:161). It is also

mentioned that effective mentoring is not a one-way activity, it is rather a professional relationship to encourage effective problem solving, nurture supportive liaisons, and increase self-efficacy for both parties (Lekhuleni, Khoza & Amusa 2012:63).

The researcher found that mentoring was poorly applied, or lacking in some midwifery areas as most of the informants expressed no support from the stakeholders they were allocated with. This lack was more pronounced in the labour ward. The observation of poor mentoring also resonates with that of other researchers who had observed poor support of newly qualified nurses (Maitland 2012; Holmes & Whitehead 2011; Hlosana-Lunyawo & Yako 2013; Thopola et al 2013). Older nurses were more difficult to work with, and were less inclined to provide assistance or guidance to new graduate nurses (Kelly & Ahern 2008:913).

There were conflicting expectations from both parties, where the experienced professional nurses expected the neophytes to know everything in the unit, as they were fresh from training. On the other hand, the newly qualified nurses expected mentoring from their seniors, in order for them to be confident and to function effectively. This expectation would address the one-year gap during which they (neophytes) did not do midwifery prior to their commencement of community service. This development is in agreement with other studies which confirmed that new nurses relied on the expertise of others, frequently seek guidance, questioning their own ability to contribute to the goals of nursing unit (Ferguson & Day 2007:108).

The non-supportive environment increased anxiety and stress levels of the newly qualified professional nurses, hence one informant was faced with challenges that led to maternal death, and two of the informants felt they were being “thrown at the deep end” (Whitehead & Holmes 2011:23; Kelly & Ahern 2008:915).

Some senior staff were regarded as being of no assistance. This prompted two of the informants' views that they were no longer interested to work in the maternity section. They intimated that they were waiting for the completion of the period of community service and thereafter leave that particular public health institution. Supportive environments help to facilitate post-registration development for nursing practice, and also to retain newly qualified nurses in practice. Unsupported graduates became less satisfied and less committed to remaining within an organisation or profession (Kelly &

Ahern 2008:911). Ultimately, improved quality patient care would have been served justifiably by supportive environments (Higgins et al 2009:508).

In areas where informants were supported by the experienced nurses, especially in the ante-natal and the post-natal wards, decreased stress levels, smooth running of the unit, and less complications were encountered.

- **Allocation**

The researcher found that the informants were concerned as they were not being rotated in their allocated areas, a factor which disadvantaged them from acquiring knowledge of working in different areas in the maternity section. Being allocated in one area for two years hindered their development and highlights of the area of interest in the profession. Allocation to other areas on relief basis and with no support from the experienced staff members was a nerve wrecking experience to the newly qualified professional nurses. This is contrary to the study by Kelly and Ahern (2008), in which the findings indicated that ward rotations led to a renewal of anxiety and apprehension, as well as and doubt in the minds of some informants. The findings in the study of Teoh et al (2012:144) were that the rotation of newly qualified professional nurses through several clinical areas throughout their transition may be potentially disruptive to their nurse-to-nurse relationship

Three monthly rotations to different area were suggested so that these nurses could learn and build confidence during the transitioning phase. Informant (I/7) indicated that it would be better if they were allocated with a colleague for moral support. This latter observation was in agreement with the findings by Maitland (2012:2), that a sense of support was derived from others who were in the same situation. Rotation of the newly qualified professional nurses during community service will enhance development.

- **Curriculum**

The curriculum process of the college also impacts on the competence of the learner (Chabeli 2005:41). The structure of the nursing curriculum as stipulated by SANC's Regulation 425 states that Midwifery Nursing Science is commenced at second year and completed at third year, leading to a one-year gap in which they were not in contact

with midwifery when they were in their fourth year. At that time, they were exposed to Psychiatric Nursing Science and Community Nursing Science.

This has a negative impact on their commencement of working as professional nurses in the midwifery section, where some of them would have totally forgotten about midwifery and lacked confidence (Clark & Holmes 2006:1217). This situation caused stress and anxiety, which would have been crucially alleviated by orientation and mentoring in the stages of transitioning to experienced professional nurses (Whitehead & Holmes 2011:1; Ferguson & Day 2007:108).

There were different suggestions from the informants regarding the positioning of Midwifery Nursing Science in the programme. There was a strong feeling for the Midwifery Nursing Science programme to continue to the fourth year, and not to be combined with other courses. Such a continuation would enable them to benefit from recency of information and knowledge, and pre-empt the congestion of the current structure.

It was further felt that the current positioning of the Midwifery Nursing Science did not prepare them sufficiently to be confident and competent in the clinical areas. Nursing and midwifery students could not link learning at the college and in practice settings, unless they occurred within a fairly short period of time (Maitland 2012:42).

The experienced professional nurses had high expectations from nurses who qualified under this programme, although these expectations were expressed condescendingly. Unrealistic expectations by clinical staff could also become a source for stressful experiences (Ferguson & Day 2007:108; Whitehead & Holmes 2011:1).

The integrated approach to training of nurse professionals, which includes midwifery, has a devastating effect on the on the quality of midwifery because those who are not interested in midwifery were compelled to study it because of incorporation in the curriculum (Motlolometsi & Schoon 2012:784), with the consequent poor outcomes to midwifery care.

- **Competence**

Competency involves theory and practical aspects and is complemented by the incorporation of sub-themes such as support and improved communication within the environment. The findings of this study indicated that informants felt more competent during the second year of community service. Lack of human and material resources hindered their progress. Their training has not equipped them with knowledge skills or confidence for independent practice (Clark & Holmes 2006:1210; Jackson 2005:26). The support of experienced professional nurses was critical in this regard. One of the informants indicated that it would be better for the nursing education institutions to support them during this phase. Lukhuleni et al (2013) also emphasised that mentors should guide and support new qualified professional nurses as that would enhance improvement in their competence.

Theory

Most of the informants indicated that they were well prepared in nursing and midwifery theory at the college. Their only challenge was that they only needed practical guidance. One informant cited that she could not cope well, as different conditions in the ward were very challenging.

- **Practica**

The researcher identified that some of the newly qualified professional nurses had insufficient skills to practice midwifery. They indicated that the curriculum did not expose them sufficiently to the clinical areas, and that the gap of one year between the third and the fourth year of study caused further challenges. Consequently, they were not confident in the performance of duties and required guidance – as was attested to by one of the informants who cited that she had a challenge of suturing an episiotomy. Higgins et al (2009:506) and Clark and Holmes (2007) stated concerns about the level of practical skills attained at the point of registration. The very concept of the very same lecturers accompanying students to their clinical area without clinical mentors at the service has negative implications on the practical part because these lectures had to attend to their class as well.

During their training, they were not allocated in areas such as the neo-natal intensive care units. If allocated, they were not allowed to perform some tasks, which became a challenge when they were became professional nurses who were expected to be proficient. One informant cited that the only time she did her practical was during community service. This was also highlighted in other studies by Teoh et al (2012:14); Clark and Holmes (2006:1214); and Hlosana-Lunyawo and Yako (2013). New nurses lacked opportunities to learn and practice their development as specialists.

It was also highlighted in the study by Duchscher (2008) that new graduates entering the workforce have neither the practice expertise nor the confidence to navigate what becomes a highly dynamic and intense clinical environment burdened by escalating levels of patient acuity and nursing workload (Duchscher 2008:441).

5.4 CONCLUSION

Studies have been conducted internationally and nationally on the lived experiences of the newly qualified nurses in other disciplines such as psychiatric and general nursing. Few have been conducted in midwifery. According to Kruse (2011:31), the South African Nursing Council reported that the number of registered nurses registered with them is higher than the number of nurses required to execute primary health care duties. A 28% decline in the number of newly qualified professional nurses and 20% of those completing their community service intended to leave after completing community service. There was an inter-relationship with the themes that emerged from other studies, which was what initially prompted the researcher to explore and describe the lived experiences of the newly qualified professional nurses during their community service in the midwifery section of a public health institution, and further make recommendations with regard to the support of these nurses during their transitional period.

Data collection was conducted through un-structured interviews. The major problems that were identified included shortage of human and material resources, overcrowding, poor support systems, as well as the structure of the curriculum for student nurses who are training under the aegis of the SANC's Regulation 425. The most highlighted curriculum-related problem was the placement of midwifery in the second and third

years of study, as the gap between the third year and the commencement of community service.

5.5 RECOMMENDATIONS

Recommendations were made with the view to overcoming the challenges experienced by the newly qualified professional nurses. These recommendations are based on the findings of the study, and some of the recommendations were highlighted by the informants during data collection. These recommendations are thematically focused on three areas: the practical, the nursing institution, and further research.

5.5.1 Practical

- The Gauteng Department of Health (GDH) must consider provision of adequate staffing in relation to the number of patients.
- The GDH should consider an agency system to assist in relieving staff shortages.
- Adequate resources should be procured in time and maintained in order to prevent time consuming and medico legal hazards that might occur during implementation of midwifery care.
- Induction programmes in the units or wards should be conducted to all staff members in order that the staff is acquainted with all the activities, protocols, procedures and policies of the units in order to render positive outcomes of patient care.
- Allocation of newly qualified professional nurses to different areas during community service, in order to gain experience. Implementation of strategies such as clinical rotation through different maternity settings provides opportunity to keep skills and consolidate their practice (Clements et al 2012:156).
- Mentoring from all the stakeholders that are allocated with the newly qualified, in order to build confidence and development of newly qualified nurse to provide quality of care to both the mother and child.
- Continuous in-service education and effective development programmes, in order to equip them with all necessary information and skills that will assist them to be effective and efficient (Hlosana-Lunyawo & Yako 2013:2).
- Adhere or revive the teaching role of a professional nurse by the experienced professional nurses (information sharing) in the unit for support, in order that they also acquire knowledge from the newly qualified professional nurses.

- Ensuring respect from all categories of the staff; leaders generate awareness of newly qualified professional nurses to other members of the health team.
- In-service education on communication skills, this will also address attitudes in the work place as this will promote professionalism and increase morale of the staff.
- Exposure of student nurses to all the procedures in high risk areas such as the neo-natal care unit with guidance during the implementation of midwifery interventions; this will help them when they are qualified professional nurses.
- Experienced nurses should recognise the value of their own expertise and clinical judgement, and learn ways of transferring that experiential knowledge to new nurses (Ferguson & Day 2007:112).
- Skills drills in Essential Management of Obstetric Emergencies (ESMOE) by newly qualified professional nurses as a reminder and improvement of competency.
- Display of the student's learning outcomes in the ward, as this will assist the experienced professional nurses to acquire knowledge of what has been previously learnt by the newly qualified professional nurses, and that would also enhance support to them.

5.5.2 Nursing education institution

- Placing Midwifery Nursing Science 100 in third year and Midwifery Nursing Science 200 in the 4th year. At this point they would have attained most of the nursing concepts, which will also increase their confidence as the knowledge of Midwifery Nursing Science will be current when they became registered professional nurses.
- Midwifery nursing Science 100 and 200 placed at 4th year, and not integrated with other courses as some of the informants indicated that this comprehensive course is congested, some of the outcomes are not grasped.
- Introduction of a clinical teaching model that will allow sufficient time of the preceptors to accompany students in order to correlate theory to practice and develop cognitive and psychomotor competencies.
- Follow up programmes of the newly qualified professional nurses should be implemented to enhance support.

- Students should be placed in specialised neo-natal intensive care units during their final year of the course, so that they are not challenged when they qualify as they are expected to provide care on registration.

5.5.3 Research

- A comparative study should be conducted of professional nurses trained under the SANC R425 and those who trained under the SANC regulation for the course for the Diploma in Midwifery for registration as a midwife Regulation 254 of February 1975 as amended.
- A follow up study should be conducted when they have completed community service to ascertain if there are any performance changes.
- Experiences of the senior professional nurses to the newly qualified professional nurses should be documented and implemented. That will give us an indication of how the experienced professionals view the quality of services rendered by newly qualified professional nurses.

5.6 CONTRIBUTIONS OF THE STUDY

The study will contribute towards improving both nursing services and nursing education and heighten awareness on the experiences of professional nurses.

The South African Nursing Council statistics of July 2003 to July 2008 reflect the misconduct cases of the registered midwives. The statistics indicated 128 mother and child cases, which reflects more litigation on the midwifery section in 2007. Saving Mothers indicated that there were a lot of maternal deaths reported in 2008 to 2010, and the maternal mortality ratio is still increasing than in any of the previous years. The findings of the study will contribute to the reduction of these maternal mortality numbers and aiming enhance the attainment of the relevant Millennium Development Goals related to the improvement of maternal health and reducing child mortality by 2015.

5.6.1 Nursing service

Community service is the period during which newly qualified professional nurses experience challenges in the practical areas before attaining independence during

practice. There should be professionally conducive inter-personal relationship between the newly qualified nurses and all the experienced team members who work with the newly qualified professional nurses.

Managers and senior experienced professional nurses must develop programmes that will assist new nurses during their transitional period, and engender positive implications in the profession. The developed programmes must include appropriate support systems (such as material and human resources) during the transition period, attend to issues of staffing to be congruent with the number of patients.

5.6.2 Nursing education

The positioning of Midwifery Nursing Science should be restructured in order to eliminate the gap between the completion of the above-cited course and the placement of newly qualified nurses. This recommendation is necessitated by the fact that newly qualified professional nurses face the challenge of being truly professional midwives.

Follow-up programme should be developed to assess the coping skills of newly qualified nurses for support in moments when they found it hard to cope in the clinical areas. Such programmes will also assist in planning for the specialisation in areas of interest of the current students in collaboration with other practitioners in the clinical areas. The college should collaborate with the staff in the clinical area in the placement of students in specialised areas during their training.

5.7 LIMITATIONS OF THE STUDY

The following identified limitations relate to the aspects of the study on whose basis the research topic would have been greatly enhanced:

- The study was conducted in only one public hospital, focusing on nurses in a particular category (that is, those who had studied for the Diploma in Nursing (General, Psychiatric and Community) and Midwifery), derived from the SANC's Regulation 425, which limits the generalisability of the findings.
- Data collection was conducted by means of un-structured interviews by the selfsame researcher who was a lecturer of the selfsame participants. A possible

likelihood is that the participants would have been uneasy to talk about issues relating to the nursing institution.

- The researcher experienced technological challenges with the audio tape recorder during two interview instances; backup written notes were available, but could have missed the originality of the research milieu.
- For informants who could only be interviewed during the lunch hour, the researcher sometimes found that they were still busy with work-related interventions. Rescheduling the missed interviews congested the interview timeframes and subsequently restricted the interview atmosphere of its ambience.
- Only female informants were interviewed in the study. The absence of male informants at that time due to their placement elsewhere has the potential to render the study gender biased.

5.8 CONCLUDING REMARKS

The newly qualified professional nurses necessarily constitute a significant part of meeting the MDGs relating to the improvement of maternal health and the reduction of child mortality by 2015. The study identified that there were multiple factors affecting the professional development and performance of newly qualified professional nurses. At the educational institution selected as the research site, newly qualified professional nurses seemed to lack some of the pre-requisite knowledge at the commencement of registration due to Midwifery Nursing Science being placed in the second and the third years of study in accordance with the structure of the curriculum.

Recommendations in the study have been made primarily in the context of the nursing education institution selected as the site of research; the sphere of nursing practicals; as well as the sphere of future research on the topic under investigation.

The sphere of nursing practicals addresses the environment within which newly qualified professional nurses are expected to acquire and accumulate competency, as well as improve professionally and experientially. In contradiction, this was an area in which it was found that the newly qualified professional nurses encountered human and capital resource challenges, poor mentoring, and a dearth of continuous development strategies. The latter state of affairs negatively affected the newly qualified professional nurses' confidence and satisfactory performance of their duties. The

researcher also found that it was unrealistic to expect the newly qualified professional nurses to be independent and competent soon after being placed in their clinical areas at registration, with little or no support from the experienced professional nurses. Some of the challenges experienced were viewed as opportunities to learn, while other challenges demoralised some of the newly qualified professional nurses to the extent that they seriously considered leaving the maternity section.

The implications of the research findings are that failure to restructure the Midwifery Nursing Science will have an adverse effect in meeting the MDGs relating to the improvement of maternal health and the reduction of child mortality by 2015, as well as the migration of midwives to other sections or disciplines on completion of their community service period. A vicious cycle of competent staff shortages will continue to prevail in the maternity section.

The implementation of the stated recommendations will yield significant improvement in the nursing profession in general, and the training of midwives in particular.

The research findings are confined to one academic institution, which may directly limit the extent of generalisability.

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ANNEXURE A: REQUEST TO UNISA RESEARCH ETHICS COMMITTEE

127 Peggy Vera Road
Kibler Park
2091
30 October 2012

The University of South Africa
PO Box 392
UNISA
0003
Ethics Committee
Sir /Madam

Re: Permission to Conduct Research

I hereby request permission to conduct research in one of the Gauteng academic Hospital i.e. Chris Hani Baragwanath Academic Hospital Nursing on **“Lived experiences of newly qualified professional nurses doing community service in Midwifery section.**

I am a student at University of South Africa (UNISA), studying Masters in Nursing Science. I am required to conduct research and submit a dissertation as a requirement for my study. The aim of this study is to describe the lived experiences encountered by the newly qualified professional nurses and to identify gaps and make recommendations with regard to their experiences to the policies and curriculum development.

Find attached research proposal.

Yours sincerely

BJ Ndaba
Telephone: 011 943 2597
Mobile: 0834458361
ndababoniswa@gmail.com

ANNEXURE B: REQUEST TO GAUTENG DEPARTMENT OF HALTH

127 Peggy Vera Road
Kibler Park
2091
30 October 2012

Gauteng Department of Health and Social Development
Private bag X35
Johannesburg
2000

Sir /Madam

Re: Permission to Conduct Research

I hereby request permission to conduct research in one of the Gauteng academic Hospital i.e. Chris Hani Baragwanath Academic Hospital Nursing on "**Lived experiences of newly qualified professional nurses doing community service in Midwifery section.**"

I am a student at University of South Africa (UNISA), studying Masters in Nursing Science. I am required to conduct research and submit a dissertation as a requirement for my study. The aim of this study is to describe the lived experiences encountered by the newly qualified professional nurses and to identify gaps and make recommendations with regard to their experiences to the policies and curriculum development.

The study will take the form of interview to newly qualified professional nurses who are willing to participate in the study.

Based on the findings of this the recommendations will be made to enhance positive development and have input in the development of policies in nursing education and in practice. The final report will be made available after the study.

Find attached research proposal and ethical clearance form the University of South Africa.

Yours sincerely

BJ Ndaba
Telephone: 011 943 2597
ndababoniswa@gmail.com

ANNEXURE C: REQUEST TO CONDUCT RESEARCH AT CHRIS HANI BARAGWANATH HOSPITAL

127 Peggy Vera Road
Peggy Vera Road
Kibler Park
2091
30 October 2012

Chris Hani Baragwanath Academic Hospital
PO Bertsham
Johannesburg
2013

Sir /Madam

Re: Permission to Conduct Research

I hereby request permission to conduct research in one of the Gauteng academic Hospital i.e. Chris Hani Baragwanath Academic Hospital Nursing on **“Lived experiences of newly qualified professional nurses doing community service in Midwifery section.**

I am a student at University of South Africa (UNISA), studying Masters in Nursing Science. I am required to conduct research and submit a dissertation as a requirement for my study. The aim of this study is to describe the lived experiences encountered by the newly qualified professional nurses and to identify gaps and make recommendations with regard to their experiences to the policies and curriculum development.

The study will take the form of interview to newly qualified professional nurses who are willing to participate in the study.

Based on the findings of this the recommendations will be made to enhance positive development and have input in the development of policies in nursing education and in practice. The final report will be made available after the study.

Find attached research proposal and ethical clearance form the University of South Africa.

Yours sincerely

BJ Ndaba
Telephone: 011 943 2597 ndababoniswa@gmail.com

ANNEXURE D: INFORMED CONSENT

You are hereby requested to participate in this research study on the “Lived experiences of newly qualified professional nurses doing community service in Midwifery section” in one of Gauteng Hospital.

Researcher: Mrs. B.J. Ndaba student at University of South Africa doing a Masters Degree in Nursing Science.

Research purpose and benefits:

The purpose of this to explore the lived experiences of the newly qualified professional nurses during the first year and second year of community service in one of the Gauteng academic hospital.

The overall purpose of this study is to explore the lived experiences of newly qualified professional nurses doing community service.

The study will be conducted in the form of recorded interview which will take 30-45 minutes or less. Anonymity will be maintained by not revealing your name on the form. All the information recorded will be kept confidentially.

Based on the findings of this study the recommendations will be made to enhance professional development and contribution to the formation of nursing education and practical policies.

You are under no obligation to participate in this study. Should you change your mind or wanting to ask something about this research please don't hesitate to contact me at 0834458361

Summary of the report results will be made available to you at your request.

If you are willing to participate fill in and sign the attached consent form as required for conducting research.

Ion this day of2013 hereby consent to:

Participate in the study of Lived experiences of newly qualified professional nurses doing community service in Midwifery section in one of Gauteng Hospital.

The following aspects were explained to my full understanding:

- The research purpose and objectives
- I am under no obligation to participate in this study and can withdraw from participating at any time.

- Anonymity and confidentiality of the information will be maintained by researcher.
- No reimbursement will be made by the researcher.

In co-signing this agreement the researcher undertake to maintain privacy and Anonymity of respondent's identity and to maintain confidentiality of information provided by respondents

Respondent's signature..... Date.....

Researcher's signature.....Date.....

ANNEXURE E: CLEARANCE CERTIFICATE FROM THE DEPARTMENT OF HEALTH STUDIES, UNISA



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

HS HDC/141/2013

Date: 6 February 2013 Student No: 569-528-7
Project Title: Lived experiences of newly qualified professional nurses doing community service in Midwifery section in one Gauteng Hospital.
Researcher: Ms Boniswa Ndaba
Degree: MA in Nursing Science Code: MPHCS94
Supervisor: Prof ZZ Nkosi
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved

Conditionally Approved

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

**Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE F: APPROVAL TO CONDUCT RESEARCH AT CHRIS HANI BARAGWANATH HOSPITAL



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

OFFICE OF THE CEO

Enquiries: Dr S. Mfenyana

☎ : 011 933 9145 ; 0862600851

✉:Sandile.Mfenyana@gauteng.gov.za

MEMO

To: MS BONISWA NDABA

From: Dr S. B MFENYANA ; CEO CHBAH

Date: 21/05/2013

Subject: APPROVAL TO CONDUCT RESEARCH :

TITLE: Lived experiences of newly qualified professional nurses doing community service in Midwifery section in one Gauteng Hospital.

Message: Your abovementioned to conduct research at CHBAH is hereby granted/approved. We hereby wish you all the success in your career pathing.

Thanking you ,

Dr S.B Mfenyana:
CEO: CHBAH

Chris Hani Baragwanath Academic Hospital
Chris Hani Road
Diepkloof Ext 6
Soweto

P.O Box Bertsham
2013

Tel: 011 933 8000

ANNEXURE G: APROVAL BY JOHANNESBURG DISTRICT RESEARCH COMMITTEE

UNISA: Boniswa Ndaba - ndababoniswa@gmail.com - Gmail

<https://mail.google.com/mail/?shva=1>

Johannesburg research <johannesburg.research@gmail.com>
to me

9:11 PM (23 hours ago)

Dear Boniswa Ndaba,

Re: Lived experiences of newly qualified professional nurses doing community service in Midwifery section in one of Hospital

Please refer to your application to conduct above research at the Rahima Moosa Hospital, which was referred to the Health district Research Committee. Chris Hani Baragwanath Hospital is a central hospital and does not fall under our Please contact the CEO of the Hospital for approval of your proposal.

We apologise for the delay in responding to your request.

With regards,

Johannesburg District Research Committee

ANNEXURE H: INTERVIEW GUIDE

Interview Guide

“Grand Tour” Questions

- Describe your experience as you are allocated in the midwifery section
- Tell me more
- Is there anything that you think I should have asked you?

ANNEXURE I: INTERVIEW TRANSCRIPT

Informant No.3 1st year operating theatre

Midwifery will be better if it continues up to fourth year ,from 3rd year to 4th year because when we go to clinical we forget .I have realized that I have forgotten some of the things I did in midwifery class ,I have to go back and remind myself how to palpate, there is no time to refer because I have to work ,I am told that I am a qualified sister .I love midwifery but I am scared to work in the labour ward. One sister is nursing 5 cubicles .I don't think I will be able to give thorough care, because of overcrowding and I am not yet experienced .I think I will miss something one is working under pressure .

I thought as a “comm serve” I will work under supervision of a qualified sister, one is on your own, It is difficult, nobody is mentoring.

No delivery pack from the CSSD, no equipment, one had to use the needle to cut the cord. The equipment that is used there is nobody to sterilize due to shortage of staff.

At theatre there is no equipment we use a disposable linen saver , green paper to catch the baby which might tear and cause medicoligal hazard .One is always worried about the medico legal hazard that may occur .

Neonatal theatre I was never orientated, no mentoring, you will only be orientated when there is an adverse effect .I had a child with a distended abdomen sets were 70% ,I did not see that the baby was disorientated and died .

One is not supposed to be alone especially when you are dealing with neonates .I think one needs somebody to mentor you.

At the college, what we were taught was good .I suggest that if it is possible if one is interested in midwifery ,the last courses to be taught should be midwifery.

Overcrowding, no enough beds, some sisters are supportive by helping you when you ask questions .Difficult situation is when the senior professional nurse is aware of the of some of the challenges that we are facing, but when there is a problem will pretend as if she does not know example – no lotion cloth we will use a swab from the scrub sister to wipe the baby, when it is lost, she does not know, you will be left alone with the problem.

Some sisters are strict and supportive and those who are not ok I avoid them .In maternity you don't feel good; one does not have time for tae and lunch, because of shortage of staff. I used to say I will retire in this hospital, I think I must go as well to the clinics unless there is a change .We work 12 hours without tea or lunch.”Lapha ukufa “ It

“was better when one was a student. What is positive, I am free to talk for a patient then I will be listened to by the doctors and sisters, feel good about it.

Informant No. 8: Second year of community service

Areas of exposure High care area, Admission ward, and labour ward and ward

Learn the hard way, no time for orientation, One have to know the geography of the ward and take the clerking sheet for the doctor’s orders to the sister e.g. doctor will be ordering then the sister will be telling you, go and do it and don’t show you how to do it. I would have last seen Magnesium Sulphate in 3rd year, and everything is new now. Delivering alone, the head sister will just say deliver the patient and end up doing the things alone, she is the only sister in charge, there is a shortage of staff in the department.

Other experiences, we are not treated accordingly, we are called “Bottle of Empty Coke” meaning inside you know nothing, we feel bad about that there is pressure of the orders you are given by the sister .when you ask questions from the senior who call themselves “KKM” “meaning Kgale kelemona”, they ask what have you learned at the college, as a result few of them will be showing you, what to do in connection with the patient. Theoretically, we know but the thing is that, we ended up in third year, we just want guidance.

Workload: we are new, we needed the sister who knows the ward e.g. labour ward there is lot of shortage, only four sisters that are allocated and one of them will go to the nursery, three sisters divided amongst twenty cubicles. I was very stressful in the labour ward, I could not cope one is running seven cubicles. You are expected to do your best anyway, “ Kuyashota Kakhulu”there is a shortage of staff, here comes a problem there was a mother with the fetal distress ,it happens by the workload and end up losing the mother. A 31 one year old from Maputo came for delivery, she was 36 weeks of gestation with haemoglobin of 7.8, I took a report from the colleagues, I dripped the patient and put on CTG machine, it had decelerations, showed the doctor .the doctor said she does not want to see the CTG (may be the pressure of the work), then I found one registrar who said I must prepare the patient for caesarean section but at 8cm the mother said “ngiphelwa amandla” there were no doctors around, I went to Theatre the doctor helped to deliver the mother, baby was flat ,the baby was begged, we were three. When I come back from the nursery the doctor was screaming because the mother was bleeding and died due to manual removal of the placenta ,then that was the time the sister were asking Sr What’s wrong? Then I was asked to complete the record of death .It was tough, difficult to accept .I did best as I have saved the baby’s life (but the mother it was the doctor).

When I came back from the offs, things were hot, I was told that my epaulettes will go with water,” you will lose the profession” I told her that you are sister in charge, you are letting us down because you are left alone to do everything alone.

Bad experience: there was this incidence in April of a mother who delivered on the floor with the placenta still attached to the mother. I asked the mother what is happening, she seemed confused, she said this is not my baby, mine was taken by the other sister. Then we cut the cords and took the baby to the nursery, the baby was pink, and shallow cry and we left off in the morning .then when we came back we were called because the mother now said she was asked to go and take the pillow hence she deliver on the floor then we were called to answer to Gauteng and account to SANC for that incident. I feel bad, anxiety, I could not cope at times, I could not go for tea, lunch because one is afraid of leaving the cubicles because of what could happen to the patients.

(She is crying) “I don’t have the love of working in the maternity” “don’t want to see a pregnant woman”, I couldn’t work, anxiety on me, I have lost interest, all in all I have learnt a lot. I have to teach the second and the third years. I do have the knowledge, one have to make decisions, good knowledge from the college, the problem is one is left alone. High care is fine, I have worked for a week we had all those conditions. Ward 57 is a septic ward, caesarean section, it was ok, one have to be alone with the auxiliary ANC ward: fine ok, it is a level three, see patients from clinics with problems. I went to the matron requesting to move me out of the maternity because of bad experiences she refused, I wanted to go to causality. Staffing, labour ward there is shortage of staff, attitude of management and sister, putting a blame but they don’t tell me what I have done. Now I can Know what is on my shoulder, tell myself that I have rendered the service. The stress made me to have diarrhoea that does end. At this time you don’t feel going to work, I will develop chest pain hence I was taken out of the ward. I was referred to psychiatric department because of anxiety (was moved to ANC ward .then the “Kgale ke lemo” will ask “wenza kanjani” because to the gravy train at ANC ward.

ANNEXURE A

REQUEST TO UNISA RESEARCH ETHICS COMMITTEE

ANNEXURE B

REQUEST TO GAUTENG DEPARTMENT OF HEALTH

ANNEXURE C

REQUEST TO CONDUCT RESEARCH AT
CHRIS HANI BARAGWANATH HOSPITAL

ANNEXURE D

INFORMED CONSENT

ANNEXURE E

CLEARANCE CERTIFICATE FROM
THE DEPARTMENT OF HEALTH STUDIES, UNISA

ANNEXURE F

APPROVAL TO CONDUCT RESEARCH AT
CHRIS HANI BARAGWANATH HOSPITAL

ANNEXURE G

APPROVAL BY JOHANNESBURG DISTRICT
RESEARCH COMMITTEE

ANNEXURE H

INTERVIEW GUIDE

ANNEXURE I

INTERVIEW TRANSCRIPT